6 August 2009

Hospital Performance Study
Productivity Commission
LB 2 Collins Street East
Melbourne Victoria 8003

Performance of the Public and Private Hospital Systems – AHHA Submission

The Australian Healthcare and Hospitals Association (AHHA) is pleased to make the following submission to the Productivity Commission's inquiry into the relative efficiency of public and private hospitals in particular.

The AHHA wishes to acknowledge the invaluable contribution of Professor John Deeble.

The inquiry has three main terms of reference, in relation to:

(1) Comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals;

(2) The rate of hospital acquired infection, by type, reported in public and private hospitals;

(3) Rates of fully informed financial consent for privately insured patients in public and private hospitals and the average out of pocket costs for people who do not receive enough information to give that consent.

The Commission will also advise the Government on the most appropriate indexation factor for the Medicare Levy Surcharge thresholds.

This submission is mainly concerned with the first term of reference. The AHHA has briefly addressed the second term of reference in relation to hospital acquired infections and expects that state and territory Governments will provide the best information on this topic.

The AHHA does not have detailed information in relation to financial consent by private patients.
The AHHA also does not have information on the detailed content of the various indictors by which the Medicare Levy Surcharge thresholds might be indexed, other than to say that since the latter are set in relation to the taxable incomes of individuals and family units, their indexation should be that which best measures changes in average incomes over time. It should not, in our view, be used to achieve any particular market structure or any objectives other than those which the Government currently intends in relation to making the system fairer for lower income earners.

1. Relative efficiency

Although efficiency sounds an easy notion to define and compare between the public and private sectors, it is in practice almost impossible to do so at present.

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Conceptually, efficiency should be related to the outcomes of treatment, not just the process; but, since the only outcomes that are recorded are the modes of discharge from hospital, they must otherwise be assumed to be medically equivalent across the sectors at that time. It was agreed at the Productivity Commission's Roundtable Conference in June 2009 that comparisons cannot be based on the performance of particular procedures alone, but on clinically relevant combinations of diagnoses and procedures. This is what hospital DRGs represent and they allow standard methods of measuring hospital activity and allocating costs to be used.

The AHHA agrees with and supports two other conclusions on which consensus appears to have been reached at that meeting:

- First, private freestanding day surgery centres should be excluded from any comparison, just as the emergency and outpatient activities of the public hospitals (which take 30% of all public hospital expenditures) are excluded; and

- Second, that it is impossible to select any subset of conditions and procedures which would be equally representative of the work that public and private hospitals undertake.

The AHHA strongly believes that any valid and acceptable comparisons will only be possible if all of the relevant costs are fully and consistently recorded for both sectors, whoever pays for them, and that all of the factors which determine those costs are taken into account. As is well known, the public and private hospitals serve different populations, do different things, operate in very different ways and are funded differently. For the 86% of public hospital patients who are "public" all operating costs, including depreciation, are included. Only the notional costs of capital usage need to be added, although some minor adjustments may need to be made to make salary costs comparable with those in the private sector.

In comparison the private hospitals provide only facilities, nursing, accommodation services and some drugs directly. Medical fees are paid for separately by Medicare, other public programs or patients, diagnostic services are outsourced, allied health services are provided by professionals in private practice and individual patient prescriptions are covered by the PBS.

There are some sources from which data can be obtained, at least at the aggregate level: for example Medicare data could be sourced on the medical services provided by each private hospital, however this would still not represent the full cost.

Broad calculations suggest that only about 60% of the total costs of private hospital treatment are covered by the published figures. However it is very unlikely that sufficient detail or linkages are available to make comparisons below the broadest level of data, not to mention other considerations as well. For example, most private hospital admissions are elective and pre-arranged for known procedures. In 2007-08 only 15% of overnight admissions were classified as 'emergency', compared with 63% in the public hospitals. That does not mean that all patients admitted through public hospital emergency departments were treated immediately, but it does mean that much of the diagnostic work for them was undertaken by the hospital, whereas in much of the elective surgery it is done outside. A full comparison would have to go outside the hospitalisation period alone.

The AHHA is therefore doubtful if any but the broadest comparisons are possible with present information. However we would be very happy to assist in any way, including by providing advice on how data can be improved for the future. Indeed, the AHHA is keen to see the development of a nationally consistent health outcome data collection that will enable these and other comparisons to made in the future.

2. Hospital-acquired infections

Comparing public and private hospitals on this measure is like comparing apples and oranges because of correlation between private/planned and public/unplanned work. Unplanned work has a higher rate of infection; planned work makes eradication of high risk organisms possible prior to admission. In at least some cases, private hospitals find reasons not to take infectious patients (ie. they say they have no bed). Infectious patients often have a lower return per bed day than elective surgery patients, and of course the infection places the elective surgical patients at risk. The kinds of units in the hospital where significant infections occur tend to be in public hospitals.

Please do not hesitate to contact me should you require further detail on the information contained in this submission.

Yours sincerely

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