Catholic Health Australia

Public and private hospitals:
CHA submission to the Discussion Draft of Productivity Commission Study 2009

9 November 2009

Public and Private Hospital Study – CHA Response to Discussion Draft

CHA welcomes the opportunity to comment on the Productivity Commission's (the Commission) discussion draft of its research study into public and private hospitals released on 15 October 2009.

CHA considers that the discussion draft provides a good snapshot of the hospital industry across the public and private sectors - no mean feat given the very complex issues it was asked to consider, the very short timeframe and limited and incomplete data sets available to the Commission.

As to be expected with a study of this kind, CHA has a number of specific comments on a number of areas relating to the detail of the study, which will be outlined later in this response.

Current context

The Commission was given very specific terms of reference. The draft report of the Commission responds to those terms of reference. However, the findings of the report contribute to the current health reform process that the Commonwealth formally commenced when it established the National Health and Hospitals Reform Commission. The draft report of the Commission has been published at a time when the Government is in full flight in preparing its response to the National Health and Hospitals Reform Commission, and the final report of the Commission will be provided to Government at a time when it will be drawing closer to making decisions about the future of the health and hospital system. For this reason, the Commission should not be bound be its strict terms of reference and should seek to provide additional recommendations to Government that acknowledge the current context in which the final report will be published.

The Prime Minister has stated that the Commonwealth is considering if it should found 40% or move to funding 100% of the "efficient" funding of public health services.

The National Health and Hospitals Reform Commission did not in any detailed way give consideration to the meaning of "efficient" funding of public hospital services by looking at national average hospital costs in the way that the draft report of the Productivity Commission has. Nor did the National Health and Hospitals Reform Commission give adequate attention to the role of private hospitals within the national health and hospital system.

CHA has said to the Commonwealth that to review the national hospital and health system without giving regard to the presence and contribution of private hospitals to the Australian community is to ignore the opportunity to immediately improve access to public health services, and to ignore the opportunity of achieving greater efficiency in the delivery of public hospital services.

CHA argues therefore that the findings of the Commission that relate to efficient hospital costs should be formally drawn to the attention of the Commonwealth as it considers its response to the National Health and Hospital Reform Commission and its policy proposals for the future of hospitals within the health system.

The Commission's discussion draft, by comparing costs and some health outcomes in public and private hospitals, provides a blueprint as to how the Commonwealth, in proposing policy for the future of the national health system, could achieve efficiencies in the delivery of public hospital services. The Commission has found, for example, that the non-government hospital sector is able to deliver some components of hospital services at significantly less cost than government owned and operated hospitals.

As the Commonwealth is seeking to fund the "efficient" public hospital services, it should seeking evidence as to how it can direct future public funding to lowest cost, highest health outcome providers - having taken into account any "confounding factors" that may go to explain apparent differences in observed costs. The Commission's draft report provides the makings of an evidence base on how public funding can be more efficiently directed across the public and private hospital sectors, and as such, the Commission should in its final report make the case to the Commonwealth as to how the Commonwealth can achieve its stated aim of best funding efficient public hospital services.

Data

CHA notes with concern and disappointment the difficulties that the Commission has reported in securing access to existing data to inform its study - including data that has been provided by CHA's own membership. From CHA's perspective, the considerable resource impost imposed on hospitals in collecting timely data and passing it onto government agencies can only be justified on the basis that it goes to improving healthcare, including ensuring that the considerable resources devoted to hospitals within the health care system are being deployed in the most effective and cost-effective manner.

The current study by the Commission is providing an all too rare opportunity in Australia to examine the effectiveness of the production and delivery of hospital services across all jurisdictions and between public and private sectors. At a time when future demand for hospital services, based on current utilisation patterns, is expected to continue to increase at a rate that will challenge funders to provide the necessary resources to meet that demand, it is imperative that both the public and private hospital systems operate to maximise their collective effectiveness. A commitment to real transparency in the timely and consistent reporting of data is a necessary prerequisite.

CHA reiterates its call contained in its original submission for an Office of Hospital Cost Data to be established within the Department of Health and Ageing (on the basis that the Commonwealth is independent of hospital operators in both the

public and private sectors and that the Commonwealth is in a position to enforce the submission of data through the National Health Agreements) - supplemented by an independent auditing agency.

Similarly, CHA supports compulsory participation of the private sector in contributing to the cost data collections and for data input into these collections to be made consistent across all jurisdictions and between the public and private sectors.

