ACT Health Submission

Productivity Commission Discussion Draft
Public and Private Hospitals

NOVEMBER 2009

INTRODUCTION

This submission has been prepared in response to the Productivity Commission's Circular inviting interested parties to provide comments on its *Discussion Draft on Public and Private Hospitals* (the Draft Report).

ACT Health supports the efforts of the Productivity Commission (the Commission) to undertake a study into the relative performance of the public and private hospital systems.

1. Data inconsistencies

There are overall inconsistencies with data sourcing, methodology and issues of comparability as discussed in most parts of the Draft Report. Although these are highlighted within each section, relevant tables that should be used and interpreted with caution are not properly footnoted. ACT Health suggests that all tables within the Final Report that are derived from inconsistent data sources should have appropriate footnotes as necessary. This will avoid misinterpretation of the data and avoid comparison of information that is based on inconsistent methodology and data sources.

2. ACT public hospitals

Chapter 2 of the Draft Report provides information on Australia's public hospital sector. ACT Health would like to provide more information that will be useful in understanding the ACT's public hospital system and provide further explanation that can be included in the Final Report (eg Sections of the Draft Report relating to 'Location of public hospitals' and 'Size of public hospitals').

Public hospitals in the ACT are located in Canberra. However, as a major referral centre, the ACT provides health services to surrounding regions of NSW. About 75.1% of public hospital separations from ACT public hospitals were for ACT residents with most of the remainder being residents of NSW[1].

ACT Health has made a commitment to provide a comprehensive health service for the ACT community. As a result, at least 95% of hospital services required by ACT residents at public hospitals are provided within the ACT.

This commitment creates diseconomies of scale. Procedures recording less than 20 separations per annum account for 44% of all public hospital activity. Services with less than 50 separations per annum account for two-thirds of all activity. However, a full operational service is required to provide a range of hospital services for ACT residents.

The small ACT population base also affects the capacity of private hospital providers to provide a comprehensive range of services. Based on estimates of hospital separations per 1,000 population, ACT private hospitals offer about

[1] *Australian Hospital Statistics 2007-08*, page 158, AIHW.

20% less admitted patient services than their counterparts interstate, principally due to the size of the ACT population.

ACT Health also considers that information should be included to explain that due to the ACT's smaller size relative to other jurisdictions, the ACT suffers diseconomies of scale which result in higher cost of providing public health services.

Without any step-down facilities, unlike most referral hospitals in other jurisdictions the two public hospitals in the ACT provide different types of care such as rehabilitation, palliative care, maintenance, psychogeriatric and GEM. The statement under section 2.3 of the Draft Report that "the ACT administers relatively less acute care, but more rehabilitation and maintenance care" is misleading. The statement can be misinterpreted that the ACT public hospitals are providing less acute care services than other jurisdictions. It is worth noting that the ACT's average cost weight (1.03) is higher than the national average (1.02) and higher than Victoria, Queensland, NT and WA[2].

3. Provision of private hospital data

Private hospitals in the ACT are not legally obliged to submit health information or specifically unit record data to ACT Health. The provision of private hospital related data to ACT Health is based on goodwill and hence subject to ACT Health securing agreement from private hospitals to provide their data to a third party. It is our understanding that most jurisdictions are in the same situation. This affects timeliness of data submission at national level and the sensitivity of publishing private hospital data by jurisdiction. The Commission should recognise this as a major issue that could be resolved by the Commonwealth at national level.

4. Private hospital utilisation in the ACT

In every year since 2000, the Private Health Insurance Administration Council's (PHIAC) ongoing annual survey has shown that more ACT residents hold private health insurance than any other jurisdictions. The latest PHIAC survey in December 2007 reported that 55% of the ACT population held private health insurance compared to 44% nationally.

The numbers of people taking out private insurance cover increased significantly after the Commonwealth Government introduced Lifetime Health Cover on 1 July 2000. The unparalleled increase in the proportion of the ACT population with cover from 33.5% in December 1998 to 55.5% in December 2007, was in line with the national trend that saw coverage increase from 30.2% to 44.4%[3]. Clearly, this has been the only effective measure to increase private

[2] Table 4.1c Cost per casemix adjusted separation and selected other statistics, selected public acute hospitals, states and territories, 2007-08, *Australian Hospital Statistics 2007-08*, AIHW.
[3] Private Health Insurance Membership Survey December 2007, Private Health Insurance Administration Council

insurance coverage. We are yet to establish the impact of the more recent changes to the Medicare Levy Surcharge income thresholds.

