Department of Health and Ageing
Submission to the Productivity Commission's Public and Private Hospitals Discussion Draft

Draft finding 1.1:
The Commission encountered significant delays in accessing hospital-related data that cannot be justified on privacy or confidentiality grounds. There is a case for making these data more accessible to a range of users because this could drive improvements in health care, especially as competitive markets only have a limited role in the health sector. It could also encourage future improvements in the data collections. One way in which data agencies could facilitate this is to strengthen the mechanisms through which data users can provide ongoing input on how data are collected and made available for analysis and research.

The Department notes the following existing public sources of information on the hospital sector:

- The annual State of Our Public Hospitals (SoOPH) reports, which provide public hospital information at state, territory and national levels. The latest SoOPH June 2009 report also provides some information on private hospital performance.
- Australian Hospital Statistics (published by the Australian Institute of Health and Welfare) provides a comprehensive range of statistics and information about public and private hospitals.
- The Australian Bureau of Statistics (ABS) Private Hospital Survey (ABS Cat No, 4390.0) presents details from the 2006-07 national census of private hospitals. Three categories of hospitals are identified: Acute hospitals, Psychiatric hospitals and Free-standing day hospital facilities.
- The National Hospital Cost Data Collection (NHCDC) was established in 1996. It produces national cost weights for Australian Refined Diagnosis Related Groups (AR-DRGs) and other statistics relevant to health service costing and planning. The current report is *NHCDC Cost Report, Round 12 (2007 - 2008).*

Notwithstanding these sources, the Department supports wider access to hospital related data in the interests of accountability and transparency and to encourage research and analysis to improve knowledge of the health sector. However, any move towards wider access must be careful to ensure appropriate protection of the privacy and confidentiality of individuals and the ability of commercial organisations to effectively compete in the private sector.

The Department agrees on the need for more timely delivery of hospital-related National Minimum Data Sets, which are the source for most national reporting of hospital reporting. The reporting requirements of the National Healthcare Agreement (NHA) could require more timely processing and delivery of these data. The Department also notes that while the NHA requires annual data submission six months after the end of the financial year to which it relates, a number of states have improved processing from source to delivery to such an extent that earlier delivery is possible.

The accountability requirements of the Elective Surgery Waiting List Reduction Plan and Emergency Departments and Subacute Care elements of the National Partnership Agreement on Hospital and Health Workforce Reform are also driving improvements in data processing, quality and timeliness.

The Department proposes that current collectors and distributors of data be encouraged to examine ways of making data more widely accessible and continue their efforts to increase reporting. The following information on governance arrangements for hospital data development might be of use.

- For public hospitals:
    - Implementation of the National Healthcare Agreement (NHA) together with associated nationally consistent 'progress measures' and Activity Based Funding (ABF) for public hospitals, will to some extent address the conceptual and data problems acknowledged in the Discussion Draft.
    - Improvements in data quality will be overseen by the National Health Information Standards and Statistics Committee (NHISSC).
    - It is anticipated that Commonwealth/State work on the implementation of ABF will lead to greater national consistency in the enumeration, classification and costs for all public hospital services, thus enabling more reliable comparisons, including of efficiency.
    - Improvements to national hospital costing data will, where applicable, be driven by the 2008 KPMG Review. This review, the first of its kind for several years, examined the costing collection development and management for both sectors and proposed a range of changes to improve national hospital costing data. The review will be considered fully as part of ABF implementation where changes to costing methodology are concerned.

- For private hospitals:
    - The Department maintains ongoing formal working group arrangements with a focus on private health data, in which insurers and providers are represented. The Health Fund Working Group represents private health insurers and is used to facilitate discussion around changes to the Hospital Casemix Protocol (HCP). This group agreed in early 2008 to facilitate improvements to the HCP through a range of measures to improve the quality of this data over time through reduced error rates in supply and regular quarterly reports on data quality and timeliness of supply to insurer chief executives.
    - The Department chaired Private Hospital Working Group includes representatives of the private hospital sector and meets quarterly to discuss a range of issues including changes to data specifications. This group is now also to become a consultative body where required on broader reporting matters as they relate to policy.
    - National costing data is also oversighted by a Technical Reference Group that represents all jurisdictions and the private sector and who meet regularly during the course of development of the costing collection each year including the final ratification of results to be published. Some changes identified in the KPMG Review, such as ensuring annual private hospital sector collections, the use of a private sector costing coordinator to facilitate collection, and increasing training in costing techniques have already been implemented (in the 2007-08 collection).
    - Other national data collections are oversighted by NHISSC. Private sector representation on this group is essential to ensure the sector is aware of national data changes and their concerns can be incorporated into this area. The Commonwealth has sought and gained agreement to this arrangement.

Further information is at Attachment A.

Draft finding 4.1:
Although there is significant diversity within and across the public and private hospital sectors in Australia, there are a number of key similarities between public and private hospitals that enable and encourage comparison between the sectors. It is acknowledged that there are some differences in the activities undertaken by public and private hospitals and that the sectors do not always service comparable patient population, which makes comparisons more difficult.

The Department agrees that there is considerable diversity within and between the public and private hospital sectors, and at the same time strongly supports the finding that there are also similarities that enable and encourage comparison between the sectors.
The Department notes that most of the comparisons in the Discussion Draft are immediately qualified due to differences in the treated populations, casemix of patients, or simply different data collection methods. The Department strongly supports further exploration of the differences and similarities in the interests of improved comparative performance reporting of the two hospital sectors. A list of some of the differences that were identified in other submissions as being important to comparative reporting is at Attachment B.

