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30 July 2009

Mr David Kalisch
Commissioner
Hospital Performance Study
Productivity Commission
LB2 Collins Street
MELBOURNE VIC 8003

Dear Mr Kalisch David

The Australian Medical Association (AMA) is pleased to make a written submission addressing the issues the Productivity Commission will need to deal with in undertaking this reference from the Federal Government.

The AMA represents medical professionals who interact with the hospital system in many different ways. Some of our members are engaged in only one sector or the other while others practise simultaneously in both public and private hospitals. Our members provide medical care and surgical procedures, they teach, they provide clinical governance and they serve the hospitals in many other capacities. Our GP members, while often not working directly in the hospital system, see the impact on their patients' health and wellbeing when access to hospital services is deeply constrained. It is often the GPs who have to pick up the pieces and help the patients and their families when hospital services are not available or fail to meet expectations.

The AMA holds that the plural nature of the public and private hospital system is one of the strengths of Australia's health system. It is readily apparent that taxpayer-sourced funding cannot bear the whole load of financing health care. It is equally apparent that in some areas of the health care system, taxpayers get much better value for money when governments buy health care services from competing providers than from trying to produce them in-house.

From the daily experiences of our members, the AMA is acutely aware of the unrelenting pressures on the public hospital system. A great deal has been written and said about the duplication of health bureaucracies in the federal system, the enormous wastage of effort in State and Territory jurisdictions in search of additional avenues to cost-shift onto Medicare and the extent to which efficiency gains might be possible.

The stark reality is that governments at all levels have failed to understand the resource implications of an ageing population increasingly beset by chronic illness and have failed to understand the significant risks from running the public hospital system at extreme levels of capacity utilization. The lack of capacity in our hospitals is being revealed right now by the swine flu epidemic.

Cost efficiency is never a sufficient measure of hospital system performance. Whenever the pursuit of budget savings (often masquerading as the pursuit of efficiency) puts patients' health at risk, political problems follow for both levels of government. The AMA is not content to have issues of quality of care and patient safety compromised. The trade-off between cost, quality & safety and access is complex and often poorly understood.

We note that the Commission's reference does encompass one explicit quality and safety issue, that of rates of hospital-acquired infections. The emergence of "superbugs" (manifesting as antibiotic-resistant infections) is a matter of considerable concern and scientific effort. Within the framework of comparative performance, if some jurisdictions are performing badly and others well, it is important that the differences in outcomes be studied and learnings shared. Improvement will happen only if the cause and effect is properly understood.

There are some limited areas where the two hospital sectors can be seen as being in competition with each other. However, the two sectors do have quite markedly differing casemix. Australia gets its best results when the two sectors have a strong symbiotic relationship. This is especially important given the cost of some advanced health technologies. It makes no economic sense to have duplicated and under-utilised resources in both sectors if there is scope for resources to be shared.

Your reference asks you to assess the relative performance of the public and private hospital systems based primarily on comparative costs. In our view, the reference the Government has given the Commission is poorly conceived. We fully expect the review to report the obvious—that each sector is relatively cost efficient in doing the things it focuses on and not quite as efficient in doing the things the other sector focuses on. Relative efficiency is, in our view, not a useful line of inquiry. As providers and as advocates for our patients, we are more interested in how each sector might be able to lift its game in what it does. For the medical profession, the question is the same—we are vitally interested in how we can improve the quality of our work and get better patient outcomes.

Many episodes of care now involve a wide range of services covering the investigation and diagnosis, the treatment (including the procedures) and the facilities that are used. It is necessary to look at each element separately to see how it can be done better. It is equally necessary to look at how the whole package is put together and how that helps, or impedes, the aims of high quality, safe and cost effective care.

While we do appreciate that the Commission is duty bound to deal with the reference as given, we express the hope that you will be able to find a way to focus your considerations on the avenues by which each hospital sector might be able to improve its efficiency but with due regard for the important issues of quality of care and patient safety.

Our submission addresses the very sturdy data challenges for this reference. This will have a significant impact on Commission's ability to address the terms of the reference.

The AMA stands ready to respond to any request for supplementary information on any aspect of our submission.

We wish you well with this very difficult task.