Within the ACT, there is no evidence that the subsidy to private health insurance reduces demand for public hospital services. In fact, since 2001-02 the utilisation rate for public hospitals in the ACT has actually increased from 219.7 per 1,000 people to 244.8 per 1,000 people in 2006-07[4].

Patients are not required to use their private health insurance when they attend a public hospital for treatment. The ACT also has one of the lowest incidences nationally of patients using their private hospital insurance in the public hospital system. Only 5.6% of people treated in the ACT's public hospitals in 2007-08 used their private health insurance. The 2007-08 national average for public hospital patients funded by private health insurance was 8.8%[5].

This data continues to show that ACT residents do not perceive private health insurance as a value for money proposition. The ACT has the highest rate of private health insurance coverage in Australia but one of the lowest private insurance utilisation rates.

The preference of residents of the ACT and surrounding regions to choose public hospitals for their treatment is testament to their confidence in the public system. In addition, access to private hospital services is contingent on the availability of private hospitals facilities and private specialists to provide the services. The ACT has low numbers of private specialists and ACT private hospitals provide a more limited range of services than private hospitals elsewhere in the country, with the exception of the Northern Territory.

Another factor discouraging the use of private health insurance is the out-of-pocket expenses that patients have to bear.

To highlight the above discussion the report should separate the ACT private insurance coverage statistics from NSW (Figure 3.2 of the Draft Report). The latest Annual Survey conducted by the Private Health Insurance Administration Council collects data for the ACT separately and reports the number of privately insured persons by age and gender category and by place of residence as at 31 December (see PHIAC website).

The above issues are relevant to the Draft Report discussions relating to Figure 2.2, Figure 3.1 and Figure 3.3 and Sections 2, 3 and 4.

5. Hospital costs

The Draft Report confirmed that its main sources of information for hospital costs are the National Hospital Cost Data Collection (NHCDC) and the Hospital and Casemix Protocol (HCP). It should be highlighted in the Final Report and in particular in all cost related tables and figures that comparison of public and

[4] Table 10A7 Separations, public (non-psychiatric) hospitals, *Report on Government Services 2009*
[5] Table 7.2 Separations, by patient election status, funding source and hospital sector, states and territories, 2007-08, *Australian Hospital Statistics 2007-08*, AIHW

private hospital costs data are not advisable. The majority of public hospitals in larger jurisdictions undertake *patient level costing* whilst most private hospitals use *cost modelling*. Within the NHCDC as briefly mentioned in the Draft Report, there are known inconsistencies between costing methodologies utilised by states and territories in addition to differences in costing standards. There are also major differences in applying cost estimates within different cost buckets.

ACT Health is concerned with the publication of the Commission's "experimental average cost per casemix adjusted separation" (Table 5.2, page 93 of the Draft Report) due to the following:

- The main sources of information (ie the NHCDC and HCP) are known to be based on inconsistent methodology, hence public and private costs data are not comparable. States and Territories costs data are also not comparable.
- There are two different sets of 'cost per casemix adjusted separation' statistics published by the AIHW and the Department of Health and Ageing. A third version of this average cost based on the Commission's 'experimental cost estimate' will potentially create mixed and contradictory messages to the public that will lead to further confusion instead of clarity on hospital costs. It is noted that average cost figures presented under Table 5.2 of the Draft Report are not the same as those published by the AIHW and the Commonwealth and ACT Health were not able to reconcile these figures with any of the published reports.

To overcome the above issues, ACT Health is suggesting the following method for consideration:

- Limit the scope of the cost analysis to compare public and private sectors to the following:
    - public and private hospitals recognised as 'patient costed sites'
    - include only records for services (or DRGs) common to both public and private hospitals, exclude outlier records and records that relate to services that are only available in the public or private sector
    - include hospitals that are of the same peer groups and exclude small hospitals (eg hospitals with available beds of less than 100)
- undertake experimental cost estimates on sample hospitals with comparable services and with cost information derived based on patient level costing methodology
- comparison can be made between large private hospitals that treat a similar casemix as the public sector, conduct teaching and research and run EDs that are likely to be sufficiently similar to many public hospitals
- present experimental cost estimates for public and private (revised version of Table 5.2) for a group of similar services provided among sample hospitals. Tables to be presented not by jurisdiction and to footnote that the estimates are derived from a sample of hospitals, title of the table to reflect as "estimate of cost per casemix adjusted separation of selected public and private hospitals, Australia, 2007-08".

