NSW HEALTH

Mr David Kalisch
Commissioner
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601

Dear Mr Kalisch

Study to examine the Relative Performance of the Private and Public Hospital Systems

Following the Roundtable discussion of 22 October 2009 concerning the draft report titled "*Public and Private Hospitals – Productivity Commission Draft*", I am writing to provide further input in relation to the above Study.

The attached submission covers a number of issues associated with:

- Hospital Casemix Protocol data and ungroupable separations
- The need for comparability and consistent treatment particularly in relation to pharmaceuticals, allied health, capital, and remote and very remote facilities
- Approaches to the treatment of hospital administration and central office overheads
- Issues associated with the provision of public sector emergency treatments
- The need for transparency in terms of separating emergency and pharmaceutical costs
- The treatment of capital
- Hospital-acquired infections
- Issues associated with the provision of data
- Issues associated with inclusions in the report

NSW Health has previously raised a number of concerns about whether the Commission's approach will produce an accurate comparison of the relative performance/efficiency of the two hospital systems. It is not clear at this time whether these concerns have been adequately addressed by the Commission through modifications to its methodology.

It would be appreciated if you could ensure that these issues raised by NSW Health are given serious consideration. Should Commission staff wish to discuss the contents of this submission, they may contact Ms Janet Anderson, Director, Inter-Government and Funding Strategies Branch (IGFSB) on 9391 9469 or Liz Hay, Policy Manager, IGFSB on 0427 459 516.

Yours sincerely

J. M. Anderson

per Dr Richard Matthews
Deputy Director-General, Strategic Development

11 November 2009

NSW DEPARTMENT OF HEALTH SUBMISISON
PRODUCTIVITY COMMISSION DISCUSSION DRAFT – PUBLIC AND PRIVATE HOSPITALS

Hospital Casemix Protocol (HCP) Data and Ungroupable Separations

Unlike private hospitals, public hospitals are not required to provide HCP data. In NSW, private health insurance funds contribute around 28% of the accommodation costs of caring for a private patient with the balance of costs subsidised by government. Given this and in the absence of cost recovery contractual arrangements with Funds, NSW public hospitals do not provide HCP data.

In light of the above, the assertions on p245 that "*the HCP is considered to be representative of all separations for which private health insurance is claimed*" and that "*a major deficiency of the HCP is that public hospitals often fail to allocate separations correctly to individual DRGs for their private patients*" are inaccurate and should be deleted.

NSW Health does agree however that a proportion of the medical and diagnostic costs would be missing from the current analysis for private patients in public hospitals. Given the need to ensure comparability, NSW Health supports the addition of these costs on the basis that they are only applied to the private patient share of activity, that is, the $80 identified should not be added to the average cost per CWS but factored into the small proportion of private patient CWSs.

The Need for Comparability and Consistency

Pharmaceutical and allied health costs must be treated differently in public hospitals versus private hospitals to achieve comparability. The Commission does not appear to have addressed this issue yet. To ensure the integrity of its analysis and findings, it is recommended that the Commission either remove these costs entirely from the analysis or develop a more valid approach.

Pharmaceuticals

The draft Report states that "*for the final report, the Commission plans to investigate what further adjustments can be made to the data to improve the accuracy of medicine costs for both public and private hospitals*". NSW supports this. In particular the full cost of drugs consumed in private hospitals must be factored in otherwise the private sector data will be artificially low. Issues associated with this were detailed in NSW Health's submission of 2 October 2009 and remain current.

An additional issue is that the draft Report states on p 91 that not all medicine costs are included in the public sector data. A review by the NSW Health Casemix Unit has found this to be untrue. All pharmaceutical costs are included either in the pharmaceutical "bucket" or allocated to the place that the cost is incurred – for example the operating theatre, ED or ICU.

In addition high cost drugs for chemotherapy are mainly provided on a non-admitted, outpatient basis as the majority of chemotherapy patients at NSW public hospitals are non-admitted. These costs should be factored into the inpatient CWS.

NSW Health requests that the costing methodology related to pharmaceuticals is corrected so that private hospital costs are properly accounted for and the Commission ensures no double counting of public hospital costs.

Allied Health

NSW Health remains concerned that the current approach to the treatment of hospital allied health services produces an artificially low cost for private hospitals. This issue was highlighted in NSW Health's submission of 2 October and is still outstanding.

In summary, while all allied health costs are included for the public hospitals, a proportion of these costs have not been captured for private hospitals because some private professionals bill the inpatients directly, in the same way that doctors do. Some of those costs (usually about half) are reimbursed by private health insurance funds under their 'general' or ancillary benefits, but there is no way to identify the in-hospital component of those benefits using existing data.

