ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION IN RESPONSE TO THE PRODUCTIVITY COMMISSION ISSUES PAPER *PERFORMANCE OF PUBLIC AND PRIVATE HOSPITAL SYSTEMS*

JULY 2009

The Royal Australasian College of Surgeons appreciates the opportunity to provide comment on the Commission's Issues Paper of June 2009, *Performance of Public and Private Hospital Systems*. The College has a strong interest in the performance of the nation's hospital systems and would like to play an ongoing role in the consultation process.

Terms of Reference

The College notes with interest the terms of reference of this review. In brief it appears that the performance of the hospital systems will be reviewed in terms of:

a) Cost;
b) Rate of hospital acquired infections;
c) Informed financial consent for privately insured patients;
d) Other measures to inform comparisons between public and private systems; and
e) Developments driven by lack of coherent data.

The Productivity Commission appears to be taking a limited view of the complexities of the health sector at a time when there are a number of other significant, and more ambitious external reviews being undertaken. These need to be fully considered. They include the recently released report by the National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*. The College notes in particular some of the background discussion papers that were prepared as part of the NHHRC process and which are salient to issues of performance. The paper titled *The Australian Health Care System: The Potential for Efficiency Gains* is of particular interest, drawing on international experience and drawing comparisons between the various sectors.

The College strongly believes that any discussion of performance should include analysis of the quality of outcomes. This is a complex area, and the Australian Commission on Safety and Quality in HealthCare is currently seeking comments on its proposed National Safety and Quality Framework, which will include key parameters by which to measure performance.

The Issues Paper refers to material produced by the Australian Institute of Health and Welfare (AIHW) such as Australian Hospital Statistics. While the regular reports from AIHW are informative and useful, they suffer from the lack of political will to ensure comprehensive and compatible data sets across the country. Much of the information that the Productivity Commission needs, and which should be readily obtainable, is not available in a reliable form across all parts of Australia. This has been highlighted by the AIHW from the time of its first report.

It is important that any work the Productivity Commission undertakes is fully informed by these other substantial reviews and reports. It would be a highly beneficial outcome if much of the good work currently being undertaken by other bodies, was complemented and supported by the Productivity Commission's work. An outcome involving alternative methodologies and recommendations would only serve to fragment the sector's limited resources and undermine will.

Comparatives between public and private sector

Although the Productivity Commission would be aware of this, it is critical to emphasise that the public and private hospital sectors are driven by different requirements. The core function may be

to assemble infrastructure, workforce and knowledge around the care of patients to improve their health, but the associated “imperatives” have created two very different structures.

The private sector could be portrayed as more focused on its core activity. Historically there has been an emphasis on elective or semi-elective presentations. However, there has also been a growing recognition that patients present as emergencies, and this has seen the development of emergency departments in the larger private hospitals. Patients are also referred by medical practitioners, usually specialists. Consequently another focus of the private hospital sector has been on securing a steady referral of patients, which has driven its development. This has resulted in the expansion of consulting room capacity, enhanced diagnostic facilities and a desire to secure a larger number of independent specialists who regard a particular private hospital as their primary area of activity.

Private hospitals have taken a variety of approaches, from dedicating themselves to certain types of work, such as day surgery or orthopaedic surgery, to providing fully comprehensive care that surpasses most public hospitals. There is an emphasis on making the patient’s interaction with the hospital as smooth and integrated as possible, while support to referring practitioners ensures misunderstandings and administrative errors are minimised. Typically, the ethos of the individual private hospital also includes a commitment to training opportunities, staff support and interaction with external agencies such as universities. Depending on the fundamental philosophy of the hospital, costs can be driven in a number of different ways. A for-profit hospital may try and reduce costs more stringently than a not-for profit hospital which has a commitment to supporting a particular community or to outreach type work.

The demands on public hospitals are substantially more complex. Government funding is deliberately structured to achieve productivity savings, forcing management and staff to be constantly on the lookout for opportunities to cut costs. Areas often targeted for the purpose of cutting costs are the maintenance of infrastructure and the replacement of outdated equipment. There has also been an absolute reduction of beds per capita across Australia over the last 25 years. This has occurred at a time of substantially increased demand for elective surgery and for treatment in emergency departments. It is no surprise that with fewer beds, poorly maintained infrastructure, and impossible demands for both emergency and elective treatment, our public hospitals are now routinely at occupancies of ninety five percent or more. There is considerable international literature indicating that efficiencies and enhanced patient safety are best achieved when occupancy is less than ninety percent, while an occupancy of eighty five percent has been identified as the most appropriate level at which to achieve optimal efficiency, quality care and staff morale.

The major public hospitals’ task is further complicated by their responsibility for a significant amount of training. They are also expected to undertake research, preferably at an international level. With the underfunding of educational activities, the lack of support for supervision and the complexities of maintaining staff profiles in an era of health workforce shortages, areas of excellence are under ongoing threat. Given their crucial role in the community, and the trying circumstances in which they operate, it is little wonder that our public hospitals are often at the centre of political controversy, and daily in the public eye – itself a complicating factor. The need for more beds, new equipment, capital improvement, and support for new initiatives is also a political imperative, which distorts the process of management and opens it up to substantial influence.

Different funding models and different imperatives have created two very different hospital systems. One is usually more focused on its core activities while the other is expected to assume responsibility for many activities that could be regarded as peripheral, although important. The funding model of one is more clearly linked to patient care, where increased activity has produced financial benefit. The funding model of the other is such that increased activity produces a worsening budgetary performance in a complex environment of conflicting requirements and political patronage.