All Governments have agreed on the importance of being able to make comparisons across public hospitals and in some instances between the public and private hospitals. The Intergovernmental Agreement (IGA) on Federal Financial Relations includes a new Performance Reporting Framework based on performance indicators in National Agreements, including the NHA. Details of the process for developing and reporting performance indicators are summarised in Attachment A, and a list of all performance indicators is in Attachment C. Indicators that will allow comparisons across sectors will include:

- Cost per case mix-adjusted separation;
- Rates of services: Outpatient occasions of service;
- Rates of services: Overnight separations;
- Rates of services: Non-acute care separations; and
- Rates of service: hospital procedures.

Draft finding 5.1:
Existing datasets on hospital and medical costs are limited by inconsistent collection methods and missing information. The Commission has sought to address these limitations by drawing on various data sources and incorporating adjustments to make the data more comparable. Nevertheless, the resulting estimates of hospital and medical costs should be considered experimental.

Draft finding 5.2:
The Commission's experimental cost estimates suggest that, at a national level in 2007-08, public and private hospitals had broadly similar costs per casemix-adjusted separation. There were however, significant differences in the composition of estimated costs.

The Department agrees that the utility of existing data sets is compromised to a degree by inconsistencies and incompleteness, and therefore agrees with the Productivity Commission's conclusion in the Discussion Draft that its estimates of hospital and medical costs are experimental.

The Department notes that considerable collaborative data improvement work is currently underway, much of which is acknowledged in the Draft Report. This work includes:

- the development and implementation of nationally consistent ABF for public hospitals under the National Partnership Agreement on Hospital and Health Workforce Reform;
    - this work, when fully implemented, will establish nationally consistent, rigorously costed patient level information across all hospital care types.
- under the same agreement, data development work in relation to subacute care and emergency departments;
- data development to support national performance reporting under the NHA; and
- work being undertaken by the Australian Commission on Safety and Quality in Health Care to establish a set of quality and patient safety indicators.

This work will bring about considerable improvements in performance and cost reporting.

In relation to methodological issues the Department would like the Productivity Commission to provide more detail on the methods used in deriving average costs and use of cost weights. The Department notes, for example, that the Productivity Commission used cost weights averaged over both public and private hospitals (as opposed to the NHCDC which uses separate sets of weights) and would like the Productivity Commission to comment on or assess the impact of their method.

It is important to note that only private overnight hospital costs are included in the cost data. Day hospital cost data is available but not included in the cost data due to the limited sample size. Costs to the community of providing the care are also not included as these cost estimates are not available.

The data sources used in Discussion Draft were the *NHCDC Cost Report, Round 11 (2006-2007) and Round 12 (2007-2008),* and HCP. These are different collections with different bases and different purposes.

The current costing standard used by the NHCDC results in inconsistencies between the data that is collected from private and public hospitals and between jurisdictions. Through the implementation of ABF, the Department will improve costing practices as follows:

- develop national standards, including for capital expenditures;
- review National Accounting Infrastructure to ensure cost allocation processes and metrics are consistent and produce reliable estimates of admitted acute care costs;
- establish, formalise and develop appropriate costing standards and processes for exceptional products (state-wide services etc) within the acute workstream that need to be addressed in a manner different to that defined for Admitted Acute patients; and
- develop documentation and training modules to promulgate costing standards nationally.

A list of counting, classification and costing issues has also been identified during the development of the ABF framework and subsequent business cases. These issues are currently being workshopped with various National Partnership Agreement on Hospital and Health Workforce Reform committees to progress and identify solutions.

The basis of the NHCDC differs between the hospital sectors and work to improve the alignment between the two is underway, with the revision of costing standards as part of ABF. The *NHCDC Cost Report, Round 13 (2008-2009)* data has not yet been provided and this data

will be more standardised. An outline of the data that the Department collects is at Attachment D.

As summarised in Attachment B, there are also a number of differences between the public and private sectors, including the clinical pathways used, the large proportion of non-admitted patient services in public hospitals, the number and types of disciplines practiced between the two sectors, and the differences in patient casemix and product differentiation.

Draft finding 5.3:
A disaggregation of the Commission's experimental cost estimates by diagnosis-related groups (DRGs) suggest that in 2007-08:

- ***One-fifth of DRGs had an average cost in public hospitals that was at least 10 per cent lower than in private hospitals, and nearly half of DRGs had an average cost in public hospitals that was more than 10 per cent higher than in private hospitals***
- ***Almost three-quarters of surgical DRGs had a lower cost in private hospitals compared to public hospitals, and medical DRGs were where public hospitals performed most strongly in terms of cost relative to the private sector.***

As noted above, the Department agrees that differences in patient profile contribute to cost differences between public and private hospitals.

The Department draws attention to the Charlson Index which in this context may be fruitful (Attachment E).

Draft finding 5.4:
A foreshadowed shift to nationally-consistent activity based funding for public hospitals is expected to eventually lead to more robust cost data for the public sector. However, there remains considerable scope to improve the quality and consistency of hospital and medical cost data in Australia. In particular, there is a need for:

- ***Private hospitals to report cost data using the same methodology as public hospitals, and to continue to have a high level of participation in the National Hospital Cost Data Collection, so that the data are reliable and can be disaggregated by sector, region, and size and type of facility***
- ***Items directly billed to private patients – such as some medical, diagnostics and medicines – to be linked with cost data reported by hospitals so that all costs associated with an episode of care are captured in a single collection***
- ***Reliable data on capital costs, hospital administration costs, central-office overheads, and the cost of medicines prescribed to hospital patients***
- ***Quantification of the additional FBT liability that for-profit hospitals incur by not having the FBT exemption that is available to other hospitals.***

This may require a strengthening of data-related provisions in the National Healthcare Agreement for public hospitals, and data reporting requirements for private hospitals. If this is the case, governments need to be conscious of the regulatory burden on reporting hospitals and, where possible, seek to limit it by avoiding duplication and inconsistency in reporting requirements, and by utilising cost-effective electronic reporting of data.

