Australian
Private Hospitals
Association

Mr David Kalisch
Commissioner
Productivity Commission
LB 2 Collins Street East
MELBOURNE VIC 3000

Dear Mr Kalisch

On behalf of the Australian Private Hospitals Association (APHA), I attach a supplementary response to the Draft Report of the Commission's Research Study into the Performance of Public and Private Hospitals.

This additional comment has been necessitated by the fact that the Queensland Nursing Union, in its response to the draft Report, has made several erroneous comments about practices in private hospitals. APHA cannot allow these comments remain on the public record without correction. We also make provide our comments to assist the Commission in the preparation of its final Report.

APHA requests that the attached response be placed on the Commission's website.

Yours sincerely

Michael Roff
CHIEF EXECUTIVE OFFICER
23 November 2009

APHA RESPONSE TO COMMENTS MADE BY THE QUEENSLAND NURSING UNION (QNU) IN RESPONSE TO THE COMMISSION'S DRAFT REPORT ON THE PERFORMANCE OF PUBLIC AND PRIVATE HOSPITALS

APHA notes with concern a number of significant inaccuracies in the submission of the QNU to the Commission's draft Report. Therefore, this supplementary submission provides the Commission with accurate information in relation to some of the statements made. Page numbers refer to the QNU submission.

QNU Statement:

- *The private sector is only required to report sentinel events under the Queensland Coroner's Act 2003 (page 3).*

In addition to the requirements of the *Queensland Coroner's Act 2003*, Queensland private hospitals have a mandatory requirement to report sentinel events under the *Private Health Facilities Act 1999 s (144)*

This Act requires licensees of private health facilities to submit reports to the Chief Health Officer, the purpose of which is to:

- Monitor the quality of health services provided at private health facilities
- Enable the State to give information to the Commonwealth or another State under agreements prescribed under Section 147 of the Act and
- Monitor the general state of the health of the public having regard to the types and numbers of health services provided at the facilities.

The following reports are required to be provided by all private health facilities, with penalties applying under the Act for breach. Reports must be in the approved form and given at the times prescribed under by regulation.

1. **Sentinel Event Notification**

Each private facility has a mandatory requirement under the Act to report incidences of unexpected death or serious harm to a patient which occurred within the facility. A prescribed Sentinel Event Notification Form must be completed and submitted to the Queensland Health Private Health Regulatory Office within two working days of the sentinel event occurring. The Chief Health Officer may request that the facility undertake a Root Cause Analysis in which case an interim or final summary should be submitted within 45 working days.

2. **Adverse Outcome Data**

Private health facilities are required to submit 6 monthly adverse outcome data to the Chief Health Officer within 35 days after the end of each 6 monthly period. Adverse Event data collection includes, Procedural and Surgical Adverse Outcomes; Medical Adverse Outcomes; & Facility Wide Adverse Outcomes; In addition to

medical, surgical and facility wide adverse outcome reporting, separate reporting is required for the following specialty units/services: Cardiac Catheterisation Unit; Cardiac Surgery Unit, Intensive Care Unit, IVF Unit, Mental Health Unit, Neurosurgery Unit, Obstetric Unit & Neonatal Services.

Private hospitals also must comply with the Queensland *Health Quality & Complaints Commission Act 2006.*

Under this Act the Queensland Health Quality and Complaints Commission has the power to make Standards. There are currently seven Standards in force. All public and private hospitals have an obligation to have systems and processes in place to comply with these Standards and must submit mandatory data in relation to these standards, which include:

- Review of Hospital Related Deaths;
- Hand Hygiene;
- Surgical Safety:
  - Antibiotic Prophylaxis
  - VTE Prophylaxis
  - Ensuring Correct Surgery
- Management of Acute Myocardial Infarction On and Following Discharge;
- Complaints Management;
- Credentialing and Defining the Scope of Clinical Practice; and
- Providers Duty to Improve the Quality of Health Services.

In addition to the above, private health facilities also provide reports in relation to the Queensland Health Clinical Governance Implementation Standard (4): Variable Life Adjusted Display.

Variable Life Adjusted Displays (VLADs) provide a graphical overview of clinical outcomes for a defined set of indicators, over the course of a selected period. It is a quality monitoring tool which when used with mortality as the outcome indicator, displays estimated statistical lives gained, by plotting the cumulative difference between expected and actual outcomes over a series of patients, ordered by discharge date, within a hospital. The VLAD also has a flagging mechanism which indicates when an investigation of the indicator is warranted. There are three levels of flag, depending on severity. The graphs are compiled from the *Queensland Hospital Admitted Patient Data Collection* which is a mandatory dataset for both public and private hospitals.

