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Submission to the Productivity Commission: Public and Private Hospitals

Thank you for the opportunity to make a submission in response to your draft report. We are an organisation of doctors and medical students which formed in 1973 to support the introduction of a universal health scheme, then Medibank, subsequently Medicare. Our concern is for a health system which ensures justice, equity and quality care for all regardless of social or economic status. We believe that efficiency is an important principle upon which to base a health system but hold grave concerns that, despite the report indicating the use of a broad definition of efficiency, others see efficiency as simply throughput without appropriate outcome measures, or fail to appropriately risk adjust data regarding outcomes.

Data

The interim report of the Commission indicates an appalling lack of data upon which to base its findings and we encourage the Commission in its final report to suggest that a condition of indirect and direct Government funding eg via the PHI rebate, prosthetic fees, drug costs etc, be that relevant data be recorded so that appropriate analysis can be made. Such data however, must be independently audited as much performance data currently available is, in the reported words of an ex Director General of NSW Health, 'not worth the paper it is written on'.

Costs vs Charges

Whilst the comparison of private and public hospital costs is relevant and important, it is not clear precisely how well costs cover actual charges. The report indicates that medical service charges are obtained from the HDC data but charges for hospital services may not be the same as costs, and it is important that the public is informed about charges as well as costs. This is particularly relevant in light of the data presented by Harper et al[1], indicating that private hospital charges were twice the DRG cost in a collocated public hospital. This excluded specialist medical rebates. Depreciation and capital costs were not included in that comparison but at most, such costs are only about 15% of total costs.
If it is found that charges are substantially greater than costs, and costs are equivalent, then that is an important finding in terms of setting future policy or reviewing current spending policies. Thus, if for example charges add 30% to the actual cost of the admission, continuing taxpayer support for private hospital care via the private funding route could reasonably be questioned. This is particularly relevant in light of the other observation by Harper that the taxpayer contribution to the private hospital admission was the same as the contribution to a public hospital admission because of the multiple subsidies to the private delivery of health care in the hospital.

Overservicing

In assessing efficiency, this issue needs some consideration. Studies by Robertson and Richardson[2,3] have demonstrated remarkable variation in the rate of interventions in different local government

areas in Victoria, but also between public and private hospitals eg in regard to angiography, stenting, and coronary artery bypass grafting, all procedures performed to improve circulation to the heart.

Table 6 Ratio of Rates of Angiography and Coronary Artery Revascularisation Procedures in Private Versus Public Hospitals

	Rate ratio (95% confidence interval)*			
	Angiography	Angioplasty/Stent	CABG	Any CARP
Public patients in public hospitals	1.00	1.00	1.00	1.00
Private patient in public hospitals	1.43	1.09	0.90	1.00
Private hospital patients	2.17	3.05	1.95	2.87

* Rates are for all Victorian residents aged 15-85 years admitted to Victorian acute care hospitals with acute myocardial infarction, July 1995 - December 1997, adjusted for age group, sex and half-year of initial admission.

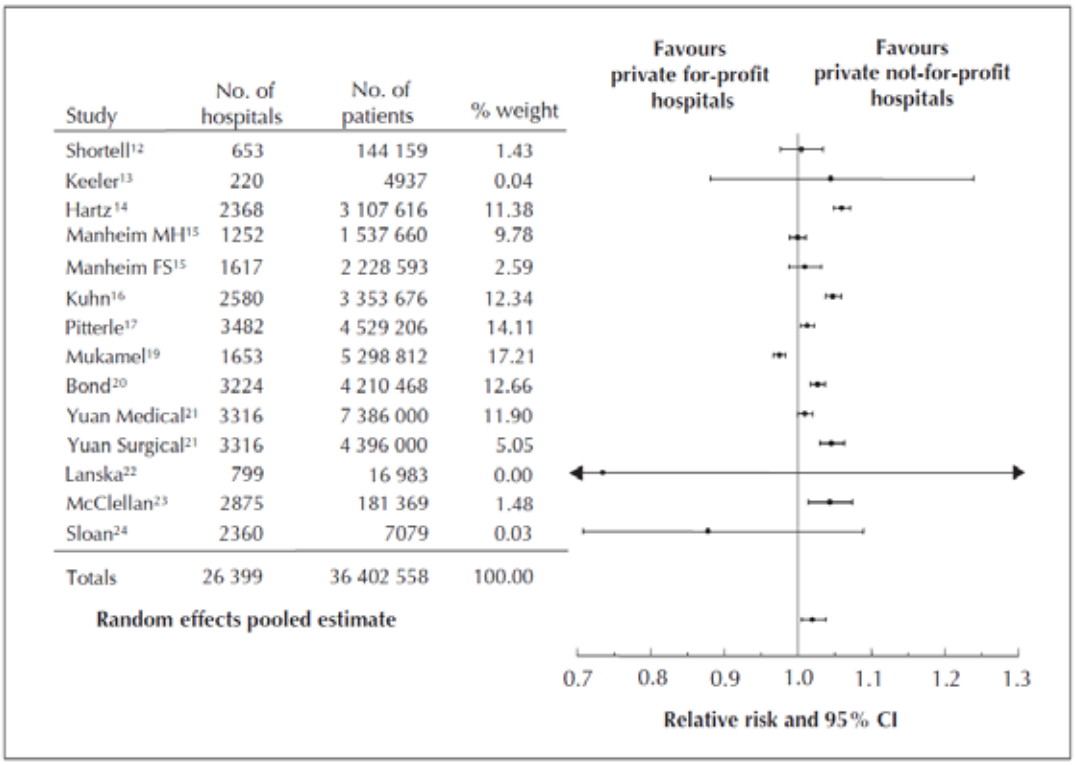
+ Rate ratios are calculated using the Cox proportional hazards model.