The Department is consulting with private health (insurers and hospitals) on streamlining admitted patient collections (NHCDC, HCP, Private Hospital Data Bureau) to try and reduce the burden of reporting patient data.

An option for data improvement could be to ensure that private hospitals provide National Minimum Data Set (NMDS) data, at the patient level. This would help enable comparability between the two sectors and ensure completeness between all hospitals and services provided. However, this change would probably require changes to Private Health Insurance legislation, or to state licensing arrangements.

Data comes from various sources and any change to data specifications will require lengthy lead times (i.e. years) to enable changes to the National Healthcare Agreement and Private Health Insurance legislation. These timeframes include provision for:

- consultation;
- system changes;
- software development;
- changes to legislation;
- data collection; and
- final reporting (18 months after the collection period).

ABF methods developed under the National Partnership Agreement on Hospital Workforce Reform, and which will be applied only to public hospitals, will result in improvements in costing all hospital treatment in the public sector, but will not assist with public/private hospital sector alignment. There is, however, considerable interest in both sectors in effecting alignment between the two sectors. The government arrangements for the implementation of ABF, includes the mechanisms for ensuring that the private hospital sector is informed of and contributes to the developments in the public sector in ABF.

Draft finding 6.1:
Australia does not have a robust nationally-consistent data collection on hospital-acquired infections. The limited available evidence suggests that private hospitals have lower infection rates than public hospitals, but this result could be misleading because private hospitals generally treat patients who have a lower risk of infection. A more definite finding will require the development of data collections that enable risk differences between hospitals to be distinguished from genuine differences in performance.

The Department acknowledges that current data collections on hospital acquired infections have limitations. The Productivity Commission noted in the Discussion Draft, for example, that conclusions drawn from the Australian Council of Healthcare Standards (ACHS) Clinical Indicator Program (CIP) could be misleading because the CIP is not designed to monitor the relative performance of the public and private sectors, but is a service offered to individual health care providers to help them improve their service quality (ACHS, sub. 13). While state and territory jurisdictions all conduct some monitoring of hospital–acquired infections, across public and private hospitals, this is not done on a nationally consistent basis, and there is no process to collate data nationally.

The introduction of NHA Performance Indicator number 39: "Healthcare-associated *Staphylococcus aureas* (including MRSA) bacteraemia in acute care hospitals", however, represents a significant step towards nationally consistent and well defined reporting of hospital acquired infection. Public reporting of NHA Performance Indictors will commence in 2010.

The Department agrees that any comparisons on hospital-acquired infection need to take into account the relative risk of infection due to, patient characteristics, type of procedure performed, and other factors such as the incidence of planned versus unplanned surgery.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) approach to reducing Healthcare Associated Infection (HAI) focuses on identifying and addressing systemic problems and gaps to ensure a comprehensive range of action. Building on facility and jurisdictional initiatives, the HAI program proposes a national and systematic approach to national surveillance, hand hygiene, infection control guidelines and building clinician capacity.

All Health Ministers have agreed that a multifaceted approach to reduce *Staphylococcus aureus* and other HAI is needed, including the implementation of a hand hygiene initiative.

ACSQHC has developed a National Hand Hygiene Initiative, which aims to prevent the spread of *Staphylococcus aureus* and other HAI by standardising hand hygiene practice in Australian hospitals.

The World Health Organization (WHO) has identified hand hygiene as a key element in reducing the rates of hospital acquired infections. ACSQHC commenced promoting its National Hand Hygiene Initiative on 5 May 2009, to coincide with the WHO *'Saves Lives, Clean Your Hands Day'*. ACSQHC is working with Hand Hygiene Australia to maximise the success of this initiative.

Draft finding 6.2:
Foreshadowed developments, such as performance reporting under the National Healthcare Agreement, will move Australia closer to a robust nationally-consistent data collection on hospital-acquired infections. However, more action will be required to enable meaningful infection-rate comparisons between public and private hospitals. An important step in this regard would be to include private hospitals in national reporting arrangements. The Australian Commission on Safety and Quality in Health Care is leading and coordinating initiatives that should improve the feasibility of future comparisons.

The Department has sought to extend the redevelopment of the ICD-10 AM revision for 2009 to include a measure for Methicillin-resistant staphylococcus aureus (MRSA) codes in the data. This will enable consistent reporting across the data collections. Hospital level data from the private sector to national collections must be provided. Presently, it varies depending on the arrangement between the private sector and the relevant state/territory.

Draft finding 7.1:
Private hospitals appear to operate relatively leaner staffing levels than public hospitals, although it is not clear as yet how much of this difference can be explained by the higher provision of emergency department and outpatient clinic services by public hospitals.

The Department notes the Productivity Commission's findings and supports the Productivity Commission's approach in using unpublished hospital establishment data to report labour intensity data for hospitals with and without emergency departments for the final report.

Draft finding 7.2:
Private hospitals exhibit shorter lengths of stay than public hospitals. This is due to private hospitals exhibiting shorter lengths of stay for surgical procedures and undertaking relatively more surgical procedures than public hospitals.

The Department notes the Productivity Commission's findings that surgical procedures in private hospitals have shorter associated patient stays than other DRGs, and private hospitals undertake relatively more surgical procedures than public hospitals.