All cost tables and graphs presented in the Draft Report combined the ACT with Tasmania and the Northern Territory cost data. It is suggested that the reason

for this approach should be clearly footnoted in all the relevant tables and graphs.

The use of the Department of Veterans' Affairs (DVA) data as benchmark

ACT Health disagrees with the Commission's statement that data obtained from DVA on the cost of procuring hospital services for war veteran and their families will be a good benchmark against which to assess the robustness of findings based on the National Hospital Cost Data Collection (NHCDC) and the Hospital and Casemix Protocol (HCP). The use of DVA data is counter productive given that DVA data consists of a different set of casemix that are not reflecting the casemix of the general population within public and private hospitals. It should be noted that cost data from DVA will reflect payments based on negotiated price and not on actual cost incurred by public hospitals. This will be the same case for private hospitals.

6. Waiting times

The Draft Report indicated that there are significant differences in the way states and territories assign clinical urgency categories in emergency departments. It is worth noting that this is also the same case for elective surgery and ACT Health is suggesting that relevant tables on emergency department waiting times and elective surgery waiting times should be footnoted to emphasise these inconsistencies.

7. Other partial indicators

The Commission includes conflicting messages in relation to labour productivity, noting on page 130 that high labour productivity is linked to greater efficiency, and then on page 132 that "high labour productivity, however, may not always be desirable". The ACT believes that the Commission should consider the desirability of reporting public and private hospital labour productivity figures given than they note that 'it is difficult to draw comparisons of labour productivity between public and private hospitals…"

8. Proposed multivariate analysis

The Commission is proposing to use multivariate analysis to generate a single measure of performance. The following are ACT Health's comments on the proposed approach:

- The Draft Report demonstrates that the majority of the data sources are problematic, of which the Draft Report confirmed comparability issue with the presented data. If the data sources for the multivariate analysis are flawed then the result of the multivariate analysis will be questionable.
- A select number of sample hospitals or reduced scope for analysis (see comments above on page 4 of this submission) could resolve the inconsistencies of data sources and methodology.

- Error rate should be calculated and statistical significance of the results should be presented together with any data results from the multivariate analysis.
- If *cost* will be one of the factors to be considered, it is suggested that only those hospitals using patient level costing are to be included in the analysis. This should be applied for both public and private hospitals with a set of comparable services or DRGs.

9. Informed financial consent

The Draft Report used information on informed financial consent determined via surveys. The Commission notes that the ACT and NT were excluded from calculations in determining the effectiveness of informed financial consent "due to insufficient same sizes". However, the Draft Report still shows the ACT results that have deteriorated over recent years. The ACT is seeking for the removal of the ACT figures on Chapter 9 or a clear comment should be in the footnotes regarding the reliability of the ACT figures due to small sample sizes.

10. Specific comments

Tables 2.1and 2.2 (pages 18 and 19 of the Draft Report)

The AIHW's publication the *Australian Hospital Statistics 2007-08* (noted as source for Tables 2.1 and 2.2) reported that there are three public hospitals in the ACT. One of the hospitals is classified as a 'mothercraft hospital' and it is a 10-bed facility. The number of patients admitted and number of separations sourced from the *Australian Hospital Statistics 2007-08* reflects the throughput of the two ACT public hospitals only. Table 2.2 (page 19 of the Draft Report) is correct to report that there are three public hospitals in the ACT, one of which is reported as having '0-50 beds'. However, Table 2.1 (page 18 of the Draft Report) should be updated to reflect that the 'number of hospitals' in the ACT is equivalent to two public hospitals to be consistent to the corresponding activity statistics of the two public hospitals.

Page 122 of the Draft Report

The Draft Report noted that data on hospital-acquired infection "…are not collected and reported on a nationally consistent basis (and the exceptions are NSW, NT and the ACT)." While the Draft Report states (in the appendix at page 303) that ACT data was not included as the data available relates to both public hospitals and only one private hospital, the ACT is suggesting that the Draft Report should make it clear that the ACT regularly reports such information.

Table 7.6 (page 140 of the Draft Report)

The emergency department waiting times for 2007-08 are available in the AIHW's Australian Hospital Statistics 2007-08. Table 7.6 can be updated to include 2007-08 data.

Table 7.12 (page 150 of the Draft Report)

All states and territories provided elective surgery data to the AIHW and the more recent data collection is for 2007-08 financial year. It will be more useful to update Table 7.12 and reflect 2007-08 data instead of 2004-05 data.