Remote and Very Remote

NSW Health argued in its first submission that the Commission must take specific account of the cost of providing public hospital services in rural and remote areas as part of governments' community service obligations. The draft Report shows a cost per CWS to the public sector of $5,178 in remote areas and $6,597 in very remote areas. However there is no comparable cost in the private sector as there are no private hospitals in these areas.

Accordingly, to ensure true comparability, it follows that the Commission must delete the costs of remote and very remote hospital services from its calculation of overall cost per CWS and instead deal with these costs in a separate discussion of public sector community service obligations.

Hospital administration and central office overheads

The draft Report states that the "*The Commission intends to further consider the estimation of hospital administration costs and central-office overheads for the final report*". The calculations involved in this work must inevitably be based on assumptions that present a high risk of producing gross inaccuracies. The following issues are relevant and require close consideration:

- In NSW the majority of public hospital administration costs are factored into DRG costs so particular care should be exercised to avoid double counting. The treatment of these costs by private hospitals would obviously also need to be ascertained with any adjustments necessary to allow valid comparisons.

- In relation to central office overheads, a strong case can be made for account to be taken of Commonwealth central office overheads that relate to private hospital funding (such as the MBS, PBS and PHI rebate) and hospital administration (for example the acute care and hospital branches). Other overhead costs that should also be allocated to private hospitals would include corporate head office costs, NSW Department of Health central office costs relating to the licensing and regulation of private hospitals, and potentially some private health insurance fund costs (for example those incurred in the negotiating of contracts with hospitals).

Emergency Departments and Emergency Admissions

The draft Report acknowledges the unique demand profile associated with public hospital EDs, but does not give sufficient weight to the fact that public hospitals account for over 90% of all emergency admissions. These admissions tend to be of a higher complexity, are more likely to be associated with multiple co-morbidities, and are potentially more costly compared to planned admissions.

It is also the case that the "clinical workup" for most planned private admissions is undertaken in the community, whereas for public hospitals this preparation is more likely to be done at the hospital, and especially for emergency admissions. This difference would necessitate either an escalation of private hospital costs or a discount of public hospital costs to ensure comparability.

Pharmaceutical and Emergency costs should be separated for transparency purposes. It is difficult to see the rationale for grouping these together particularly as the private hospital sector has relatively little emergency activity. For this grouping the draft report shows an average public sector cost per CWS that is nearly 4 times higher than the private sector (refer to Table 5.2). If this relativity is retained in the final report, it will be important for the Commission to comment that the difference is largely a reflection of the fact that the public sector provides a service that on the whole is not provided by the private sector.

Capital

NSW Health remains concerned about the approach adopted by the Commission to costing capital across the two sectors. The substance of these concerns was detailed in NSW Health's October submission.

This issue was discussed at length at the recent Roundtable and the Commission has been made aware that its treatment of capital in the draft report is inconsistent with standard accounting and economic approaches and is biased in favour of the private sector. It is hoped that the Commission has reviewed its approach and satisfactorily addressed this problem.

An additional issue which was raised by others at the Roundtable concerns whether and how to take into account the costs to the community of private hospital services. NSW Health has considered this perspective and concluded that it must be addressed as part of the treatment of capital. In particular, profit as the return on capital is basic economic theory and should not be ignored.

Hospital-Acquired Infections (HAI)

NSW Health notes that the Commission has been asked to compare the rate of hospital-acquired infections in public and private hospitals.

NSW Health agrees with the Commission's assertion that without a robust nationally consistent data collection system to measure rates of HAI it is impossible to draw comparisons from the measures currently collected.

The current systems operating in Australia arguably have a surfeit of indicators relying on data of uncertain validity in terms of its completeness and accuracy. This means that comparisons between hospitals and across sectors are not likely to produce an accurate picture.

NSW Health's experience shows that a few high quality data measures collected and reported in a simple and consistent manner can be a powerful driver of improvement in infection rates, underpinned by successful campaigns such as NSW Health's "Clean Hands Save Lives" campaign.

NSW Health agrees with the proposed strengthened surveillance program to include Bloodstream Infections (BSI), Surgical Site Infections[1] (SSI) and bacterial sepsis in the first week of life. In addition to these indicators it is suggested that a number of other measures should be included which provide an indicator of the infection control processes in a hospital. These include:

- Hand Hygiene Compliance rates
- Compliance with process measures for SSI reduction including antibiotic prophylaxis, hair removal, wound management, perioperative normothermia and glycaemia control via a standardised checklist
- Surveillance for VRE

NSW Health agrees with the Western Australian submission that the first two of these measures do not need to be adjusted for patient risk factors

Specific comments on the HAI chapter are as follows:

- the proposed risk stratification processes which impose a significant data collection impost may not necessarily add value to the notion of data to drive improvement but rather provides a means of explaining why rates can be different.
- The assertion on p119 that low procedure volume has been associated with higher SSI risk is misleading. Recent evidence[2] suggests that SSI is not related to volume but is clearly related to the frequency and application of best practice "bundles" of care
- Accurate collection and reporting of Hand Hygiene compliance data on a national level requires a database with capacity to manage this data collection on a large scale. Such capacity does not currently exist within the NHHI.