Draft finding 7.3:
Timely access to elective surgery is less likely in public hospitals than in private hospitals. The relatively high bed occupancy rates in public hospitals restrict their ability to manage their unpredictable workload. Equity of access is more likely in public hospitals than private hospitals, since public hospitals provide relatively more elective surgery to patients from poor socioeconomic areas and from more remote areas of Australia.

The comparability of elective surgery waiting times between the public and the private sector are difficult due to different policy approaches between the two sectors, and that private hospital operators do not maintain elective surgery waiting list data. Due to uncapped funding of the private sector, one can assume that the private sector will perform better for elective surgery (AHSA, sub. 1, pg 8). There is also evidence of considerable variation between clinical urgency categories (AIHW 2008e, p.4).

The Department supports the Productivity Commission's finding on equity of access, noting that patients from poor socioeconomic areas are more likely to use public hospitals due to cost and access issues.

Draft finding 7.4:
There are a range of partial indicators that can provide information on the performance of public and private hospitals. The work of the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare to develop a national set of safety and quality indicators could provide a basis for future comparisons between public and private hospitals. However, the paucity of published, comparable and reliable hospital-level data severely limits these comparisons, and will continue to limit such comparisons in the future. Making consistent hospital-level data available to all interested parties would assist with future comparisons between hospital sectors and contribute to improvements in care.

The comparability of safety and quality indicators would need to be addressed with caution to ensure appropriate protection of the privacy and confidentiality of individuals and the ability of commercial organisations to effectively compete in the private sector. Caution would also need to be exercised to ensure accuracy in recording, for example, coding differences may exist between hospitals, and raw data needs to be weighted to take account of differences between hospitals, such as patient age, Indigenous status, co-morbidities and treatment types.

The Department notes that the Australian Health Ministers' Conference decision of December 2008, made mandatory the national surveillance of healthcare associated infection for public hospitals, with monitoring and reporting of healthcare-associated *Staphylococcus aureus bacteraemia* and *Clostridium difficile* to jurisdictions nationally.

At their meeting on 13 November 2009, the Australian Health Ministers' Conference agreed to fast-track the implementation and reporting of a core set of the following nine national indicators of safety and quality for hospitals:

Whole-of-System Quality Indicators

1. *Potentially avoidable deaths such as*
    a. *potentially preventable deaths and*
    b. *potentially treatable deaths,*
2. *Selected potentially preventable hospitalisations*

Hospital-level Outcome Indicators

3. *Hospital standardised mortality ratio (HSMR)*
4. *Death in low-mortality Diagnosis Related Groups (DRGs)*
5. *In-hospital mortality rates for:*
    a. Acute Myocardial Infarction (AMI)
    b. heart failure
    c. stroke
    d. fractured neck of femur,
    e. pneumonia
6. *Unplanned hospital re-admissions for patients following:*
    a. AMI
    b. heart failure
    c. knee and hip replacements
    d. depression
    e. schizophrenia
    f. paediatric tonsillectomy and adenoidectomy
7. *Healthcare associated Staphylococcus aureus (including MRSA) bacteraemia*
8. *Clostridium difficile infections*
9. *Obstetric trauma - third and fourth degree tears*

Overall, the provision of hospital level data to all interested parties will assist many different levels of requirements for comparison and analysis. While one of these is the need for Governments (as funders) to assess performance, another important consideration is that consumers should have information to make decisions about their health care
In recent speeches, Minister Roxon has noted increased public interest in standards of performance and accountability in the health system and information on cost comparability from one hospital to the next. The Minister has also acknowledged that in some areas of Australia the cost of treatment will be higher, and patient choice will be limited, but where it is possible to compare similar services, 'apples with apples', we should. Comparisons drive efficiency and innovation and this is why the Government has agreed to make comparable information available.

Australian consumer representative bodies are also strong advocates for more performance indicators being made available to consumers of healthcare. The National Health and Hospitals Reform Commission report also identifies the need for 'a culture of improvement through health system reporting', including providing comparative clinical performance data back to health services, hospitals and clinicians. Consumer peak bodies would like this information to also be available to health consumers. Consumer Health Forum (CHF) members had some strong views about what information should be available and how it should be

provided. Areas that they wanted to see public reporting on comparative data for different health services included:

- access, efficiency, safety and quality;
- number of complaints;
- details of adverse events and pay-outs; and
- employment and salary information.

CHF members suggested a range of ways for this information to be disseminated, but stressed that national reporting against consistent standards was required. Consumer peak bodies consider that nationally consistent information on health system performance should be made available to consumers, on a regular basis and through a range of media[1].

The department already publishes high level performance indicators, targeted at the healthcare consumer through such publications as the *State of Our Public Hospitals* report.

International examples exist of ways for healthcare consumers to access comparative hospital level information. In the UK, Dr Foster, an independent organisation designed to help patients make informed decisions about their health, produces comparative information on the performance of National Health System (NHS) hospitals. Indicators are available by hospital and specific treatments and include:

- Waiting times;
- Expected lengths of stay in hospital;
- Whether hospital stays will need to be overnight;
- The risk of urgent re-admission;
- Which consultants are most likely to treat the patient; and
- Comparative hospital rates of MRSA and C Difficile.

Dr Foster also produce comparative adjusted death rates or Hospital Standardised Mortality Ratios (HSMRs) for all NHS hospital trusts.

