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eA276675
2009-00597

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Dear Commissioner

RE: SA HEALTH SUBMISSION TO THE PRODUCTIVITY COMMISSION DISCUSSION DRAFT ON PUBLIC AND PRIVATE HOSPITALS

Please find attached SA Health's submission on the Productivity Commission Discussion Draft on Public and Private Hospitals.

If you have any questions or queries regarding this submission please contact Dr David Filby, Executive Director, Policy and Intergovernment Relation on telephone (08) 8226 7057 or via email david.filby@health.sa.gov.au.

Yours sincerely

DR TONY SHERBON
Chief Executive
5 / 11 / 09

SOUTH AUSTRALIA DEPARTMENT OF HEALTH

COMMENTS ON THE PRODUCTIVITY COMMISSION DISCUSSION DRAFT: PUBLIC AND PRIVATE HOSPITALS, OCTOBER 2009

Introduction

This submission provides commentary on a number of specific areas raised in the Productivity Commission's Discussion Draft, namely focusing on:

- Multivariate Analysis
- Standardised Mortality Rates (SMR)
- Prostheses costs
- Teaching costs
- Capital costs
- Community Service Obligation (CSO) hospitals
- Partial Indicators - Waiting lists
- Hospital Casemix Protocol (HCP) data
- Comparability of private and public cost per casemix adjusted separation - Table 5.2
- Data accessibility
- Data improvement

Discussion

Multivariate Analysis

It is difficult to provide specific comment until a more detailed methodology is provided regarding the proposed multivariate analysis and it is concerning that the proposed timelines may not provide sufficient opportunity to examine and respond to the draft multivariate analysis.

Multivariate analysis is suggested as overcoming the shortcomings of reporting individual partial indicators. A critical factor for this will be the robustness and comparability of the data and variables used.

Many of the data shortcomings appear to remain and any findings will be compromised by the inconsistencies in the data.

Limitations in the data are acknowledged throughout the Discussion Draft report, for example only a sample of private hospitals will be covered in the data used for the analysis, and data is inconsistent for different jurisdictions.

The report states that Victoria and South Australia (SA) data are grouped into health service boards and regional health services respectively, and Tasmania has chosen only to report a single observation for all its public hospitals and was unable to provide more than one observation for all private hospitals.

These kinds of data inconsistencies seriously challenge the robustness of any modelling based on the data.

It is not clear why the SA data from Australian Institute of Health and Welfare (AIHW) for SA public hospitals is grouped according to regions. SA Health information provided to AIHW includes hospital codes and authority was given for SA public hospital identifiers to be released.

Standardised Mortality Rates (SMR)

The previous submission identified that there were concerns regarding private hospitals transferring older patients to public hospitals. SA Health data shows that over the past four years between around 5 - 6% of all transfers from private to South Australian public hospitals resulted in a discharge due to death. This should be factored into the analysis.

Prostheses costs

As reflected in the Discussion Draft the inconsistency in collection methods and missing data is detrimental to the level of accuracy stated in the Report particularly in relation to public and private pricing, therefore it is difficult to make an accurate determination.

The price differences between public and private prostheses stated in the Report seem excessive. It is SA Health's understanding that prostheses prices across both sectors are in the main similar and we have inadvertently seen evidence of this showing that prices paid for similar items by private hospitals were the same as those paid by SA public hospitals. However it is recognised that whilst prices for similar items may be equitable, private health services may provide a wider range and more expensive products to meet the choices and expectations of private patients and specialists. Public hospitals typically elect to use less expensive prostheses due to budgets limitations.

In addition it is noted that the cost of prostheses per casemix adjusted separation (page 93) is not comparable between the public and private sectors because the casemix adjustment is done at the total DRG level. Therefore the variation in costs for individual cost buckets like prostheses are not appropriately adjusted for in the calculation. That is, the relativities between DRG costs for individual components like prostheses (with relatively small contributions to the overall costs) will not match those of total costs.

It is expected that private hospitals have a higher total spend per patient on prostheses and a higher proportion of patients in DRGs where prostheses are used. Without an appropriate adjustment based on the 'prostheses casemix', they are likely to show higher average prostheses costs.

Teaching costs

Teaching costs are excluded from the cost data submitted to the NHCDC.