Provision of Data

The draft Report states that "*officers responsible for managing data collections in jurisdictions are often termed 'data custodians', implying that their role is to hold and safeguard data potentially from a range of users*." While the Commission makes clear its view that data should be more readily available, the above observation is regrettably and uncharacteristically gratuitous and prejudicial.

Data custodians perform an important role in the public health system. Their key responsibilities include:

[1] NSW Health contends that major joint prothesis SSI should only be monitored in cases where hospitals are performing a caseload which is greater than 100 per year - infections rates are likely to be unreliable at lesser numbers and that there is a need to review the validity of the current definition for LSCS

[2] Auberbach AD et al, Shop for Quality or Volume? Volume, Quality and Outcomes of Coronary Artery Bypass Surgery. *Ann Intern Med* 2009; 150:696-704

- ensuring that patient privacy is maintained
- ensuring compliance with data provision legislation, probity issues and other protocols (eg. protecting the commercial interests of private providers and obtaining any relevant consents required for the release of data)
- ensuring due consideration of any ethical issues associated with the use and release of data
- ensuring the completeness and accuracy of data to be released, or if necessary, providing specific caveats regarding the data to be released where there are issues relating to its completeness and/or accuracy

A logical extension of the Commission's interest in ensuring appropriate access to data is the largely unexplored potential of data linkage. For a range of reasons including the involvement of two levels of government as funders and regulators, as well as the involvement of another two sectors (commercial and not-for-profit) as providers, it is impossible to chart a patient's journey through the health system by analysing a "data trail" because no such trail exists or can be constructed. The databases for MBS and PBS managed by Medicare Australia (access to which is extremely restricted) are entirely separate from the admitted and non-admitted databases maintained by States and Territories, and also distinct from private hospital databases.

As discussed at the Roundtable, the community is logically uneasy about possible secondary uses of databases. This means that if the full benefits of data linkage are to be realised, it will be necessary to demonstrate the value to be gained by linking health activity data from different sources, and to be very clear about the "rules" that will govern this process.

The Report on p16 states that "In New South Wales, instead of a casemix scheme, funding is allocated according to each area's population characteristics". This is incorrect. NSW Health has used a two-tiered funding model since 2008/09. A population-based, needs-weighted resource distribution formula is used to guide the proportional allocation of total recurrent resources among Area Health Services. Areas then allocate hospital budgets which include an episode (activity-based) funding component for specified admitted activity.

It is noted that only 23% of private hospitals in Australia have participated in the Study (130 out of 556). The draft Report states that this represents about 50% of private hospital separations. In order to demonstrate that this sample is not biased and is instead a true representation of private hospital activity, the Commission should address the following questions in its final report:

- What proportion of private sector separations are reflected on a cost weighted basis?

- What proportion of these separations are overnight, same day, result from emergency and planned admissions respectively? (This is important to assess whether the public-private comparisons are based on relatively similar samples.)

- What is the spread of separations in relation to hospital location and size?

Scope of study and presentation of information

It is unclear why the Commission has chosen to reproduce in its draft report, without explanatory context or further analysis, data and information that is published and readily available elsewhere. The rationale for including data which is only available for public hospitals is especially unclear. A notable example of this is data on elective surgery waiting times and emergency department performance for public hospitals. In the absence of any comparable data for private hospitals, or an informed analysis of the many factors affecting these measures, it is difficult to discern the point being made. If the Commission is interested in reflecting on the consumer's experience of health care, average waiting times to see a general practitioner or medical specialist may be a more material measure.

As stated in NSW Health's first submission, if the Commission is interested in taking a more encompassing view of its study of public and private hospitals, then it should consider issues relating to the lack of a level playing field between the private and public health sectors based on the principles of competitive neutrality, equivalence, economic charging and enhanced consumer access to affordable services. Among the issues warranting attention are parity and competitive neutrality between the public

and private hospital sectors in relation to private health insurance arrangements. Key elements for consideration include those relating to:

- The reimbursement received for the treatment of private patients in public and private hospitals, the utilization of private health insurance across the two sectors and the impact on a cost weighted basis of the subsidisation of private health insurance on private and public sector activity and costs
- Access to comprehensive services at public and private hospitals. For example, the considerable difference between private and public hospitals in the provision of emergency and intensive care, which is in part related to funding arrangements.
- The ability of the private sector to indirectly "choose" who they treat, to be able to rationalise access and to focus of high volume, lower cost treatments/procedures
- Access to services on a geographical basis, the community service obligations of public hospitals and the impact this has on efficiency (noting the above comments).
- The opportunity cost of diverting health funding to the cost of an insurance product (that may or may not be used to fund a health service)