The Health and Ageing Portfolio Budget Statements 2009-10 note that the Department will "develop processes to publish information about the performance of private hospitals against performance indicators that are consistent with those agreed by the Council of Australian Governments for reporting by public hospitals, where relevant, for example safety and quality indicators. The Department will also collect information from private health insurers about average charges for commonly used private dental services. With the cooperation of private hospitals, dentists and private insurers, the information will be published on an appropriate website by the end of 2009-10 to ensure that consumers are better informed to make decisions about whether and when to use their private health insurance, and to improve choice for consumers in health services".

[1] Consumer Peak Bodies Position Paper on the National Health and Hospitals Reform Commission Final Report – A Healthier Future for All Australians, September 2009

Draft finding 9.1:
According to the Private Health Insurance Administration Council, around 90 per cent of hospital services for privately-insured patients do not have out-of-pocket expenses that require informed financial consent. Complaints data collected by the Private Health Insurance Ombudsman suggest that the rate of informed financial consent has been increasing in recent years.

The Department acknowledges the improvement in the levels of Informed Financial Consent (IFC). The Government has worked with doctors over several years to improve the rate of IFC and while there has been some improvement, people are still experiencing large surprise gap fees for doctors' services. Assuming that the proportion of privately insured people experiencing a surprise gap is 10%, this means around 2,596,407 medical services for privately insured patients involve a surprise gap, which is a significant number.

Draft finding 9.2:
The incidence and average size of out-of-pocket expenses for privately-insured patients appear to be overstated in available survey data collected by Ipsos, due to sample-selection and self-reporting bias. Subject to this qualification, the data suggest that privately-insured patients have a higher rate of informed financial consent and lower out-of-pocket expenses in public hospitals. Few conclusions can be made about out-of-pocket expenses due to small sample sizes.

The Department notes the data limitations of the Ipsos survey. The Department acknowledges that estimates are just that, an estimation of out-of-pocket expenses which will differ depending on the jurisdiction of participants, the medical practitioner used and the hospital.

Medibank Private recently surveyed over 20,000 of its members. According to this survey, average out-of-pocket gap was $1,086 (see Fact Sheet at Attachment F).

Draft finding 9.3:
A more robust future data source on informed financial consent could be created by requiring privately-insured patients to indicate on their health insurance claim form whether they provided financial consent prior to the procedure. This information could be collected and reported by the Private Health Insurance Administration Council.

The suggestion that the Private Insurance Claim Form could be used to collect data on IFC is not particularly useful. Some claims are paid directly to the provider without necessarily involving the patient. Also, the onus to ensure IFC occurs should be on the health provider and not the patient. It is the doctor's responsibility to obtain IFC before treatment is undertaken. Information provided by the patient is not necessarily reliable due to the limitations identified in the interim report relating to the Ipsos surveys.

Furthermore, the suggestion that the Private Insurance Claim Form could be used to collect data on IFC, is unlikely to be satisfactory, as private patients typically claim once for hospital benefits only, and then have numerous claims for medical costs (both in and out of hospital).

Draft finding 9.4:
The medical profession has sought to promote best practice for informed financial consent in recent years. This has included educational campaigns for practitioners and Internet-based packages to inform consumers of their likely expenses.

The Commission requests further best-practice examples where informed financial consent is provided by every procedure. This includes best-practice examples that occur in specialities where a lack of informed financial consent is most common.

The Department notes initiatives undertaken to promote best practice for informed financial consent in recent years, and supports the Productivity Commission's request to obtain further examples of best practice where informed financial consent is provided for the study.

The 2007 Consumer Informed Financial Consent Survey conducted by Ipsos indicated that problems with surprise gaps (i.e. out-of-pocket and no IFC) are largely associated with medical specialists who have limited patient contact – anaesthetists, pathologists, radiologists and surgeons' assistants.

The Department provided funding to the Australian Medical Association (AMA) in June 2007 to undertake activities to increase the incidence of IFC obtained by medical specialists with limited patient contact. The activities included developing a best practice billing model for pathologists. A package has also been developed by the Australian Society of Anaesthetists.

Draft finding 10.1:
Average weekly ordinary time earnings is the most appropriate indexation factor for the Medicare Levy Surcharge income thresholds.

The Productivity Commission's findings on the best indexation measure for the Medicare Levy Surcharge income thresholds are consistent with the Department's support for the use of full time adult average weekly ordinary time earnings (AWOTE) as the most relevant measure of the 'normal' earnings of workers.

ATTACHMENT A

National Health Care Agreement

The Intergovernmental Agreement on Federal Financial Relations (IGA) includes a new Performance Reporting Framework based on performance indicators in National Agreements, including the NHA. Since February 2009, the NHISSC has worked closely with its membership and with a range of expert data committees to develop technical specifications for the 70 NHA performance indicators. The Department led the development of 18 specifications.

The technical specifications were finalised in mid-September and sent (through the Australian Health Ministers' Advisory Council) to the Steering Committee for the Review of Government Service Provision (SCRGSP). The SCRGSP endorsed the specifications out of session in late September 2009.

Data custodians, including the Department, are currently supplying data and data quality statements to the SCRGSP by 6 November 2009. Fourteen performance indicators will use data held by the Department (for example, Medicare and aged care data).

The SCRGSP will collate the NHA performance data and supply it to the Council of Australian Governments (COAG) Reform Council (CRC), along with commentary on the quality of the data, by 31 December 2009. The independent CRC will provide annual reports to COAG containing the performance indicator data and an assessment of the performance of government in meeting the objectives and outcomes of the NHA.

The CRC's first report on the NHA performance indicators will be provided to COAG in March 2010. These reports will be made public.