Reports are provided monthly to hospitals and if any indicators have been flagged there is a recommended investigation process depending on the severity of the flag. Copies of these reports are also provided to the Chief Health Officer who may require a facility to conduct an investigation within a defined timeframe.

QNU Statement*:*

- *To some extent the private sector self regulates. The accreditation tool varies from organisation to organisation, however many accreditors are from the private sector (page 3).*

This statement is totally incorrect. The private hospital sector in Queensland does not self regulate, but is in fact governed by one of the most comprehensive and robust licensing and compliance regimes in Australia. The extract below is taken from the home page of the Queensland Government – Private Health Regulatory Office (http://ww.health.qld.gov.au/privatehealth/default.asp)

The Private Health Regulatory Office is responsible for the strategic direction and management of a whole of state compliance, corrective action, clinical audit, operational and environmental safety and advisory role for the protection of the health and well being of patients receiving health services at private health facilities, ensuring that the private health care sector complies with the accreditation, licensing and any other regulatory and legislative requirements of the Private Health Facilities Act 1999

Underpinning the *Private Health Facilities Act 1999* are the *Private Health Facilities Standards*, compliance with which is mandatory. These standards (available from the above website) include:

- Continuous Quality Improvement
- Credentials and Clinical Privileges
- Ethics
- Infection Control
- Information Management
- Management & Staffing
- Minimum Patient Throughput
- Patient Care
- Physical Environment
- Specialty Health Services

In addition to the Act and the Standards, private health facilities must also meet the requirements of the Clinical Services Capability Framework. As noted on the website of the Private Health Regulatory Office this framework specifies:

The support services, staff profile, minimum safety standards and other requirements to be met in private health facilities to ensure safe and appropriately supported clinical services……The level of a service describes the complexity of the clinical activity undertaken by that service and is chiefly determined by the presence of medical, nursing, support and ancillary health care personnel who hold qualifications compatible with the defined level of care.

The Private Health Facilities Act 1999 – Part 1 3 (2) (d) *provides for compliance with this Act to be monitored and enforced.*

Part 8 Division 1 – s 88 (1) Functions and Powers permits an Authorised Person (appointed by the Chief Health Officer) to have the *'functions of conducting investigations and inspections to monitor and enforce compliance with this Act.*

In accordance with this provision, the Private Health Regulatory Office conducts regular onsite inspections of all private health facilities to monitor compliance with the Act, the Standards and the Clinical Service Capability Framework. An extremely detailed audit tool (available from the website previously noted) is used during the onsite audit. If any non-compliance is identified, facilities are issued with a compliance notice and have a statutory obligation to remedy the breach within the timeframes prescribed. Significant penalties apply under the Act for any breaches of the Act with the ultimate sanction being loss of licence to operate.

The Chief Health Officer may immediately suspend a licence if:

S85 (1)

(a) a ground exists to suspend or cancel the licence
(b) the circumstances are of a nature that it is imperative to suspend the licence immediately to ensure the health and wellbeing of patients are not affected in an adverse and material way.

As can be evidenced, the private sector is not self regulated but is required to meet stringent legislative and regulatory requirements, accompanied by onsite independent audit and inspection. It should be noted that no such regime applies to public hospitals in Queensland which are effectively self regulated at the District level.

QNU Statement*:*

- *According to the Queensland Licensing Unit each accreditor has a different approach in spite of the chosen tool including the same question (page 3).*

Inter-Rater Reliability amongst accreditation surveyors has been identified by both public and private hospitals nationally as an issue and is not specific to private facilities. There are significant differences between the public and private sectors in terms of their regulatory and compliance regimes and medical model of care. It is therefore imperative that surveyors have a sound understanding of the regulatory requirements governing the organisations they are surveying. Inevitably this results in a tendency for the majority of the survey team to have a public sector background when surveying public hospitals and similarly a private sector background when surveying private hospitals. However, generally there will be at least one surveyor from the opposite sector included in the survey team

QNU Statement:

- *Organisations require accreditation before they can negotiate with private health funds. This creates a pressing need to be successful in accreditation in the private sector (page 3).*

It is correct that private health Insurers require private hospitals with whom they choose to contract to maintain accreditation with a recognised 3rd party health care accreditation agency. This is completely appropriate. Of far greater importance, and a fact ignored by the QNU, is that in Queensland, it is a requirement under the *Private Health Facilities Act 1999* for all private health care facilities to be accredited as evidenced from the following extract from the Act:

S48 – Conditions of Licence (1)

(b) within 90 days after the day of issue of the licence, the licensee must start a quality assurance program, conducted by a quality assurance entity;
(c) within 3 years after the day of issue of the licence, the licensee must receive certification from the quality assurance entity that the facility operates under a quality assurance system;
(d) after the certification mentioned in paragraph (c) is received, the facility must continue to be certified under the program as a facility that operates under a quality assurance system.

