NSW HEALTH

Mr David Kalisch
Commissioner
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601

David

Dear Mr Kalisch

Study to examine the Relative Performance of the Private and Public Hospital Systems

I am writing to seek additional information in relation to the above Study. Receipt of further advice will enable NSW Health to make an informed decision about how best to respond to the Study. In particular, NSW Health needs to be satisfied that the methodology will produce an accurate comparison of the relative performance/efficiency of the two hospital sectors. Specific issues are detailed in the attached document.

Issues raised in this correspondence could also be addressed through a more formal submission (following the prompts contained in the Productivity Commission's Issues Paper). However this would not give NSW Health an opportunity to make a considered judgement in a timely manner on the issue of the data to be released/provided for the Study.

At our recent meeting, you and your colleagues advised us that a key purpose of the study was to assess whether government's investment in public and private hospitals was efficient. NSW Health is concerned that the Study methodology in its current form will not allow such an assessment to be made accurately and fairly. To address this issue, NSW Health suggests in the attachment that the Commission should broaden its approach to include a number of other relevant considerations.

It would be appreciated if you could provide advice on these matters as soon as possible. Should Commission staff require further information, the contact in NSW Health is Ms Janet Anderson, Director, Inter-Government and Funding Strategies Branch on (02) 9391 9469.

Yours sincerely

3/7/09

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NSW DEPARTMENT OF HEALTH KEY ISSUES:

PRODUCTIVITY COMMISSION'S STUDY OF THE PERFORMANCE OF PUBLIC AND PRIVATE HOSPITAL SYSTEMS

Scope of Study

NSW Health has long advocated for the development of a level playing field between the private and public health sectors based on the principles of competitive neutrality, equivalence, economic charging and enhanced consumer access to affordable services. Among the issues warranting attention are parity and competitive neutrality between the public and private health systems in relation to private health insurance arrangements. The key elements for consideration include those relating to:

- The reimbursement received for the treatment of private patients in public and private hospitals, the utilisation of private health insurance across the two sectors and the impact (on a cost weighted basis) of the subsidisation of private health insurance on private and public sector activity and costs
- Access to comprehensive services at public and private hospitals. For example, the considerable difference between private and public hospitals in the provision of emergency and intensive care, which is in part related to funding arrangements.
- The ability for the private sector to indirectly "choose" who they treat, to be able to rationalise access and to be inclined to focus on higher volume lower cost patients
- Access to services on a geographical basis and the community service obligations (CSOs) of the public health system. In considering this NSW is not supportive of the intention of the Commission to remove the remote and very remote hospitals from consideration as this will mean that the cost of CSOs and the impact this has on efficiency is largely overlooked.
- Issues associated with the opportunity cost of diverting health funding to the cost of an insurance product (that may or may not be used to fund a health service)

Given the different motivators and incentives across the private and public hospital systems, NSW Health believes it is not possible to accurately assess and compare the efficiency of private and public hospitals without consideration of the above environmental factors. Accordingly we seek to have these items included in the Study.

NSW Health notes that to date approximately 138 of the 552 private hospitals or around 25% have indicated that they will participate in the study. NSW Health needs to be assured that there is a critical mass of private hospitals that will participate and that the process of self-selection will not skew the results.

Types of Efficiency to be evaluated

The Issues Paper notes that although there may also be "insights" provided into other forms of efficiency such as allocative and dynamic efficiency, the Study will focus on productive efficiency. This focus may produce an artificial outcome that does not accurately reflect core differences between the two sectors. In addition the use of a relatively narrow definition of efficiency, particularly in relation to the provision of a "public good", may result in a partial assessment of efficiency.

NSW Health is keen to ensure the study will produce a multi-dimensional view of efficiency, that is, that technical, allocative and dynamic efficiency and any other relevant aspects will be considered. Accordingly, NSW seeks to have allocative and dynamic efficiency included as equal rather than secondary considerations in the Study.

Basis for comparison and DRGs to be considered

NSW Health notes that the Commission is considering expanding the list of DRGs to be compared.

NSW Health did not support the original proposal to select 20 "clinically similar procedures". This was viewed as extremely problematic as the proposed list of DRGs selected for comparison

included only DRGs without complication or co-morbidity. This would have resulted in a simplistic analysis that would potentially ignore the significant differences in the groups of patients treated in public and private hospitals and would focus on services provided to those aged under 65 years.

A comprehensive consideration is required of the clinically different (as well as the homogeneous) groups of patients and services found in public and private hospitals. For example the treatment of patients coded to specific DRGs by private and public hospitals could be assessed against the age profile of patients, a breakdown of services into surgical, procedural, diagnostic and medical groupings, co-morbidities, along with the availability of services on a geographical basis and the patients' point of entry to the hospital (for example planned or emergency).