National Health Information Agreement

Background **-** The National Health Information Agreement 2004-2009 (NHIA) governs the processes through which the Commonwealth, State and Territory health and statistical authorities develop, collect and disseminate health information, including national data standards. Since its inception in June 1993, the NHIA has enabled the development of infrastructure to underpin national health data frameworks, including the National Health Data Dictionary (NHDD) and the National Minimum Data Sets. The Agreement has also facilitated national data reporting requirements such as the Australian Health Care Agreements.

Ownership of data **-** Under the NHIA the owner of the information is the collecting authority. Owners may also have a custodial role for information they receive from and manage for other parties. The handling of data from the private sector is not covered by the agreement.

The data owners may specify conditions regarding the use, release and publication of information and additional conditions as are reasonable and necessary. Release of unpublished information to any party requires the approval of the owner unless it meets specific conditions. The NHIA does not provide guidance on such conditions.

The terms 'owners', 'custodians' and 'providers' are used interchangeably.

Intellectual Property **-** Unless in the public domain, data provided by a party to the Agreement remains the sole property of that party. Release, publication or other use of the data by any other party or group will be within any arrangements set by the providing party.

Supply of data **-** The supply of data is not dealt with in the NHIA – it only notes that the data provider has responsibility for the quality and completeness of data.

Data specifications and timing **-** Data specifications in terms of agreed definitions and standards are to be applied rigorously to ensure that information can be compared nationally. Therefore, the level of data contributed to national collections needs to be agreed for each collection. The Australian Institute of Health and Welfare is responsible for maintaining the NHDD and other quality control standards to encourage accuracy and consistency in the collection and reporting of health information as agreed by the National Health Information Group reporting to the Australian Health Ministers' Advisory Council. Timing is noted in a general way: information is to be collected with agreed timeframes.

ATTACHMENT B

Differences between public and private hospitals identified in submissions relating to the Productivity Commission's Public and Private Hospitals Issues Paper

The Discussion Draft recognises differences between public and private hospitals, and stresses that a key issue between the sectors is the type of product they deliver (p. 74). The Productivity Commission noted key differences which were identified in the first round of submissions including:

- *Clinical education and training* – the primary responsibility for clinical education and training rests with the public hospital system, particularly the major tertiary hospitals (Qld Health, p. 2; SA Health, p. 2).
- *Capital investment, development and maintenance* – generally more actively pursued in the private sector (Rhonda Kerr, p. 11).
- *Clinical pathways* – 'For example, private hospitals specialising in major surgery usually discharge post surgery to specialist rehabilitation services, while in public hospitals rehabilitation is provided in house' (SA Health, p. 3).
- *Funding models* – Public hospitals have 'limited (and generally fixed) access to benefits from private health insurers' (SA Health, p. 2).
- *Geographic distribution* – 'In February 2009, 51.9% of public hospitals compared with 4.5% of private hospitals, were located outside major cities and inner regional areas' (DoHA, p. 4).
- *Non-admitted patient services* – public hospitals account for the vast majority of unplanned services provided by EDs, and the vast majority of planned services provided by outpatient clinics (DoHA, p. 8).
- *Number of disciplines* – private hospitals have the option of restricting their clinical activities to a small number of DRGs, whereas public hospitals are expected to sustain a broad range of disciplines (SA Health, p. 4).
- *Patient casemix* – private hospitals are primarily concerned with planned procedures, while public hospitals are concerned with all possible medical contingencies, including emergency admissions (DoHA, pp. 9-10).
- *Product differentiation* – 'The private product is distinct from the public product in the sense that patients who elect to receive private treatment have already made a full, compulsory contribution to the public hospital system through their taxes as part of the universal Medicare coverage. This means that patients need to be convinced to spend additional money in order to receive private treatment. (CHA, pp. 1-2).
- *Role* – 'Public hospitals have an obligation to provide all Australians who present to them with free public hospital care and access to services based on clinical need. Public hospital access also needs to be provided across the state to ensure reasonable access to hospital care by residents. This means providing the full range of specialist inpatient, outpatient, emergency and diagnostic services at all times…This compares to private hospitals that can choose where, how and what they offer' (SA Health, p.2).
- *Workforce structures* – Public hospitals employ primarily salaried medical staff, while private hospitals have primarily fee-for-service staff (SA Health, p.2).

ATTACHMENT C

National Healthcare Agreement - Performance Indicators

1. Proportion of babies born with low birth weight
2. Incidence of sexually transmitted infections and blood-borne viruses
3. Incidence of end-stage kidney disease
4. Incidence of selected cancers
5. Proportion of persons obese
6. Proportion of adults who are daily smokers
7. Proportion of adults at risk of long-term harm from alcohol
8. Proportion of men reporting unprotected anal intercourse with casual male partners
9. Immunisation rates for vaccines in the national schedule
10. Breast cancer screening rates
11. Cervical screening rates
12. Bowel cancer screening rates
13. Proportion of children with 4th year development health check
14. Waiting times for GPs
15. Waiting times for public dentistry
16. People deferring recommended treatment due to financial barriers
17. Proportion of diabetics with HbA1c below 7%
18. Life expectancy
19. Infant/young child mortality rate
20. Potentially avoidable deaths
21. Treated prevalence rates for mental illness
22. Selected potentially preventable hospitalisations
23. Selected potentially avoidable GP-type presentations to emergency departments
24. GP-type services
25. Specialist services funded through Medicare
26. Number of dental services
27. Optometry services claimed through Medicare
28. Public sector community mental health services
29. Private sector mental health services
30. Proportion of people with diabetes who have a GP annual cycle of care
31. Proportion of people with asthma with a written asthma plan
32. Proportion of people with mental illness with GP care plans
33. Antenatal visit in the first trimester of pregnancy
34. Waiting times for elective surgery
35. Waiting times for emergency department care
36. Waiting times for admission following emergency department care
37. Waiting times for radiotherapy and orthopaedic specialists
38. Adverse drug events in hospital
39. Staphylococcus aureas (including MRSA) bacteraemia in hospitals
40. Pressure ulcers in hospitals
41. Falls resulting in patient harm in hospitals
42. Intentional self-harm in hospitals
43. Unplanned/unexpected readmissions within 28 days of selected surgical admissions
44. Survival of people diagnosed with cancer
45. Rates of services: Overnight separations
46. Rates of services: Outpatient occasions of service