Yours sincerely

Francis Sullivan
Secretary General

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AMA Submission on to the Productivity Commission on the Performance of public and private hospital systems

Measuring comparative costs

Reference: *The Commission should consider a) comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals, using baseline data to be provided by states and territories under the new National Healthcare Agreement, and existing data provided to the Government by private hospitals. The analysis is to take into account the costs of capital, FBT exemptions and other relevant factors.*

The data shortcomings are so large, the AMA has grave doubts that the Commission will be able to draw any reliable conclusions.

There are significant differences between the casemix of the public and private hospital sectors. The most likely result of the investigation, assuming that the data shortcomings are not insurmountable, is that each sector is more efficient than the other in the areas it specializes in. However, that comparison is unlikely to tell us whether, or the extent to which, each sector might be able to improve its efficiency.

The cost structures in the large teaching hospitals in particular reflect the teaching and research components of the work that is done. Both these activities are inseparable from the provision of care. A doctor can be treating his patients, teaching his registrars and gathering material for research all at the same time, using all the same facilities and drawing on the same support staff and services. In some cases it will be possible to identify revenue streams for research activities, but that data is unlikely to inform any assessment of the costs of conducting research. Our members have commented that elective surgery throughput is significantly higher in the private sector. It is universally understood and accepted that surgery will take longer if doctors in training are being taught during it. That said, there are also cultural and industrial differences between the sectors which may have implications for relative cost efficiency. Unraveling the manifold influences on apparent cost differences is going to be extremely difficult.

Much of the current data is enterprise based and, accordingly, does not provide a suitable basis for comparing the aggregate costs of the two sectors, let alone any specific comparison for clinically similar procedures.

To progress this task, the AMA considers that the Commission will need to take account of costs at the enterprise level, the overhead costs in governance and all revenue expenditure. In particular:

- Governance costs need to encompass corporate governance in the private sector while, in the public sector, part of the Commonwealth health department's operating costs, much of State and Territory health departments' operating costs and the operating costs of the area health authorities and other relevant government agencies;
- Given that public hospital infrastructure has been funded by grants of capital—whereas the for-profit private sector has to service capital—considerable care will be required in factoring in the opportunity cost of the capital employed;
- The revenue expenditure (special tax breaks), focused on government-owned public hospitals and on church and charitable hospitals in both sectors, is very large and poorly

measured. FBT and payroll tax exemptions are two large items. A comprehensive assessment is required and should ideally encompass all revenue expenditure including income tax exemptions and tax deductible gift status.

The Commission will also have to develop a cost accounting methodology for attributing overhead costs across clinically similar procedures. The arbitrary nature of this allocation is a severe problem for the credibility of the work. Indeed, attributing overhead costs to broad activities (eg, outpatient services versus inpatient services) is arbitrary and very difficult.

The AMA notes two other issues that it considers to be relevant in this context:

- The Commission will need to objectively examine claims from some quarters that there is no level playing field for the two sectors. It has been suggested that some State and Territory health departments subject private hospitals to a more stringent licensing and regulatory regime than they apply to State-owned hospitals;
- Enterprise costs mask cross-subsidies. Many doctors working in both sectors undertake their public hospital work of treating patients and teaching young doctors as part of their commitment to community service. They understand the value of the training they were given and, in the nature of a true profession, they make a commitment to the next generation of doctors, aiming to give them the same hand up that they themselves received. They are only able to do this when they can cross-subsidise from the revenues earned in their private patient workload but, even so, they still try to moderate their fees for needy private patients.

There is increasing pressure, placed on salaried or contracted doctors by State and Territory health departments, to bill patients under the Commonwealth-funded MBS program, patients who really should be treated as public patients for free. This is, of course, very naked cost-shifting. It is questionable whether the State and Territory governments are acting in contravention of the law and the AHCAs. That issue aside, it will be readily apparent that such billings significantly skew the financial costs as measured. State and Territory governments will seek to extract any marginal revenues from cost-shifting as long as they are not penalized for doing so. It is therefore irrelevant whether the fee covers the cost of rendering the service. For its part, the Commonwealth has preferred to turn a blind eye to some of this cost-shifting while cutting its share of aggregate hospital funding through the AHCAs. The Commission should not fall into the trap of comparing rates of charging between those two sectors as if that informs relative costs.