The NHCDC definition is that for costing purposes, teaching is an activity where the primary aim is the transfer of clinical knowledge for ongoing development via a teacher or mentor to a student or candidate in a recognised program/course that will result in either:

- qualifications that meet registration requirements, or

- re-entry and refresher training for staff returning to workforce following long periods of in activity.
- Where there is a requirement to complete a program or course.

In practice this has been interpreted to include direct class room teaching and ward rounds.

If part of the purpose of the exercise is to reflect the true cost of public hospitals then teaching should be included, both the direct costs (teaching time) and indirect costs (eg supervision time, additional diagnostics, time impacts on theatre usage). As stated in our previous submission the provision of teaching is a significant role played by public hospitals which has subsequent cost implications which are not incurred by the private sector.

Whilst it is difficult to quantify these flow on impacts in South Australian metropolitan public hospitals, teaching costs represented over five per cent of the total costs in those hospitals. South Australian casemix funding rules applied in public hospitals allocates 25 per cent of senior medical officer time for supervising junior staff, which clearly impacts on services. Teaching is a major role public hospitals perform and it is important that this function and its impact on public hospital performance is adequately accounted for in the Commission's study.

Capital costs

As acknowledged in the Discussion Draft the inclusion of the cost of capital in the cost-per-casemix-adjusted-separation relies on a number of assumptions and adjustments in an attempt to make the data comparable. The figure in the table of costs is therefore not robust and should not be included in the total costs-per-casemix-adjusted-separation as it could distort the total and skew the results particularly at jurisdictional level.

Various issues, acknowledged in the report, include:

- inconsistent accounting practices among jurisdictions
- the lack of Victorian data for disaggregation
- the potential for the value of capital in both public and private systems to be underestimated due to under-reporting of capital used in public-private partnerships and the contracting out of public hospital services to private operators within the public system
- under-reporting of actual asset values in private hospitals.

In addition the age of some infrastructure may lead to a very low user cost of capital that may be distorting when trying to provide an accurate indication of the costs of running hospitals.

The sensitivity analysis undertaken does illustrate the broad conclusion that for a range of different asset values the capital cost-per-case-mix-adjusted-separation in public hospitals may be consistently higher than in private hospitals. However it does not provide an indication about the accuracy of the actual figures except that the scale of the difference in capital costs could vary considerably from those included in the totals for hospital costs.

Community Service Obligation hospitals
As indicated in SA's initial submission 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.

For South Australia, it also means operating minimum volume hospitals in country areas. Due to size and location, such country hospitals are often relatively expensive to operate, but their importance to communities cannot be underestimated.

Almost 50 per cent of South Australia's country hospitals (n=35) are treated as minimum volume hospitals in its case mix funding model and receive $16 million in subsidy under the Rural Access Grant, with the State providing an additional $115 million for their minimum budget.

Partial Indicators - Waiting Lists
The use of waiting lists for elective surgery as a partial indicator for access to hospital services does not seem relevant to examining the relative performance of public and private hospitals, given these are only applicable to public hospitals.

HCP data
The Discussion Draft comments that around 80% of separations for private patients in public hospitals were classified as 'ungroupable' in the HCP. It is noted that there is considerable variations between States and Territories in regard to 'ungroupable' HCP data information, from between 98% ungroupable (NSW) to 37% ungroupable (SA).

Public hospital protocols for completion of HCP information has varied and given that for these patients private health insurers only pay the default benefit there is limited value for public hospitals in providing additional information.

Following the changes to the Commonwealth private health insurance legislation in 2007 there were a range of issues which arose for jurisdictions. In March 2008 the Commonwealth met with States and Territories to discuss these issues. At that meeting it was agreed that the accreditation requirement for public hospitals would not be tied to the provision of complete HCP data and public hospitals could continue supplying the same level of information as previously provided.

Comparability of private and public cost per casemix adjusted separation - Table 5.2 (p 93)
Table 5.2 provides a comparison of cost per casemix adjusted separation by jurisdiction and sector. To enable a fair comparison between public and private hospitals, a suggestion is to produce the same table but exclude the

Remote and Very Remote hospitals as the private sector has no hospitals in those locations (as shown in table 5.3 on page 97).

Data accessibility

SA Health is committed to enabling and supporting research. Access to data is governed through a number of mechanisms and proper process must be followed when providing access to data.

In SA the Department of Health Code of Fair Information Practice provides standards, based on the National Privacy Principles contained in the Commonwealth *Privacy (Private Sector) Amendment Act 2000* which are applicable nationally to the private sector.