47. Rates of services: Non-acute care separations
48. Rates of service: hospital procedures
49. Residential and community aged care services per 1,000 population aged 70+ years
50. Staphylococcus aureas (including MRSA) bacteraemia in residential aged care
51. Pressure ulcers in residential aged care
52. Fall resulting in patient harm in residential aged care
53. Older people receiving aged care services
54. Aged care assessments completed
55. Younger people with disabilities using residential, CACP and EACH aged care services
56. People aged 65 years or over receiving sub-acute services
57. Hospital patient days used by those eligible and waiting for residential aged care
58. Patient satisfaction/experience
59. Age-standardised mortality by major cause of death
60. Access to services by type of service compared to need
61. Teenage birth rate
62. Hospitalisation for injury and poisoning
63. Children's hearing loss
64. Indigenous Australians in the health workforce
65. Net growth in health workforce
66. Public health program expenditure as a proportion of total health expenditure
67. Capital expenditure on health and aged care facilities as a proportion of capital consumption expenditure on health and aged care facilities
68. Proportion of health expenditure spent on health research and development
69. Cost per case mix-adjusted separation
70. Accredited and filled clinical training positions

ATTACHMENT D

Data Collections managed by the Department of Health and Ageing

APC – Admitted Patient

- Annual dataset. (Latest 2007/08)
- First supply in December 2009 (submitted by States/Territories)
- Three further supplies in 2010 (submitted by AIHW) – February, April, May

Covers all hospitals, all patients

Non-Admitted ED

- Annual dataset. (Latest 2007/08)
- Public Hospitals only
- First supply in December 2009 (submitted by States/Territories)

Three further supplies in 2010 (submitted by AIHW) – February, April, May

Outpatient

- Annual dataset. (Latest 2007/08)
- Public Hospitals only
- First supply in December 2009 (submitted by States/Territories)

Three further supplies in 2010 (submitted by AIHW) – February, April, May

ESWT – Elective Surgery Waiting Times

- Annual dataset. (Latest 2007/08)
- Public Hospitals only
- First supply in December 2009 (submitted by States/Territories)

Three further supplies in 2010 (submitted by AIHW) – February, April, May

ESWL Reduction Plan

- Quarterly data. Latest June 2009
- Public Hospitals only
- Submitted by States/Territories

Due one month after end of separation quarter (i.e. June quarter due July 31st)

PHE – Public Hospitals Establishments

- Annual dataset. (Latest 2007/08)
- Public Hospitals only
- First supply in December 2009 (submitted by States/Territories)

Three further supplies in 2010 (submitted by AIHW) – February, April, May

PHDB – Private Hospitals Data Bureau

- Monthly submissions
- Data is due 6 weeks after separation month (i.e. June 2009 data is due mid-August 2009)
- Approximately 500 private hospitals and day surgeries submitting

Submissions cover all patients treated in private hospitals. Includes DVA, Third-Party, Workers' Compensation, Dept Defence, Privately Insured & Self-Insured

HCP – Hospital Casemix Protocol

- • Monthly submissions
- • Data is due 12 weeks after end of separation month (i.e. June 2009 is due end September 2009)
- • 38 health funds submitting

Submissions cover privately-insured patients, admitted to private or public hospitals

HCP2 – Hospital Casemix Protocol

- Quarterly submissions
- Data is due 12 weeks after end of treatment quarter (i.e. quarter for January-March 2009 is due end of June 2009)
- 36 out of 38 health funds submitting, two are currently building systems

Submissions cover privately-insured patients, treated by (but not admitted to) private or public hospitals

HCPGT – Hospital Casemix Protocol (General Treatment) – Dental

- Monthly submissions
- Data is due 6 weeks after the end of treatment month (i.e. June 2009 is due mid-August 2009)
- 38 health funds will submit this data – the collection is due to commence as of 1 July 2009

Submissions cover dental services for which health funds have paid benefits

Preliminarily Investigations of Comorbidities using the Charlson Index

The Charlson Index is a well validated measure of comorbidity in adults. It predicts the 1 year mortality for a patient who may have a range of significant comorbid conditions such as diabetes, heart disease, renal disease, cancer, dementia and AIDS. A higher Charlson Index score signifies greater comorbidity and a greater likelihood of death within one year, in addition to the primary disease for which they were initially hospitalised.

The original Charlson Index was calculated from the relative risks of mortality in a small cohort of medical patients; the risks were adjusted and used as weighted measures for a variety of comorbid conditions. In total, 30 comorbid conditions were identified with 17 of these having adjusted relative risks of death at one-year of 1.2 or above. The summed weights for these 17 comorbid conditions produce an ordinal score or index weight for each patient. The validation of the final index was on a cohort of breast cancer patients.[2]

Several researchers have adapted the original Charlson Index to use International Statistical Classification of Diseases and Related Health Problems (ICD) codes because these are how comorbidities and procedures are commonly documented in administrative health records. Romano et al in 1993[3], Deyo et al in 1992[4], and Ghali et al in 1996[5] have all published competing versions of the Charlson Index using ICD codes. Deyo et al were stricter in their interpretation of the Charlson comorbidities whereas Romano et al tended to be more conceptual in their approach; however, both adaptations are similar in identifying acute complications associated with the index admission versus those related to chronic conditions.