Measuring hospital acquired infections

Reference: *The Commission should consider b) the rate of hospital-acquired infections, by type, reported by public and private hospitals, using baseline data to be provided by states and territories under the new National Healthcare Agreement, and existing data provided to the Government by private hospitals.*

The emergence of "superbugs" (manifesting as antibiotic-resistant infections) is a matter of considerable concern to all stakeholders. Given the trends in incidence, we expect increasing scientific efforts and a greater resource focus. The AMA will support any process that helps identify the scope of the problem and leads to better performance. The Commission's role seems to be limited to measuring hospital acquired infections. This is a necessary first step but it is not sufficient. The next step has be more clinical studies to establish both causes and

remedies. In medicine, there are many situations where solutions to problems in one area come from scientific advances in another. In this case, part of the solution may be external to the hospital sector (from advances in pharmacology), and part may be internal (driving improved performance by changing clinical practices within the hospital). The great challenge for the hospital sector is to find solutions that are both clinically effective and cost effective.

Within the framework of comparative performance, if some jurisdictions are performing relatively badly and others relatively well, it is important that the differences in outcomes are studied and learnings shared. There is a need to distinguish between apparent gaps in performance (due to differences in casemix) and real gaps in performance (due to practices and procedures). There is no roadmap for improvement if the causes of hospital acquired infections are not properly understood.

Adverse drug reactions are another costly issue for the entire health sector and have a material impact on the quality of outcomes. The same scientific approach is required in this area. This should be kept in mind for the future as it is outside the Commission's terms of reference.

Notwithstanding some concerns about the merits of a limited analysis of incidence, the AMA urges the Commission to take a very careful look at the reliability of the data on hospital-acquired infections. The track record of hospitals in reporting on performance measures, including hospital acquired infections, is generally poor. Negative trends are too often masked by government-orchestrated changes in definitions and categories. These changes are made under claims of improving data collections. In most cases, the aim is rather more obvious. Series breaks prevent comparisons over time and impede assessments of performance.

Informed financial consent (rates of IFC)

Reference: *The Commission should consider c) rates of fully informed financial consent for privately insured patients treated as private patients in both public and private hospitals, categorised by type of provider (that is, public hospital, private hospital, medical practitioner [by Speciality]), and by Statistical Local Area (SLA) or equivalent, including:*

i. *the average cost of out of pocket expenses for patients who do not receive enough financial information from the provider to give fully informed financial consent, the range of these costs and the maximum out of pocket cost incurred by in-hospital patients categorised by type of provider (as detailed above).*

ii. *best practice examples where fully informed financial consent is provided for every procedure, (with a specific emphasis on any best practice examples occurring in specialties where lack of fully informed financial consent is most common).*

The AMA strongly encourages its members to practise informed financial consent (IFC). It believes that policy objectives around IFC are best pursued through a voluntary framework, based on a strong foundation of education. Punitive regulatory approaches will lift compliance costs and add yet another burden of red tape on a system that already has surfeit of red tape.

