Private and Public Hospitals: Productivity Commission Discussion Draft October 2009
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- To improve transparency, accountability and performance reporting within the health system – with nationally consistent performance reporting for public and private hospitals in terms of performance, safety (hospital-acquired infections) and efficiency
- And consider comparative costs; and informed financial consent in the private system

The purpose is to provide a safe and effective health system in Australia that is available to all Australians.

In the following brief document I have used the overview to focus the points that come out through my reading of the Discussion paper from a consumer perspective. The paper is long and has a lot of repetition but is an impressive amount of work highlighting major collection issues for monitoring health and the health system in Australia.

Overview
Pxxxi: ***Definitions and clarity needed***
Complex health services – that are relatively costly to provide and inherently more risky to patients
Last dot point: More complex conditions and from lower socioeconomic groups are likely to require more intensive and expensive health treatment and be susceptible to hospital-acquired infections

- To the patient/member of the public these ‘riders’ are ill defined – particularly as the human body and mind are complex – so what is the definitions and categories of ‘more complex medical conditions’?
- We are aware that socioeconomic factors have a large impact on health (and may well be considered necessary to address in some instances as part of health care)

Medical staff at private hospitals
One point that did not come across is that many/a number of private hospitals do not have permanently employed/resident doctors who are available at all times
- Where do the costs of bringing medical assistance into the hospital lie, ie with the private patient or the hospital?

Potential stays in hospitals without the required procedures
Pxxxiv, Table 1: would also be useful to have number of beds as well as hospitals by region

I am interested in the last dot point on this page – where ¾ of the episodes of care are in public hospitals and 60/75% of procedures and surgeries are in public hospitals. For me this raises the question of whether public hospitals are actually following through with the required delivery of care within the same episode of care. If so, this is an incredible inefficiency and a cause of a lot of angst for patients and their families.

The definition of elective surgery and procedures is not clinically tight as far as consumers are concerned. I would like you to consider that if these actually went ahead in the one episode of care we would reduce both overall costs and waiting lists.

Evidence medicine
Out of this, I can see the need for national guidelines based on the best evidence available with recommendations on delivery of care across the health system – to address unnecessary variations in delivery of care, use of ineffective practices and transparency in any delays in delivery of appropriate care.

In the discussion paper at present ‘evidence-based health care’ is poorly addressed. If guidelines can be linked to implementation and performance indicators we could also put some wins on the table and start to address outcomes as well as outputs.

Existing comparative performance indicators
The Australian Council on Healthcare Services performance outcome measures may not be complete (ppxlv) - because of their voluntary nature (despite inferences that they should be mandatory) but they are the best comparative data we have at present for determining variations in practice and areas where we the public can have the greatest health gains in services (and transparency).
I would like these used to inform where the clinical practice guidelines are most needed, with input from all stakeholders including consumers and the public.
I suggest if you consider that this is not comparative data you have discussions with the statisticians involved in this work.
Also if this data is so easily dismissed so also should a lot of the data that you have used in the report.

Pxxxvii: `The health care delivered by the Department of Veterans' Affairs is certainly not representative of that available to the whole population, is well researched, which can raise issues in itelf in terms of applicability tooter population, and is only a small proportion of patients.

Prostheses
Pxxxix: Have you compared 'buying power' of public versus private hospitals? This is particularly pertinent to prostheses and the unit cost because of the ordering capacity and negotiating power.

Another concern is that to receive private health insurance payments prostheses have to meet clinical evidence criteria. This is not the case in public hospitals and some prostheses being used in this system are unproven and may not be as safe as well established prostheses documented in the Australian Orthopaedic Association National Joint Registry, for example.

Pl: Have you looked into whether 'internet-based packages provided by specialists to inform patients' are tied to the use of a particular company's product? I would be interested to know who pays for these packages.

Appendices B and C
The National Healthcare Agreement Reporting Structure is an excellent framework
The National Health Performance Framework Indicators for 2003 are a good basis from multi-stakeholder discussions and broadening

- As well as reporting publically to inform the users of health care.