The Romano version, known as the 'Dartmouth-Manitoba algorithm', has become the most widely used, although Romano argued that a variety of indices for different purposes may be useful. The disease groups included in the Romano version are: myocardial infarction, congestive cardiac failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic pulmonary disease, rheumatological disease, peptic ulcer, liver disease – mild, diabetes – mild to moderate (weighting = 1), diabetes – chronic complications, hemiplegia or paraplegia, renal disease, any malignancy including lymphoma and leukaemia (weighting = 2), liver disease – moderate to severe (weighting = 3), metastatic solid tumour, and auto-immune deficiency disease (weighting = 6).

However, the Romano version used the superseded ICD-9-CM codes. The Centre for Health Services Research at The University of Western Australia has updated the Romano version of the Charlson Index to use ICD-10-AM codes.

In comparison to the two decades of research effort that lies behind the Charlson Index, the development of an internationally accepted paediatric equivalent is still in its formative years.

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[2] Charlson M, Pompeii P, Ales K, McKenzie C. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *Journal of Chronic Diseases* 1987; **40**: 373-383.

[3] Romano P, Roos L, Jollis J. Adapting a clinical comorbidity index for use with ICD-9-CM administrative data: differing perspectives. *Journal of Clinical Epidemiology* 1993; **46**: 175-1079.

[4] Deyo R, Cherkin D, Ciol M. Adapting a clinical morbidity index for use with ICD-9-CM administrative databases. *Journal of Clinical Epidemiology* 1992; **45**: 613-619.

[5] Ghali W, Hall R, Rosen A, Ash A, Moskowitz M. Searching for an improved clinical comorbidity index for use with ICD-9-CM administrative data. *Journal of Clinical Epidemiology* 1996; **49**: 273-78.

Fact Sheet

Member Experience Survey 2009

Survey results

Average national Member Experience Index rating of 70/100, based on 21,621 responses, covering 144 private hospitals Australia wide

Top ranked hospitals by state:

Western Australia

1. South Perth Hospital, with a Member Experience Index score of 81
2. Mercy Hospital Mount Lawley, with a Member Experience Index score of 76
3. Bethesda Hospital, with a Member Experience Index score of 76

South Australia

1. Sportsmed - SA Hospital, with a Member Experience Index score of 78
2. Burnside War Memorial Hospital, with a Member Experience Index score of 76
3. North Eastern Community Hospital, with a Member Experience Index score of 76

New South Wales

1. Port Macquarie Private Hospital, with a Member Experience Index score of 76
2. Brisbane Waters Private Hospital, with a Member Experience Index score of 75
3. Berkeley Vale Private Hospital, with a Member Experience Index score of 75

Tasmania

1. Calvary Hobart, with a Member Experience Index score of 72
2. Calvary Launceston, with a Member Experience Index score of 72
3. Hobart & St Helens Private Hospital, with a Member Experience Index score of 67

Victoria

1. St John of God, Berwick, with a Member Experience Index score of 78
2. Shepparton Private Hospital, with a Member Experience Index score of 78
3. Glenferrie Private Hospital, with a Member Experience Index score of 78

Queensland

1. Mater Hospital Redland, with a Member Experience Index score of 79
2. Mater Hospital Gladstone, with a Member Experience Index score of 77
3. (tied) Sunshine Coast Private Hospital, with a Member Experience Index score of 76
   St Stephens Private Hospital , with a Member Experience Index score of 76

Top ranked hospitals – national:

1. South Perth Hospital, with a Member Experience Index score of 81
2. Mater Hospital Redland, with a Member Experience Index score of 79
3. St John of God, Berwick, with a Member Experience Index score of 78
4. Shepparton Private Hospital, with a Member Experience Index score of 78
5. Glenferrie Private Hospital, with a Member Experience Index score of 78
6. Sportsmed - SA Hospital, with a Member Experience Index score of 78

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State rankings:

1. Western Australia, with an average Member Experience Index score of 72.5
2. South Australia, with an average Member Experience Index score of 71.6
3. New South Wales, with an average Member Experience Index score of 70.5
4. Victoria, with an average Member Experience Index score of 70.4
5. Tasmania, with an average Member Experience Index score of 70.3
6. Queensland, with an average Member Experience Index score of 69.7

The top three reasons reported for satisfaction with accommodation:

1. Easy access to bathroom
2. Access to TV, telephone
3. Good condition of bathroom facilities

The top three reasons reported for dissatisfaction with accommodation:

1. noise and being disturbed by others
2. lack of privacy in the room
3. shared bathroom facilities

Gap:

- Average gap $1086
- 22% of respondents were not advised they would have a gap by treating specialist
- 5% of respondents were advised an incorrect gap amount by treating specialist
- 32% of respondents were not advised they would have a gap by anaesthetist
- 9% of respondents were advised an incorrect gap amount by a anaesthetist
- 65% of respondents were not advised they would have a gap for pathology and x-rays

Other facts:

- 73% of respondents stayed in a private room
- 87% of respondents would recommend hospital
- 10% of respondents perceived they experienced a harmful event
- Nationally, 46,000 people have taken part in two Hospital Experience Surveys conducted by Medibank Private, the only study of its kind

About Medibank

- Medibank Private covers 3,089,448 resident members across all states and territories
- Total hospital admissions (2007/08): 810,663
- Medibank Private contracts with all major private hospital groups and independent hospitals in Australia