Funding / costing models

Despite its reservations about comparing public and private hospitals, the College does support funding based on outputs. Victoria introduced casemix funding in the early nineties and has substantial experience of it. Concerns are now being expressed that modifications to the various formulae have produced a "multiple layers of band-aids" situation, and the entire program needs to be reviewed. Political intervention has seen distortion of the model, as has the progressive inclusion of areas previously block grant funded. Given the patchy reliability of the various financial feeder systems in the health sector, the actual data integrity of the costing weights always needs to be questioned. An overall review of the program would enable a clearer understanding, and comparison, of the various clinical outputs.

The Productivity Commission raises the issue of comparative tax situations. The College notes the differences between jurisdictions with regard to payroll tax and fringe benefits tax, and the fact that these can apply differently to private and public hospitals. Such differences need to be taken into account when considering issues of cost and funding.

Hospital Acquired Infection

The College has a longstanding interest in hospital based infections, infection control, the use of antibiotics, approaches to hand hygiene and the impact of these on individual patient care. Substantial work over the past decade has again highlighted the importance of system wide approaches to hand hygiene and its impact on key infections like MRSA bacteraemias and Surgical Site Infections. The College would certainly support the introduction of nationwide reporting on some of these key measures. To our knowledge, however, there is no current methodology for this at the individual state and territory level for public or private hospitals.

The College would also caution that while the incidence of bacteraemias can be measured largely from microbiology report data, Surgical Site Infections require clinical review by an experienced clinician. It is not possible to collect data of significance without the involvement of staff trained in the assessment of wounds. This must involve the treating surgeon as well as staff such as Infection Control Nurse Practitioners and Infectious Diseases Physicians. The collection of reports based or administrative based data in this regard produces inadequate comparative reports.

Comparative Indicators

The College strongly supports the use of comparative data sets, the mandatory audit of mortality cases and the more comprehensive development of registries. In particular, we believe mandatory peer review and audit should be prerequisites for hospital accreditation.

Comparative data sets should include such issues as unplanned returns to operating theatres and unplanned returns to intensive care units. Ideally, these can be captured reliably through administrative data sets.

The College continues to raise substantial concerns with the Australian Council on Healthcare Standards (ACHS) over its Clinical Indicator program. Twenty years ago the program was very useful in raising clinicians' awareness of the importance of monitoring clinical outcomes. It provided some useful measures and encouraged audit. However it has relied for too long on administrative data sets with limited clinician involvement, or with limited quality-based clinical activity at the local hospital level. Accordingly, the College no longer supports the ACHS Clinical Indicator program and does not believe it provides a measure of clinical safety.

The College remains a strong supporter of registry or audit activities. Examples include the National Joint Replacement Register supported by Commonwealth funding and undertaken by the Australian Orthopaedic Association (AOA). The Melbourne Vascular Surgical Association (MVSA), through Victorian Health Department funding, produces state-based audit outcomes that are now being made available nationally. The Cardiothoracic Surgeons are also establishing a national audit approach based on the success of the Victoria-wide audit of all cardiac surgery cases. The Breast Audit is available to all breast surgeons in Australia and New Zealand, enabling them to capture data points appropriate to breast cancer surgery and treatment. A number of trauma

registries are being created but a national approach needs to be funded. The CSSANZ is developing an Australian and New Zealand dataset on colorectal cancer surgery. The College co-ordinates the Surgical Mortality Audits that have now been introduced in each state of Australia and will soon begin in the Northern Territory and the Australian Capital Territory. The initial reports of these are available under the Research and Audit Division of the College website at www.surgeons.org

The College has been working with the Australian Commission on Safety and Quality in Healthcare to pilot operating standards for registries. This should enable high quality and standardised datasets to be generated nationally. It should be noted, however, that the issue of funding for audits and registries remains a major challenge.

As can be seen, the use of comparative indicators is in a state of substantial change. This is partly because the value of administrative data sets is limited by the quality of the data. Administrative data sets may be able to produce reliable information on key processes like admissions and unplanned returns. However indicators of clinical activity require active clinical involvement and "ownership". The College remains a strong supporter of the mandatory review of all deaths related to surgical care, mandatory local peer review and audit at a hospital level, and the development of registries for each specialty. The College sees limited benefit in clinical indicators without clinician involvement.

Informed Financial Consent

The College is surprised at the inclusion of this issue in a review of the performance of public and private hospital systems. The College is a strong supporter of Informed Financial Consent and has been involved in a number of educational campaigns to raise awareness of the issue. It is also a measure of professionalism in our code of conduct discussions. Patients have a right to know what costs will be incurred as a result of clinically related activities.

The College does not, however, see this as a measure of private or public hospital performance. It correctly sits with the individual professional group to advise its members to ensure Informed Financial Consent. Previous Ipsos reports have indicated that pressures of time and distance might compromise the quality of communication between healthcare provider and patient, and these areas need to be addressed. However the College would strongly dispute that this is a valid measure of responsiveness on a national basis or a credible measure of private hospital performance.

Responsibility for ensuring Informed Financial Consent should sit with the various professional groups. If these groups have concerns regarding the policy of Informed Financial Consent, they are free to revisit it at a political level.

Indexation of Medicare Levy Surcharge

The College has previously made submissions about the Medicare levy surcharge when it was an issue of public debate (attached). The College supports ongoing indexation and believes the public understanding of CPI makes it the appropriate indexation methodology. Other measures may be more valid but they are not as readily understood by the public.

Ongoing consultation

More than 60% of elective surgery is based in the private sector. The Surgical Education and Training program is based dominantly in the public but increasingly in the private sector. Surgeons are therefore critically concerned about the viability of Australia's health sector, as well as health related education and research. All surgeons are driven to provide excellence in their surgical services and to ensure that these are reviewed on an ongoing basis using reliable and comprehensive measures.

The College would therefore like to be involved in the Commission's ongoing consultation and roundtable process, and thanks the Commission for this opportunity to respond to its Issues Paper.