There is no Queensland legislative requirement for public hospitals to maintain accreditation, although accreditation is encouraged. It should be noted that it is a requirement under the *Commonwealth Private Health Insurance Act 2007* for **all** hospitals treating privately-insured patients to be accredited before they can obtain a Commonwealth-issued provider number that allows them to claim benefits from private health insurers. This accreditation must be maintained.

QNU Statement:

- *Our members in the private sector have claimed their reports on adverse events have been destroyed at the ward/unit level and that incentive bonuses paid to managers for meeting performance targets sustains this practice (page 3).*

The QNU provides no evidence for what can only be described as a spurious and outrageous allegation.

The Private Health Facilities Act 1999 contains significant penalties for private facilities which:

- Fail to comply with the standards relevant to the facility
- Contravene a condition of licence

- Fail to give information
- Fail to produce required documentation/reports or
- Provide false or misleading reports

Not only are private facilities subject to penalties for a breach of the Act, but s143 requires their Executive Officers to ensure that the corporation complies with the Act. Penalties apply to individual Executive Officers for breaches of the Act.

It is a condition of licence that all Queensland private health facilities maintain appropriate indemnity insurance. Indemnity Insurers require private hospitals to complete detailed service and risk management profiles and impose stringent notification requirements in terms of circumstances which have or have the potential to, give rise to a claim. Failure to notify an incident which subsequently gives rise to a claim, would not only invalidate the insurance cover in relation to the claim, but in all probability would result in either substantially increased premiums in the future or the insurer declining to cover the hospital for its future indemnity insurance requirements.

With both a statutory obligation to report, combined with a business imperative to maintain indemnity insurance as a condition of licence, it would be a very foolish Chief Executive who encouraged the destruction of ward level adverse incident reports and therefore APHA contends that there is no credibility to this allegation.

QNU Statement:

- *As the private sector provides services that will give the best return on investment, they will perform surgery in the most profitable areas. This leaves the community with limited meaningful choice in health services, particularly in rural areas and puts more pressure on the public sector (page 3).*

Private hospitals receive no direct funding for capital equipment and improvements, safety and quality activities or education and training of clinical personnel. The hospitals meet these costs out of operating margin, derived from individual case payments for hospital episodes of care. For private hospitals offering a comprehensive range of services, this inevitably results in an element of cross subsidization within organisations. However, to suggest that the private sector only *offers surgery in the most profitable areas and leaves the community with limited meaningful choice, particularly in rural areas and puts more pressure on the public sector,* ignores the reality of the private hospital sector in Queensland.

As noted in the most recent ABS report on Private Hospitals, of the 5,687 licensed beds in Queensland, **2,824 (49.65%)** of these were outside the capital city of Brisbane.

In Queensland private hospitals are located in Cairns, Townsville, Mackay, Rockhampton, Gladstone, Yeppoon, Bundaberg, Hervey Bay, Maryborough, Buderim,

Cooroy, Gympie, Caboolture, Caloundra, Maroochydore, Nambour, Noosaville, Clifton, Pittsworth, Kingaroy, Toowoomba, Stanthorpe, Ipswich, and the Gold Coast. Clearly, private health consumers in Queensland have access to a broad range of private hospital services throughout the State, although the scope of services offered in some towns is largely governed by the hospital's ability to attract Visiting Medical Officers to the region.

Contrary to placing pressure on the public sector, Queensland private hospitals have actively participated in the State Government's Surgery Connect Program which provides an opportunity to treat additional elective surgery patients who have been waiting longer than clinically recommended.