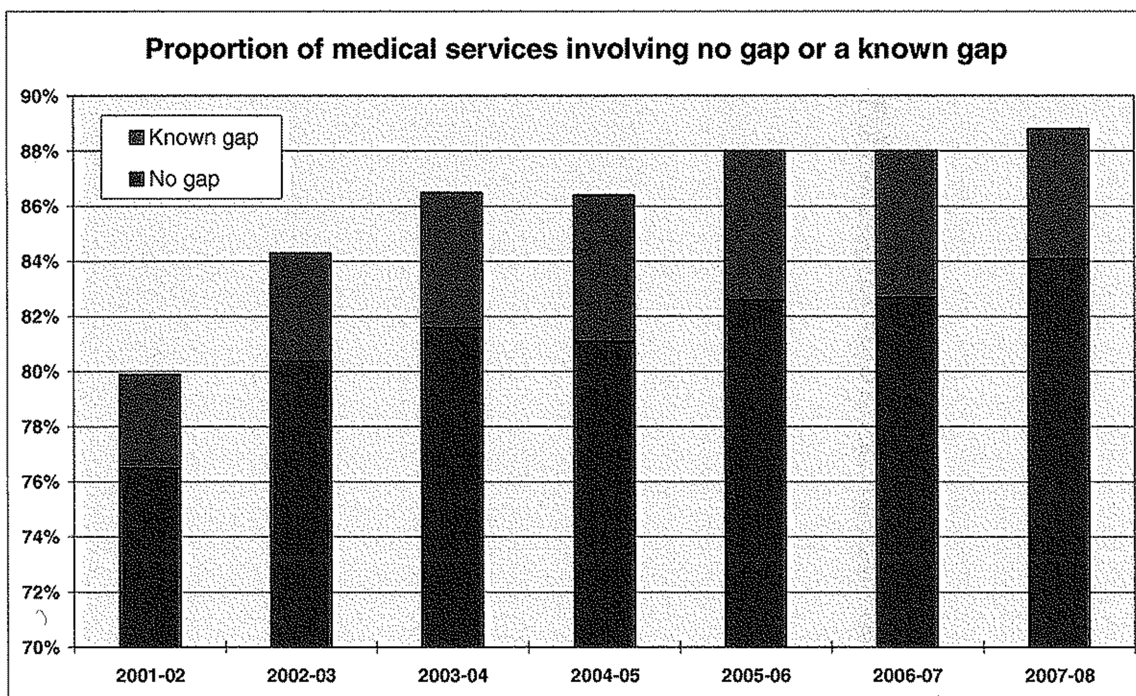
The reference as given the Government inappropriately overlooks a third player in the IFC equation—the private health insurer. Patients should be able to obtain prompt and reliable information on their benefit entitlements from their health fund. Sadly, this is too often not the case.

The IPSOS (TQA) data on rates of IFC for medical services is widely misunderstood and misconstrued. Before we address that issue, however, it is worth restating the policy context.

In August 2000, the government allowed private health insurers to offer gap cover schemes. These schemes worked far better than the previous arrangement (introduced in July 1995) that permitted above-schedule benefits only where purchaser-provider agreements existed. The introduction of gap cover schemes was a tacit acknowledgement by the government that MBS fees were no longer accepted by any parties as fair and reasonable fees. Under gap cover arrangements, private health insurers can set their own schedule of fees that allows the vast majority of patients to access medical services without a gap. Gap cover arrangements have been the major policy advance to deal with patient disquiet over uninsured gap amounts.

PHIAC reports that:

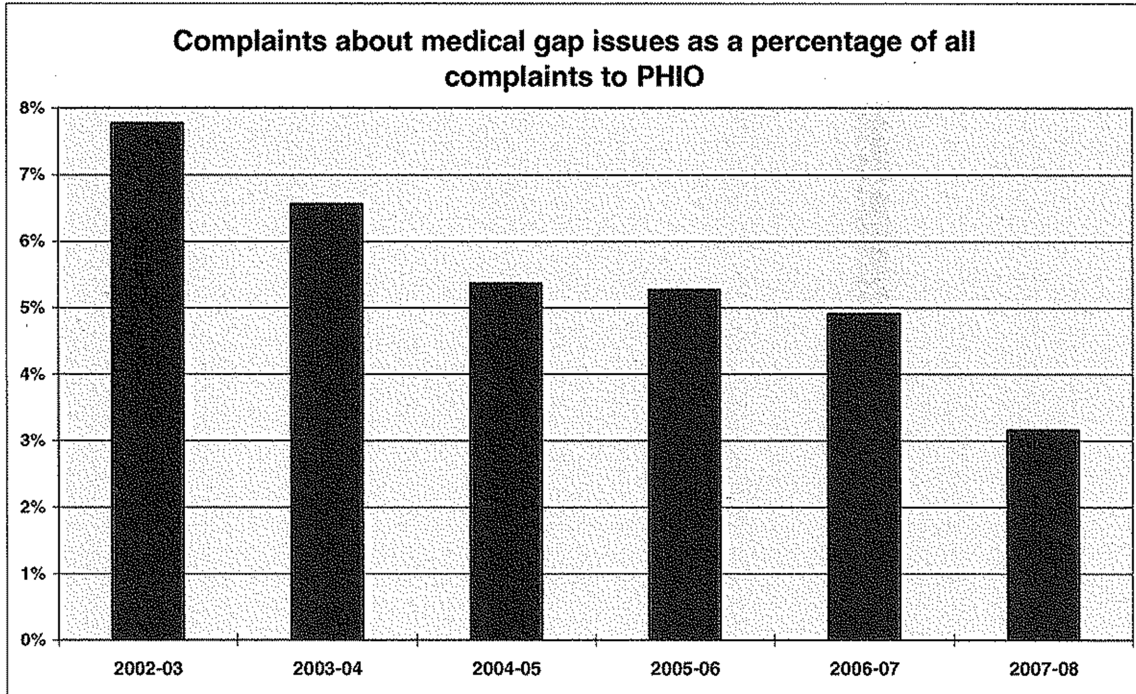
- The proportion of services with no gap costs at all has risen steadily from 76.5% in 2001-02 to 84.1% in 2007–08;
- The proportion of services with a known gap has increased from 3.4% in 2001-02 to 4.7% in 2007-08. However, it peaked at 5.4% in 2005-06, so part of the gain in the no-gap category represents a switch from known gap to no gap;
- For no gap and known gap products together, the proportion of services covered has risen from 79.9% in 2001-02 to 88.8% in 2007-08.