It is instructive to note that despite the significant burden imposed on health services to contribute to data collections from Federal and State Governments, licensing authorities, statutory 'quality' and accreditation agencies such as the Queensland Health Quality and Complaints Commission (HQCC) and private health insurers, that when an agency such as the Productivity Commission seeks to undertake a study such as this, the data that is available is singularly unsuited to purpose. CHA reiterates its call for a rationalisation of existing data collection requirements to ensure that the objectives of all those with a legitimate interest in gaining access to data can have their needs met whilst minimising the imposts on health care providers resulting from the ad hoc proliferation of multiple data sets and overlapping and inconsistent collection requirements.

Hospital costs

Based on publicly available material and data collections, CHA takes that view that the Commission's overall findings in relation to hospital costs are within expected bounds. Given the inconsistencies and gaps in current data collections, the characterisation of the findings as "experimental" would appear to be appropriate. CHA considers that it has been useful to report the cost component outcomes against a number of different categories – noting that some areas of cost such as "general hospital" are within the direct controls of private hospitals whereas other groupings of reported cost such as medical and prostheses costs are set outside the control of hospitals and also reflect a price that includes a profit margin.

There are a number of areas of costs set out in the discussion draft that CHA considers further scrutiny is required. These are addressed in turn below.

<u>Prostheses</u> - CHA notes the Commission's observations in relation to the large disparity between prostheses costs in the public and private sectors. Some of the difference may be accounted for by the use of bulk purchasing and limited choice of prostheses in the public sector, differences in case-mix between the public and private sectors – simple prostheses are often used in repair of fractures after trauma (public hospitals) whereas replacement of a failed hip prostheses (hip revisions) is usually a private hospital procedure. Private hospitals also provide greater access to pacemakers, implanted defibrillators, implanted spinal prostheses etc, which are not available or strictly rationed in public hospitals.

<u>Medical costs</u> - CHA notes the Commission is aware of the difficulties in allocating medical costs for the treatment of private patients in public hospitals particularly

given the inability to group up to 80% of the HCP records. This may have led to the underreporting of medical costs in public hospitals. The impact of this problem varies between jurisdictions - with the greatest impact being in New South Wales which has the highest proportion of all the jurisdictions of private episodes undertaken in public hospitals.

CHA considers that the Commission's medical and diagnostics cost for public hospitals New South Wales (Table 5.2 at page 93 of the discussion draft) is unexpectedly low compared to some other jurisdictions - such as Victoria. In raising this question, CHA refers to Australian Hospital Statistics 2007 - 08[1] Table 4.1d at p57 which adds both the costs of salaried staff and VMO payments to give a total medical cost of $953 per case-mix adjusted separation in NSW compared to $781 in Victoria. CHA also contends that a comparison of equivalent levels of salaried medical staff suggest higher costs in NSW (under the Health Professional and Medical Salaries (State) Award)[2] compared to Victoria (Heads of Agreement beween the Australian Medical Association (AMA Victoria) and ASMOF (Victorian Branch) and Department of Human Services and Victorian Hospitals' Industrial Association[3]. For example these instruments set out payment levels of $98,731 at 1 July 2009 for a Grade 1 Career Medical Officers in NSW[4] compared to $79, 248 in Victoria from 1 October 2009 for a Year 1 Medical Officer[5].

The private hospital medical and diagnostic costs are prices, not cost, and hence include a substantial profit margin, especially for diagnostics and particularly in NSW, which has a long history of highly priced diagnostic services. This is not a like-for-like comparison, and is a major element (with prosthetics costs) contributing to the conclusion that the costs of public and private hospitals are close. When adjusted for costs (at public sector rates) instead of price, it is contended that the private sector is 'cheaper' by up to 30%.

Allied Health

[1] Australian Institute of Health and Welfare 2009. Australian hospital statistics 2007-08. Health services series no. 33. Cat no. HSE 71. Canberra: AIHW p57

[2] Health Professional and Medical Salaries (State) Award accessed at http://www.health.nsw.gov.au/resources/jobs/conditions/awards/pdf/hsu_he_profmed_salaries.pdf on 9 November 2009

[3] Victorian Heads of Agreement accessed at http://www.wh.org.au/library/scripts/objectifyMedia.aspx?file=pdf/425/17.pdf&siteID=1&str_title=Bul-1435-Attachment%20HoA.pdf on 9 November 2009

[4] NSW Award, p 8

[5] Victorian Heads of Agreement, p 10

In response to some submissions to the Commission (for example Sub no 41, NSW Health pp 1 and 4) that assert that allied health costs are not recorded in private hospital cost collections, CHA indicates that for a significant part of its membership, the vast majority of allied health costs are actually captured within hospital costs rather than being directly billed to patients by independent practitioners – although this is not uniformly the case in all jurisdictions or with all health fund contractual arrangements.