As noted in the Queensland Health publication – *Quarterly Public Hospitals Performance Report – September Quarter 2009:*

> *The strategy enables patients to receive their treatment through the private hospital sector where the demand for these services cannot be met in public hospitals. This innovative strategy also helps ease the burden on our public hospitals which are experiencing increasing demands.*

In releasing the June 2009 Quarterly Report – Deputy Premier and Minister for Health Paul Lucas stated:

> *"It is important to note that Queensland still has the shortest elective surgery waiting times in the nation with a mean wait time of 27 days compared to the national average of 34 days. The current total number of 'long wait' patients has decreased across all categories from the same period last year by 19.1%. That is an encouraging sign that the 'long wait' reduction strategies Queensland Health has put in place, particularly Surgery Connect, are having a positive effect in ensuring timely access to elective surgery for Queenslanders."*

These comments are in stark contrast to the observations made by the Queensland Nurses Union.

When comparing Queensland public and private sector data, the growth in private sector activity is significant, as evidenced by the following table:

	PUBLIC HOSPITALS (QLD)	PRIVATE HOSPITALS (QLD)
Total Hospitals	177	108 (comprising 56 inpatient facilities and 52 day hospitals)
Available or Licensed Beds	10,354	6,343
Total Separations	784,630 **51.4%**	742,014 **48.6%**
Separations per 1,000 population	**190.2**	**177.9**
Increase in Total % share of Separations over time	**1998-99** 63.2% **2006-07** 51.4%	**1998-99** 36.8% **2006-07** 48.6%
Total Patient Days	2,872,078 60.2%	1,900,834 39.8%
Patient Days per 1,000 population	**697.1**	**457.4**
Increase in Total % share of Patient Days over time	**1997-98** 69.2% **2005-06** 60.2%	**1997-98** 30.8% **2005-06** 39.8%
ALOS (including same day)	**3.7**	**2.6**

Source: Australian Hospital Statistics – AIHW 2006/07 Released May 2008
Australian Bureau of Statistics – Private Hospitals 2006/7

QNU Statement:

- *True count of patients in most facilities is done at midnight. In some private facilities this means the count does not include day patients (page 3).*

This statement is incorrect. Inpatients are counted at midnight but day patients are counted as the total number of discharged day patients in the 24 hour period. Private hospitals separately report inpatient days & day patient separations.

QNU Statement:

- *Without sufficient data to demonstrate the ratio of registered numbers to other nursing staff in each sector it is difficult to determine how 'lean staffing costs' in the private sector provide quality outcomes (page 4).*

Nursing ratios per se do not guarantee quality outcomes. Quality outcomes are a result of the combination of medical, nursing and allied health clinical expertise, facilities and equipment & robust clinical governance processes.

QNU Statement:

- *The private sector employs unlicensed practitioners who do not hold formal qualifications, but we believe these unlicensed practitioners have been included in this category in the draft. In Queensland these staff and administrators are included in nursing hours for the cost centre budget. As there is no transparency or indeed reliable data on the actual workforce profile in the private sector, there is no dependable evidence available to make comparisons (page 4).*

Both the public and private health care sectors employ" unlicensed practitioners". These employees are referred to either as Assistants in Nursing or Patient Care Assistants/Attendants depending on the industrial instrument under which these personnel are employed.

The QNU is incorrect in its belief that there is no transparent and reliable data on the actual workforce profile in the private hospital sector.

Private Hospitals are required to submit admitted patient data to the Australian Bureau of Statistics which produces an annual private hospitals report.

In relation to staffing this report identifies by State by the following Full Time Equivalent staff categories:

Nursing Staff
Registered Nursing Staff
*Other Nursing Staff **
Salaried Medical Officers and Other Diagnostic Health Professionals
Administrative and Clerical
Domestic and Other Staff

** Other Nursing staff includes enrolled nurses.*

This report also identifies the average number of staff per occupied bed on a State by State basis under the following categories:

Nursing Staff
Registered Nursing Staff
*Other Nursing Staff **
*Other Staff ***

* Other Nursing Staff includes Enrolled Nurses.
** Other Staff includes salaried medical officers, diagnostic health professionals,

administrative, domestic and other staff.

As can be evidenced, the Australian Bureau Statistics Private Hospitals Reports clearly distinguish Registered Nurses from other nursing staff, including unlicensed practitioners, on both an FTE and average number of staff per occupied bed day basis.

QNU Statement:

- *Nursing/Midwifery workload management tool utilised in QH matches demand with supply for nursing/midwifery resources and incorporates a requirement for service profile to be built for each clinical unit (pages 4-5).*

The implication is that the private sector does not do this. In fact, the private hospital sector has used acuity based rostering systems for many years to ensure that staffing is appropriately aligned to the clinical care requirements of patients admitted to a particular ward or unit on a given day, based on casemix and patient acuity. An example of one such acuity based rostering system is Trend Care, widely used by Queensland private hospitals. .