Australian Health Service Alliance (AHSA) Observations on Productivity Commission Draft Report on Public and Private Hospitals

1. Introduction:

AHSA has read the draft above report with interest and a senior staff member (Dr Brian Hanning, Medical Director) attended the 22nd October Roundtable discussion on the Report. AHSA agrees with what appeared to be the unanimous view of the Roundtable participants that the Productivity Commission has produced a first rate Report on a very difficult topic despite major time constraints. AHSA congratulates the Commission in general and the relevant staff in particular on achieving so much in such a short time.

Having said this there are a number of comments AHSA wishes to make on the Draft Report. These should be viewed as trying to improve what is already a very good draft report rather than significant criticisms of its contents. The comments that follow in general follow the order in the Report.

2. Comments:

a. Future Data Improvements Page (8): AHSA endorses without reservation the comments on page 8 concerning improved data availability. AHSA like many other groups has been frustrated when attempting to analyse industry issues by its inability to access relevant data. Privacy and confidentiality have been given as reasons for refusing to release data in situations where AHSA has been unable to conceive of how release of the data requested would be inconsistent with either of these concerns.

b. Hospital and Medical costs (Section 5 – pages 83 to 108): AHSA has considered in depth the contents of this section and reviewed the findings to the extent possible using the data in the spreadsheets in Appendix G of the draft report. Our comments are as follows:

   i. In general terms AHSA agrees with the methodology used. DRGs are an appropriate method of classifying cases and the reasons given for excluding some DRGs are in our opinion entirely reasonable.

   ii. The NHCDC private sector is a well based costing study and AHSA uses it as the basis of its private sector cost payment model. In particular we note the prostheses costs by DRG in the private sector arm of the NHCDC study and the charges in internal AHSA data are very similar. Capturing prostheses costs accurately is one of the more difficult aspects of costing studies and success in doing so is a powerful marker of well based studies. AHSA also noted other positive markers in the Round 12 study such as minimal theatre costs in what are generally non-procedural DRGs and the average cost per case following the hierarchy of complexity within DRG groups.

   iii. AHSA has been able to replicate the findings in Table 5.2. It took a little trial and error to do and while AHSA considers the methodology used is valid and the results shown accurate it is suggested rather more detail on the methodology used should be included in the final report. This would assist other interested parties to replicate the Commission's work and thus enhance the understanding of the validity of the Commission's work.

iv. AHSA has some concerns about aggregating the costs as shown in Table 5.2. Table 5.2 does not really compare hospital and medical costs but rather compares case costs. While this is a valid and reasonable measurement there is a danger of some aspects of the Commission's work will be lost because of the aggregation of hospital, doctor and prostheses costs into case costs. As an example AHSA has seen media reports to the effect that "private hospitals pay their doctors more" which reflect a significant misunderstanding of the basis of the Commission's work and its results.

v. AHSA would suggest this section of the report be restructured as follows:

1. There should be a comparison of what can reasonably be regarded as core or common hospital costs over both sectors by the casemix adjusted methodology used. Whether the three groups of hospital related costs (General, Pharmacy & Emergency and Capital) remain separate or are amalgamated is a matter which should be considered further. There are advantages in providing more detail but amalgamating these costs removes any issues related to misallocation of costs into the component cost buckets.
2. Medical costs should be treated separately given these are not generally hospital costs in the private sector. Any comparison of medical costs should explicitly note that in the public sector these generally relate to doctor salaries and in the private sector to fees charged to patients by doctors. By having a separate section that makes this point very clear the chances of journalist repeating the erroneous comments noted in section 2 iv are reduced. These could be based either on the overall hospital weights or on specifically derived medical weights. AHSA's studies suggest there will not be a large difference between the findings for medical costs under either of the two methodologies.
3. Prostheses costs should be in a section of their own. The prostheses used are determined by the doctor and in the case of the private sector fully paid for by the patient (via their insurance fund).They are therefore not a hospital cost in the private sector but rather a cost generated by the doctor and the supplier bills the patient through the private hospital which acts simply as a conduit through which the device is provided. The private hospitals have no influence on the price paid by the patient. While it may be reasonable to include prostheses costs in total case costs it is quite inappropriate to include prostheses costs in comparable hospital and medical costs.
4. There is a further issue related to prostheses. While agreeing with the Commission's methodology in most areas AHSA would suggest the methodology is not quite appropriate for prostheses charges. This is because there are many DRGs in which prostheses costs are minimal if not zero. It is suggested a more appropriate method of investigating a relative prostheses costs is to restrict this. analysis to DRGs with a minimum average prostheses cost. This then eliminates cases with no prostheses from the averaging. AHSA has used a $30 average prostheses cost per case as its threshold for the DRGs included in its prostheses comparison

because **it wishes to compare prostheses costs only in DRGs where there are significant prostheses costs. The average prostheses cost in** DRGs with significant prostheses costs as defined by AHSA is $781 in the public sector and $1,512 in the private sector. This is based on prostheses only weights for the relevant DRGs derived by replicating the Commission's methodology. AHSA notes that prostheses charges are the only area which should be calculated from a limited range of DRGs as other costs such as general hospital, doctor, pharmacy and emergency, capital will occur to a greater or lesser extent in all DRGs.