The Department of Health has developed the Code of Fair Information Practice to outline what it and its service providers should do, and what clients can expect, in protecting personal information. This is balanced against the genuine, controlled and legitimate use of personal information in providing and improving service delivery to clients. This Code provides a framework to ensure that personal information privacy issues are handled in an appropriate manner across the Department and its funded service providers.

SA Health needs to balance the privacy of individuals with research needs and follow due process when providing access to data for which it is a custodian.

The term 'data custodian' is not one of restricting access but about appropriate governance and management of data bases, many of which contain significant personal information. The Discussion Draft is particularly negative about the role of data custodians and does not give fair weight to the importance of good governance around these significant data bases.

The significant investments made by health authorities in developing national data standards and national datasets simplified the Commission's task of assembling comparable data for its study. The fact that national collections exist is good indication of value placed in making hospital data available for policy development, research and performance assessment.

SA Health approved the release of data on public hospitals once details of the study's approach were finalised, and also directly provided data on asset values.

In regards to private hospitals SA Health policy is not to release hospital identifiable data unless the hospitals in question have consented. Private hospitals provide data to SA Health on a voluntary basis on the understanding that the data will be treated as "commercial in confidence", and not released without proper authorisation. SA Health requested that the normal approach to the release of private hospital data (permission form each hospital) be followed. SA Health did not do anything to delay this process.

Data custodians play an important role in managing research access to data. Whilst an ethics committee may approve a research proposal, a data custodian has to assess the project and authorise the release of data. Data custodians will assess the data request, if the data is held by the Department, if the data can be provided in the format requested by the researcher and the conditions under which the data can be accessed, analysed and then managed (ie disposal and destruction issues).

Ethics approval does not provide automatic access to data. Final approval for access to and release of data must be sought from the data custodian. The data custodian determines if the Department has the data being requested, if the data can be provided to the researcher in the form requested, and the conditions under which the data may be accessed, analysed and destroyed. This is an important governance role played by data custodians, particularly given the sensitivities associated with the data held by SA Health and the potential for identification of individuals.

SA Health, in recognition of the importance of health research has invested significantly in developing linked data systems to aid and improve research by being a major partner in the SA NT Data Linkage Consortium. This consortium, in addition to SA Health, has involved participation and funding from the three SA Universities, the Cancer Council of SA, the SA Department of Education and Children's Services (DECS), the SA Department for Families and Communities (DFC), the SA Motor Accident Commission (MAC) and the Northern Territory Government.

Funding has been provided which will enhance development of data linkage capacity in South Australia as well as providing support for data linkage based research in the areas of early childhood development; healthy ageing and chronic disease management; Indigenous health and injury.

SA NT DataLink (the registered name of the SA NT data linkage entity) will provide project specific record linkage keys that data custodians attach to de-identified data for statistical purposes across a number of administrative and other datasets, thereby facilitating an improved evidence base for research, evaluation and policy development for enhanced delivery of health and human services.

Meta-data collection (providing information about, or documentation of, other data or data collections) using an outposted ABS officer is now well advanced across DECS, SA Health and DFC, in relation to datasets that might potentially be included in the data linkage system.

A demonstration project around Early Childhood is being developed as well as a Colorectal Cancer demonstration research project.

This major project clearly demonstrates SA Health's commitment to assisting health researchers through the provision of and access to improved data bases.

Data Improvement

The development of improved data sets and greater accessibility is not a simple one and the complexity of issues to be worked through should not be underestimated.

Data consistency has improved over time but we acknowledge that inconsistencies still exist and need to be addressed. There is a national data development work program, and suggestions from the PC for improving data standards would be welcomed.

The primary purpose of the NHCDC is to produce AR-DRG cost weights for each sector and a secondary purpose is to provide a level of costing information to undertake high level benchmarking across jurisdictions within sectors but not across sectors. The limitations and inconsistencies in the costing processes across jurisdictions are well known to jurisdictions and this influences the extent to which they undertake cost comparisons using these data.

The NHCDC program was never designed to facilitate detailed benchmarking of costs between jurisdictions within the same sector, let alone compare costs across sectors. It does not have the rigour in costing (ensuring consistent costing processes and precision in the assignment of costs) or the robustness in checking results to enable in depth comparisons to be made. A major task of the COAG Activity Based Funding project is to address these inconsistencies through better costing standards and agreed approaches to the allocations of costs. South Australia is participating in and supportive of the national ABF work.