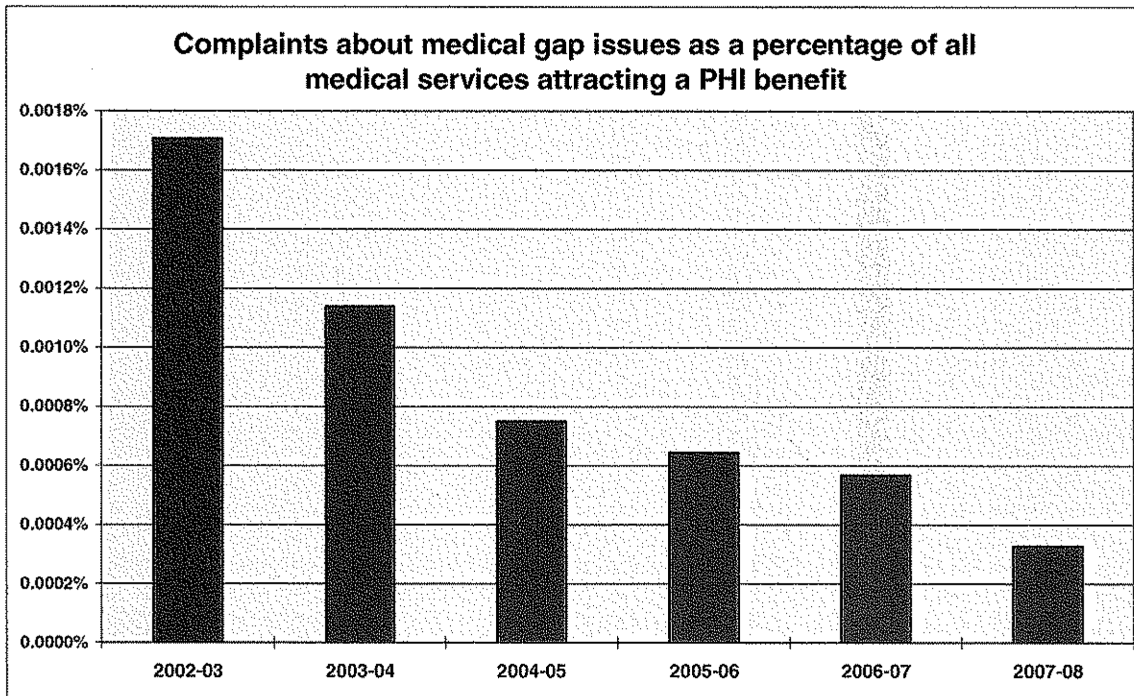
These trends have continued. By the March quarter 2009, no gap services had risen further to 84.9% of the total while no gap and known gap services together accounted for 89.4%. They

are clear evidence of health insurers and medical practitioners reaching common ground to make the private health insurance system more effective.