5. It is possible to then amalgamate these costs into a total case cost but it is suggested that this be explicitly differentiated from hospital and medical costs. In addition AHSA would point out that while medical and hospital costs are common over all DRGs prostheses are not. Prostheses costs should therefore be considered separately and not amalgamated into total case costs.

c. Medical and diagnostic costs (page 94-95) :

AHSA notes the Commission expressed some concern that medical costs in the public sector may have been allocated into other cost buckets. While AHSA is unable to comment on this point it should be noted that the ward medical cost bucket is a misnomer as this cost bucket is intended to be a total medical cost bucket. The following small table is copied from the spreadsheet outlining the Public Sector Round 12 results and is informative on this point.

Ward Medical									
Also known as Medical Clinical Services, this bucket includes the salaries and wages									
of all medical officers including sessional payments.									

AHSA notes some refinement of data in regard to medical charges for private cases in the public sector will be undertaken and agrees this is appropriate. It is impossible for the Commission to accurate quantify the value of unpaid time doctors contribute to the public sector although this is likely to be substantial. If such hours were paid they would significantly increase medical costs in the public sector. AHSA also notes that its earlier submission on the higher medical charges in the private sector is endorsed by other parties making submissions.

AHSA is not surprised by the finding medical charges are higher in the private sector given that many doctors provide services to the public sector for remuneration which barely covers their expenses and rely on their private sector work to generate their income. This cross subsidy of the public sector by the private sector also facilitates the retention of specialists in Australia by making their income internationally competitive. AHSA does not see any practical way to change this situation without creating a risk of many Australian specialists going overseas with the loss of specialists to both the public and private sectors given they are very employable overseas.

d. Prostheses (page 95-96)

AHSA is not surprised that prostheses costs were found to be higher in the private sector although it believes that the methodology used inflates the relative difference. This is because there are proportionally fewer cases with significant prostheses costs in the public sector due to large cases in DRGs

such as L61Z – Renal Dialysis where there is no prostheses component. This creates a large case numbers denominator which reduces the quotient of average prostheses cost per case.

AHSA believes based on prostheses invoices seen from member funds that the major factor driving the difference in average charge by DRG is differential pricing at the prostheses item level. As an example in nearly all cases in DRG D01Z (Cochlear Implant) the prostheses used are manufactured by Cochlear Ltd. However Appendix G from the interim Report states the average prostheses charge for this DRG is $15,425 in the public sector but $23,047 in the private sector despite there being a higher case volume in the private sector – 244 cases compared to 213 in the public sector. AHSA has reason to believe this example of market failure to equalise prices occurs in regard to the price of many other prostheses items.

AHSA recommends this issue to be investigated further perhaps as part of a separate Productivity Commission study. It may be possible that some of the differences between the two sectors relate to data issues or the differing uses of devices in the but AHSA is sceptical that such issues explain most of the differences found. Any such study should consider the prices charged for like items in the two sectors to determine how much of the difference in average price at the DRG level relates to difference in price on a like device basis. In practice there might be some significant challenges in getting complete and accurate data.

Given AHSA has in the past noted prostheses are much more expensive on a like item basis in the private sector it is of the view there is a compelling case for a body which approves and set prices for all prostheses used in Australia similar to the Pharmaceutical Benefits Schedule (PBS) used for pharmaceuticals. Such a body would have considerable negotiating power and this could well lead to lower prostheses prices for all Australian hospitals. If this did not happen it would be a major market failure.

It would also end the situation in which the private sector pays much more for prostheses devices on a casemix adjusted basis and what amounts to a cross subsidy of the public sector in regard to prostheses costs without creating a significant public sector cost exposure. AHSA is sceptical that the current market failure in regard to prostheses prices can be solved other than by a PBS like body and would welcome comments from the Commission in its finalised report on how this issue can be investigated and remedied.

e. <u>Alternative costs per weight:</u>

As intimated in section 2 iv AHSA believes that the costs of prostheses and doctors should be calculated separately from other costs. Accordingly in the attached spreadsheet we have calculated a number of alternative parameters. The methodology used is the same as that used by the commission but applied only to the costs under consideration.

