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Mr David Kalisch
Commissioner, Hospital Studies
Productivity Commission
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Dear Mr Kalisch

The Australian Health Insurance Association (AHIA) welcomes the Productivity Commission's release of the discussion draft prepared for further public consultation and input as part of its research study into public and private hospitals.

The AHIA congratulates the Commission on the delivery of this discussion draft, given that this is the first time a comparison of relative efficiencies of the public and private hospital systems has been attempted. Overall, the AHIA supports the general direction of this discussion draft.

The AHIA would like to make a number of comments regarding particular aspects of the discussion draft:

1. **Cost comparisons between public and private hospitals**

The AHIA believes that the Commission's final report would benefit from publishing the cost differentials between the two sectors by individual Australian Refined Diagnosis-Related Group (AR-DRG), rather than just comparing the two at a broader level.

The Commission's draft discussion suggests that public hospitals are more efficient in the delivery of medical separations, while the private hospital sector is more cost-effective at delivering surgical separations. The AHIA encourages a review by individual AR-DRG to provide a greater appreciation at the micro-level of how those efficiencies are achieved by each sector.

The AHIA is aware that Private Health Funds experience significant under-reporting of prostheses costs for their Members who receive care as private patients in the public hospital system and is therefore concerned that this reality may distort the Commission's findings. It is important that the average costs of prostheses be calculated across only procedures that have prostheses used, rather than all separations as this would distort the Commission's calculations.

2. Informed Financial Consent

The lack of fully Informed Financial Consent (IFC) by providers to patients continues to be a significant issue for Australians with private health insurance. The AHIA is disappointed with the indifferent approach taken by the Commission in the draft discussion towards the seriousness of the issue.

The AHIA notes that the Commission concludes through PHIAC data that a maximum of 10 per cent of privately-insured *services* do not receive IFC. IPSOS reported in 2007 that 42 per cent of all patient *episodes* which experienced a gap did not receive IFC. It is important that the Commission make the point that whilst the number of services might be considered low, IFC rates are considerably higher when measured at the episode level.

The AHIA suggests that the Commission seek to report in its findings the total number of privately-insured people who experience an unexpected gap payment associated with their treatment. The AHIA also encourages the Commission to recommend to the Australian Government ways that full IFC can be mandated to ensure that, as close as is practicable, no privately-insured patient receives unexpected gaps associated with their care.

3. Safety and Quality data

The AHIA welcomes the opportunity to continue to assist the Productivity Commission in the provision and interrogation of data related to the performance of both the public and private hospitals systems.

The AHIA encourages the Commission to seek access to long-established clinical data sets available from the Commonwealth Department of Health and Ageing to assist in its analysis of quality and safety experiences in the respective hospital systems.

In relation to the Admitted Patient Care National Minimum Data Set (APCNMDS) the Commission should seek information on the following episodes:

1. Where there has been an in-hospital separation and the hospital has reported a principal diagnosis, and at least one secondary diagnosis (in both the public and private hospital sectors);

2. Where separations have been reported with the ICD-10AM information collected containing a code of:
    a. B95.6 *Staphylococcus aureus* as the cause of diseases classified to other chapters AS WELL AS either:

        i. Z06.8 Agent resistant to multiple antibiotics *(Note:* This category is used to identify multiple-drug-resistant microorganisms such as multidrug resistant *Staphylococcus aureus); or*
        ii.

iii. Z06.32 Methicillin resistant agent for (i) public hospitals and (ii) private hospitals; and

3. Of the total number of separations identified in Part 2 above, how many of these also had an ICD-10AM code of Y92.22 reported for the in-hospital procedure [Health service area or **Y95 Nosocomial condition** or **T81.4 Infection following a procedure, not elsewhere classified**[1] **[1,2,5,6,7,8, or 9]].**

The AHIA is confident that the Commission can also adopt information from other hospital-acquired infections it has identified, such as Vancomycin-resistant enterococci (VRE) to assist in its assessment of the quality and safety aspects of the hospital sectors.

If the Commission is unsuccessful in obtaining APCNMDS information from the Department of Health and Ageing, then it is suggested that its final report note the absence of such information, which if publically-released, would reduce adverse events in all hospitals.

The AHIA looks forward to the release of the Commission's next paper, due in December, and the release of the planned supplementary report in March 2010. In the meantime, the AHIA will continue to extend the opportunity to continue to work with the Commission, through the provision and analysis of information related to this study.

Please feel free to contact me on 02 6202 1000 for any further information.

Yours sincerely

Michael Armitage

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER

6 November 2009

[1] Extracted from NCCH eBook, July 2006, Injury and Poisoning.