The Private Health Insurance Ombudsman (PHIO) reports on complaints about medical gap issues. These complaints cover both complaints about the size of the gap where there is IFC and complaints about lack of IFC. No breakdown is given. The number of complaints is very small and has contracted sharply, from 280 in 2002-03 to 76 in 2007-08.



As a proportion of all medical services attracting PHI benefits, the number of services involving complaints to the PHIO is miniscule. The 76 complaints made in the 2007-08 year represented 0.00033% of the 23 million services attracting a PHI benefit in that year.



In its 2008 annual report, PHIO commented that:

> *"Over the last few years practitioners have improved their advice to consumers and their efficiency in seeking informed financial consent (IFC) from patients. The number of complaints regarding IFC and medical gaps is now lower than at any time since the Ombudsman's office was established."*

The AMA's own IFC campaign ("*Lets talk about fees*") has undoubtedly contributed to that outcome.

The only conclusion to be drawn from the data is that lack of IFC for privately insured medical services is a small and rapidly diminishing issue.

We turn now to the foreshadowed issue, namely that the IPSOS (TQA) data on rates of IFC for medical services is widely misunderstood and misconstrued.

The IPSOS (TQA) data ascertains the proportion of episodes of care in which the patient considers that he or she has not received IFC. An episode of care will typically involve one transaction with a hospital. However, it often also involves a significant number of medical services rendered by a wide range of practitioners (physicians, surgeons, anaesthetists, pathologists, radiologists and so forth).

The way IPSOS (TQA) constructs the data, if just one doctor involved in an episode of care is perceived by a patient as having failed to give IFC, then the entire episode of care is classified as lacking IFC. There might have been another 5 or 10 doctors involved in the episode of care who did give IFC.

It follows that the IPSOS data cannot be used to inform the question of the rate of IFC by members of the medical profession. Notwithstanding this, the data still shows a fall in the percentage of episodes of care where there is not ***perfect*** IFC across all medical service providers. The latest survey indicates that 15% of such episodes did not involve perfect IFC. This cannot be taken to mean that 15% of doctors failed to give IFC. As the PHIAC data

shows, nearly 90% of medical services attracting a PHI benefit involve no gap at all or a known gap.

In conclusion, the AMA reiterates that the lack of IFC for privately insured medical services is a small and rapidly diminishing issue, and that the AMA will continue with its efforts to encourage doctors to practice IFC. Each week the AMA provides "Lets talk about fees" brochures to more medical practices, indicating that many doctors are making good use of these materials.

Informed Financial Consent (best practice examples)

Reference: *The Commission should consider best practice examples where fully informed financial consent is provided for every procedure, (with a specific emphasis on any best practice examples occurring in specialities where lack of fully informed financial consent is most common).*

There are particular provider groups for which it is more difficult to provide IFC because they rarely, if ever, see the patient before an episode of hospital treatment. With funding from the Department of Health and Ageing, the AMA has supported projects by the Australian Society of Anaesthetists (ASA), the Australian Association of Pathology Practices, the Australian Diagnostic Imaging Association (ADIA) and the Australian Association of Practice Managers (AAPM) to encourage best practice in the provision of information about fees to patients.

The ASA provides a suite of resources and an online IFC training module for its members which has also been adopted by the Australian and New Zealand College of Anaesthetists as part of their curriculum for trainees (www.asa.org.au). The ADIA has a dedicated website where member practices post fee information (www.adiaifc.com.au). The AAPM has developed an IFC Toolbox that provides information, resources and tools for member practice managers to review and update their business practices for the provision of IFC. It has provided each member with the IFC Toolbox CD.

Indexation factor for the Medicare Levy Surcharge (MLS) thresholds

Reference: *The Commission will also provide advice to the Government on the most appropriate indexation factor for the Medicare Levy Surcharge thresholds.*

The AMA considers that the **Labour Price Index** published by the Australian Bureau of Statistics (Catalogue number 6345.0) is the most appropriate index for MLS purposes. The ABS itself has noted that other measures of earnings, such as survey-based AWE and AWOTE, are affected significantly by changes in the composition of employment. As such, the trends in AWOTE bear little relation to the experience of the typical householder.

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