Tax concessions

As the study takes into account the potential cost impact on for-profit hospitals of a number of tax concessions available to the not-for-profit and public sector hospitals, CHA is providing - as a separate document to this submission - a report prepared by KPMG for CHA on the potential impact of their removal. CHA considers a continuation of these tax concessions as being important in ensuring the ability for not-for-profit hospitals to continue to be able to attract and retain staff as well as to ensure the continued operation of a number of health services that may be rendered marginal in the absence of these concessions. It should also be noted that in some cases the competition for staff is not always between for-profit and not-for-profit hospitals but rather for medical specialist time spent between private and hospital practice. Depending on the specialty/sub-specialty, some medical specialists may earn substantially more income (from 4 up to 10 times) by remaining in private as opposed to hospital.

Catholic health services provide, as an integral part of their mission, services targeted at the disadvantaged and vulnerable - many of whom fall through the cracks of existing health services. This includes offering private health services outside metropolitan areas – where Catholic hospitals have a disproportionate presence compared with for profit operators. Whilst Catholic health providers will strive to continue to serve the community, including in the provision of services specifically targeted at the disadvantaged, regardless of the underpinning taxation framework, this will be made more difficult should the concessions be removed.

CHA's arguments for the retention of the tax concessions will be more fully developed in our submission in response to the Commission's current draft report into the not-for-profit sector.

Multi-variate data analysis

CHA notes and supports the Commission’s intention to undertake and release the results of the multivariate analyses being undertaken to provide further insight into the apparent differences in costs between the private and public sectors. CHA supports the Commission’s stated intention of releasing the initial results as a draft for comment which will be separate from the final report published in December. In particular the highly technical nature of this work necessitates that interested parties have the opportunity to examine the methodologies used prior to the outcomes being able to be regarded as definitive conclusions.

Specific comments

CHA makes the following specific comments in relation to particular parts of the draft discussion paper.

Age of patients treated in public and private hospitals

At pages XXXV and 24, the discussion draft makes reference to patients admitted to public hospital being older than those admitted to private hospitals. This would appear to be inconsistent with Tables 2.5 and 3.5 in the discussion draft which shows patients over 65 years old comprise a higher proportion of total admissions in private hospitals as compared to public hospitals.

In addition, based on Table 8.1 of Australian hospital statistics 2007-08, CHA calculates the average age of patients admitted to private hospitals was 55.5 compared to 51.3 for public hospitals[6].

The following breakdown of admissions by age group as a proportion of total admissions is also derived from Table 8.1:

Age Band	Public hospitals % of total admissions	Private hospitals % of total admissions
65-69	15.3	19.6
70-74	16.6	17.4
75-79	17.2	17.2
80-84	13.6	15.8
85+	11.4	11.5

Prostheses

As noted above, most prostheses are actually purchased by the hospital and supplied to the patient by the hospital – although the choice of prosthetic devices is made by the treating doctors. Benefits for prostheses are payable to hospitals by private health insurers on the basis of amounts determined by the Minister for Health and Ageing and promulgated in the Prostheses List twice a year.

Rights of Private Practice

At page 54, reference is made to "rights of private practice" and "employment arrangements" (3rd paragraph) by independent medical practitioners. By definition independent medical practitioners working in private hospitals do not have any form of employment relationship with the hospital. They are however granted admitting rights by the hospital and credentialed to provide certain medical services

[6] AIHW 2009 – accessed at http://www.aihw.gov.au/publications/hse/hse-71-10776/hse-71-10776-c08.xls 4 November 2009

within the hospital to patients (depending on their qualifications). The medical practitioners bill the patient's independently of the hospital for the medical services provided.

Rights of private practice is more appropriately a term that refers to salaried medical specialists employed in the public sector, who have an agreement with their employing hospital that allows them to earn private fee for service income from private patients in addition to their salaried position.

Adverse Event Data

Whilst noting the Commission has used multiple sources of data to measure the incidence of adverse events, the outcomes are always surrounded by caveats on caveats. CHA would encourage the Commission to recommend that ICD codes be developed that would allow accurate and meaningful assessments of adverse events that occur in a hospital during an episode. These codes could be classified into groups such as an adverse event where harm occurred, where no harm occurred, preventable etc. This would result in an increased level of transparency for facilities across Australia in both sectors. CHA contends that it defies logic that every hospital in Australia pays people to sit and read and code charts and yet no codes are available that allow the measurement and reporting, in a meaningful way, of the rates of adverse events.