Dr John Deeble recently undertook an analysis for NSW Health that compared the public and private hospital sectors. Key issues contained in this analysis that relate to the Commission's methodology and need to be further considered are:

- While reported separations data are comparable over time within the sectors, they are not equivalent across them. For the same burden of illness, private hospitals will always report more inpatient separations than public hospitals.
- Comparison of DRGs will only measure the average costliness of cases if private hospitals had the same cost structure as public hospitals. However, they do not have the same cost structure so any comparison is somewhat hypothetical.
- There are significant differences between private and public hospitals including:
  - Private hospitals concentrate on elective surgery and non-major medical cases. They have very few emergency admissions.
  - Private hospitals do not operate the same type of ambulatory emergency services as in the public hospitals and they have significantly fewer older-age 'bed blocker' patients than the public hospitals. In particular, the average stay of patients aged 65 and over is more than 40% longer in public hospitals than in the private sector.
  - Private hospital pathology and radiology services are outsourced, their clinicians work independently through Medicare and their pharmacies can use the Pharmaceutical Benefits Scheme. Most can accept quite complex surgical cases but not the longer stay and more difficult medical patients. Admissions are therefore selective. The older and most complex cases go to the public hospitals.
- Although patients may see it as seamless, the private health sector is much more fragmented than the public one and that can produce quite different reporting. For example, continuous hospitalisation is not essential for many, even most, hospital patients and both public and private hospitals have same-day patients whose subsequent re-admission inflates the reported data to varying degrees (dialysis, for example). However the incentives to subdivide treatment are much greater in the private sector, partly for logistic reasons but also because on the whole (and despite the recent reforms) private health insurance payments usually require an admission before any hospital or medical fund benefit can be paid.

Advice is sought as to how these factors will be accounted for by the Productivity Commission so as to ensure that comparisons are soundly based.

In relation to the use of HCP data and private sector DRG data:
Reported costs are vastly different, the funders share them differently by type of hospital and type of patient, and there are differences in how the hospitals are paid, basically on fee for service in the private sector, and annual budgets in the public sector. They are clearly not comparable.

Public hospital expenditures are all-inclusive but those for private hospitals cover only the costs incurred by the hospitals themselves, mainly for nursing, accommodation and infrastructure. They exclude all medical services (for privately insured patients, paid partly by Medicare, the health insurance funds and patients), prostheses and appliances (paid fully by the health insurance funds) and drugs (shared between the hospitals, the Pharmaceutical Benefits Scheme and patients). Comparability requires that they be supplemented. However it is not clear how the HCP data will be supplemented to ensure comparability.

In relation to remote hospitals:
It is also of concern that issues associated with the provision of services in remote and very remote settings will be ignored given that there are around 160 public hospitals in these areas in NSW. Surely an issue for the Study should be to consider how people with private health insurance who live in these areas (and who may be "forced" into insurance due to Lifetime Health Cover or taxation penalties) access private services.

The Productivity Commission's proposed approach will also largely ignore the overall impact on public hospital efficiency of the public sector's commitment to ensure access to services on a geographical basis and the public hospital community service obligations (CSOs). NSW is not supportive of the intention of the Commission to remove the remote and very remote hospitals from consideration as this will mean that the cost of CSOs and the impact this has on efficiency is largely overlooked.

End Product
It is unclear why information needs to be published on a State/Territory basis given that the intent of the Study is to compare private and public hospitals. The jurisdiction in which the facility operates should be irrelevant. What is relevant is the geographical location of the facility such as metropolitan/regional/rural.

Multivariate Analysis
NSW Health notes that the Commission intends to use a number of different complexity indices to compare efficiency and that this is likely to be an improvement on previous studies.

It is assumed that these measures will capture the very different patient profiles across the two sectors, different points of entry which influence complexity (for example emergency departments), and different services offered by different facilities (such as teaching and research).

A related issue is that the measures are not widely used across the health system and this issue may need further consideration in light of measures that the Australian Government is planning to use to evaluate the effectiveness and efficiency of the health system.

Informed Financial Consent (IFC)
NSW Health notes that IFC is included along with patient satisfaction as an indicator under "Responsiveness". It is not clear how IFC will be used to assess efficiency or effectiveness, let alone responsiveness.

An associated measure should be utilisation of private health insurance in the context of the number of people with insurance and the level of incentives for people to have, and to use their, insurance.

Indexation of the Medicare Levy Surcharge (MLS)
The indexation methodology chosen could create a perverse outcome. For example, Private Health Insurance Funds are likely to advocate a relatively high rate of indexation so that fewer people reach the threshold.

It is unclear how the Productivity Commission will factor in the impact of changes to the Medicare Levy Surcharge Threshold levels on public and private hospital service provision. Without such a consideration it will be difficult to determine a suitable indexation regime.

Furthermore, although the Study may be determining ways to index the threshold levels, it is not clear whether it is going to consider if the changes in the thresholds are likely to have any impacts on utilisation of private health insurance in the public and private sectors and the effects on activity. Clarification is sought on this matter.