The total relevant charge for each DRG in each of the sectors, public and private, is calculated by multiplying the cases in each sector by the relevant average charge in each sector then adding these to derive a total charge for the DRG. The average charge per case over the two sectors is derived by dividing the total charge over the two sectors by the total cases over the two sectors for each DRG. Similarly the average charge over all DRGs over the

two sectors is calculated by dividing the total charges over the two sectors by the total cases over the two sectors. The average charge in each DRG is then divided by the overall average charge for the parameter concerned to derive a relative weight for that DRG. The total weighted cases for each of the two sectors are calculated and total relevant charges divided by the weighted cases to derive average charge per weighted case.

It will be noted that the weights will differ as will the charge per weight depending on the parameter being considered e.g. prostheses weights will differ from medical weights and both will differ from the weights outlined in Table 5.2 on page 93 of the draft Report.

Average charge per weighted case - National

	Public	**Private**
All charges (Replicates Commission)	$4,224	$4,119
Common hospital charges (All charges except Medical and Prostheses)	$3,216	$2,447
Medical only	$793	$1,224
Prostheses - Prostheses Cases (DRGs with $30+ average prostheses charge only)	$782	$1,512

It is emphasised that it is inappropriate to add the above components of total charges as shown under "All charges" above to derive the overall average charge because there are many cases excluded from the above calculation of prostheses charge given the minimum average of $30 per case in prostheses charges used to determine inclusion of the DRGs in the calculation of this parameter.

AHSA suggests the above table more clearly shows the differing charges between the two sectors particularly in relation to charges comparable between the two sectors and prostheses.

f. Improving future cost comparisons (pages 103 to 108)

AHSA endorses the suggested improvements in data collections made by the Commission. AHSA is particularly keen to have all except perhaps the smallest private hospitals participate in the National Hospital Cost Data Collection (NHCDC) and to see private sector funders involved in the NHCDC process. AHSA is unaware as to why this has never occurred to date given this would improve the industry wide acceptability of the collection. AHSA would also like to see DRG level information available for public sector HCP. Standardisation of methodology is likely to be helpful and is supported by AHSA. We also agree it would be desirable for all medical costs to be captured although the optimal means of achieving this will require some further thought as this is likely to lead to changes in data collection.

g. Hospital Acquired Infections (pages 109 to 125)

It is noted from Table 6.1 on page 121 of the draft report that infections appear to be somewhat lower in the private sector. AHSA also noted that the comparisons are not case mix adjusted and based on a limited number of hospitals in both sectors. AHSA therefore considers that further work is needed to improve both the number of hospitals contributing data and the methodology by which such data is compiled and analysed. AHSA feels that Draft Finding 6.2 on page 125 is a good basis to move forward and endorses it.

There is one other issue that AHSA feels needs consideration. While overall sector information is useful when comprehensive and robust, such aggregate information may conceal the existence of a small number of hospitals with particularly low quality. Expanded and improved data collection will not only allow any such hospitals to be identified with certainty but will also catalyse appropriate corrective action.

h. Other Partial Indicators (pages 127 to 163)

AHSA would suggest the productivity partial indicators in themselves are of much less use in making comparisons than are the casemix adjusted charges per separation in Table 5.2 whose parameters reflect the net effect of all the factors contributing to cost of cases treated. Where partial parameters would be of help is in understanding why sectors and hospitals why are different and facilitate investigations which can indicate feasible improvements.

The results of the section on access are entirely predictable. However AHSA noted with interest and some surprise the finding in Table 7.12 which suggest the elective surgery rate in the most socioeconomically disadvantaged group was nearly as high in the private sector as in the public sector and for the second most disadvantaged group it was higher in the private sector. This counteracts the view sometimes expressed that the private sector benefits only the wealthy.

AHSA agrees that current available data makes it hard to compare quality and safety between the two sectors let alone between individual hospitals. AHSA considers it more important to compare individual hospitals rather than the two sectors as identification of low quality outlier hospitals, if such exist, offer an opportunity to improve quality for a clearly identifiable group of patients at risk. It endorses Draft finding 7.4 on page 163 about the need to make consistent hospital level data available to interested parties. AHSA considers that the interested parties should be defined as including, among other others, private sector funders, as there is no doubt that the health funds and other private sector funders have a very strong interest.

3. Conclusion

AHSA trusts these comments and the attached spreadsheet will be of assistance to the Commission and is willing to clarify or elaborate on any relevant matter.