
Findings

Data availability

FINDING 1.1

The Commission encountered significant delays in accessing hospital-related data beyond what could reasonably be expected to address privacy or confidentiality concerns. 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. Data agencies could facilitate greater data access by:

- having established protocols allowing access to data that does not breach privacy rules and meets certain public-interest requirements*
- strengthening the mechanisms through which data users can provide ongoing input on how data are collected and made available for analysis and research.*

FINDING 1.2

Information collected by the Australian Bureau of Statistics (ABS) at considerable public expense is a valuable resource for Australia. The Commission found that the ABS has a number of requirements that can restrict measured use of these public data, which the Commission suggests be reviewed by the Australian Government. There are also barriers to accessing data held by the Australian Institute of Health and Welfare (AIHW), due to a requirement to obtain approval from jurisdictions to release the data. This could be addressed by the states and territories delegating the approval of individual data requests to the AIHW, particularly where information would only be divulged to established data users and in a form that does not identify individual patients or hospitals.

Australia's public and private hospital systems

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 a comparable patient population, which makes comparisons more difficult.

Costs

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 where possible, as well as noting data deficiencies where they exist. The resulting estimates of hospital and medical costs should be considered experimental.

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 combined cost of nursing and other salaries, allied health, operating rooms and specialist suites, critical care, hotel costs, supplies, and on-costs were on average higher for public hospitals*
- medical and diagnostics costs were higher for private hospitals, although there are some recognised constraints with available data not separately identifying all medical costs in public hospitals*
- prostheses costs were higher in the private sector, but this is also likely to reflect a broader range of products being available for use in private hospitals compared to the public hospital sector*
- capital costs were estimated to be somewhat higher for public hospitals, but the extent of this result is particularly reliant on a range of data sources and adjustments to make the data more comparable.*

These differences were also evident when the estimates were disaggregated by jurisdiction, region and hospital size.

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

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

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, head-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 arrangements, and by utilising cost-effective electronic reporting of data.

Hospital-acquired infections

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 definitive finding will require the development of data collections that enable risk differences between hospitals to be distinguished from genuine differences in performance.

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 actions 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.

Other partial indicators

FINDING 7.1

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

FINDING 7.2

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

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.

FINDING 7.4

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.

Multivariate analysis

FINDING 8.1

A multivariate analysis of Australian hospital-level data established the best-practice benchmarks for each hospital in the sample. The benchmarks were influenced by a number of factors. The best-practice benchmarks were lower for hospitals that treat:

- *highly morbid patients*
- *patients from lower socioeconomic communities*
- *relatively more medical cases, as these cases are more difficult to manage*
- *more complex cases, although this is less so for the largest hospitals.*

FINDING 8.2

After controlling for differences in services provided and types of patients treated, the efficiency of public and private hospitals is, on average, similar. It was estimated that the output of individual hospitals in both sectors is, on average, around 20 per cent below best practice among the sampled hospitals. Among large and very large hospitals, the scope to improve technical efficiency is slightly greater for public hospitals. At the other end of the scale, the scope to improve efficiency is higher for small and very small private hospitals, although these results may be partly due to a number of factors that could not be accounted for in the analysis.

Informed financial consent

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.

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.

FINDING 9.3

A more robust future data source on informed financial consent (IFC) could be created by requiring privately-insured patients to indicate on their health insurance claim form whether they provided IFC prior to the procedure. Alternatively, medical specialists and service providers could be required to include as part of the billing and insurance-claim process an indication of whether documented evidence of IFC is held for the relevant item. This information could be collected and reported by the Private Health Insurance Administration Council.

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.

Indexation of Medicare Levy Surcharge thresholds

FINDING 10.1

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