CABG = Coronary artery bypass grafting. CARP = Coronary artery revascularisation procedure.

Whilst there is no proof that such variations are due to overservicing, the alternative is gross underservicing in the public system. It is likely that the truth is a mixture of overservicing in the private sector and underservicing in the public sector. Overservicing does impact on both dynamic and allocative efficiency.

Private for Profit vs Private not for Profit

Whilst the terms of reference require a comparison of the private and public hospital systems, we believe that in the light of extensive data available from the USA, there should be a further analysis of the differences in outcomes and costs between private for profit and private not for profit hospitals. Whilst our system is quite different from the USA in many respects, this data from Deveraux et al[4], looking at 36 million patients demonstrated that case adjusted mortality in for profit hospitals (and renal dialysis centres), is higher than not for profit hospitals, as the following extract from this meta-analysis summarizes.



Study	No. of hospitals	No. of patients	% weight
Shortell[12]	653	144 159	1.43
Keeler[13]	220	4937	0.04
Hartz[14]	2368	3 107 616	11.38
Manheim MH[15]	1252	1 537 660	9.78
Manheim FS[15]	1617	2 228 593	2.59
Kuhn[16]	2580	3 353 676	12.34
Pitterle[17]	3482	4 529 206	14.11
Mukamel[19]	1653	5 298 812	17.21
Bond[20]	3224	4 210 468	12.66
Yuan Medical[21]	3316	7 386 000	11.90
Yuan Surgical[21]	3316	4 396 000	5.05
Lanska[22]	799	16 983	0.00
McClellan[23]	2875	181 369	1.48
Sloan[24]	2360	7079	0.03
Totals	26 399	36 402 558	100.00
Random effects pooled estimate			

Fig. 2: Relative risk of hospital mortality for adult patients in private for-profit hospitals relative to private not-for-profit hospitals. CI = confidence intervals.

This analysis explored the status of the service providers rather than the mechanism of funding, but given we have a very mixed method of funding of the 'private' system in Australia, it would seem pertinent to explore the effects of type of provider in determining efficiency.

Outcomes

Determining appropriate outcome measures which should be collected is difficult and we appreciate this is an evolving area of research. The paper referred to above used case adjusted mortality. Despite its imperfections, this would seem to be a performance measure worth recommending for the future analysis of efficiency. Whatever measures are used however, must risk adjust to allow for the fact that private hospitals inevitably tend to see the more simple cases.

Timely Access

Whilst the report recognises that assessment of this on the basis of waiting times is unreliable and suggests that bed occupancy rates may be a better indicator, this fails to assess a related measure of access. Private hospitals manage bed occupancy and waiting lists by controlling and limiting access to beds for medical patients. Thus, a patient, usually elderly, who needs admission for pneumonia may be refused on the basis that there are no beds, when in fact, empty beds exist but are reserved for elective or more remunerative admissions. Public hospitals cannot do that to anywhere near the same extent. Such patients are sent to the public hospital emergency department, and, even if they have to wait on a trolley in the corridor, will eventually be given a bed, and an elective surgical patient will be cancelled. This capacity of private hospitals to determine admissions on the basis of policy rather than medical need contributes to the decreased capacity of public hospitals to manage elective admissions. Evidence for this practice was collected by the Victorian AMA [5]. The

Commission's report defines economic efficiency as 'in its broadest sense, refers to how well resources are used to benefit the wellbeing of the community'. It would seem appropriate in a comparison of the efficiency of public and private hospitals, that this issue is considered as timely access to elective surgery of private hospitals is dependent on policies and practices which force public hospitals to deal with the consequences of such policies which in turn could impact negatively on their capacity to deal with timely access for all patients.

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President

1. Harper RW, Sampson KD, See PL, Kealey JL, Meredith IT. Costs, charges and revenues of elective coronary angioplasty and stenting: the public versus the private system. Med J Aust 2000 Sep 18;173(6):296-300

2. Richardson J. Supply and Demand for Medical Care: Or, Is the Health Care Market Perverse? Working paper 123, 1999, Centre for Health Economics, Monash University

3. Robertson IK, Richardson JR. Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction. Med J Aust 2000 Sep 18;173 (6):291-5

4. Devereaux PJ, Choi PT, Lacchetti C, Weaver B, Schunemann HJ, Haines T, et al.
A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *CMAJ* 2002;166(11):1399-406.

5. AMA Victoria media release: accessed 8-11-2009.
http://www.amavic.com.au/page/Media/Media_Releases/2001/Private_Hospital_access_fears_confirmed/