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09/186

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 have the opportunity to offer comments on the draft report.

As you already know, we consider the reference given to the Commission by the Government to be misconceived. It would have been far more useful if the Commission had been asked to inquire into the scope to improve hospital performance (quality and cost-effectiveness) in each sector. That is water under the bridge now.

If the inquiry has the outcome of forcing the jurisdictions to improve the quality of the data and to be more open in sharing the data, then it will not have been a complete waste of time.

We commend the efforts the Commission has made to deal with the task and support most of the draft findings.

We offer relatively brief comments in three areas only. The first issue (central office costs) is significantly more important than the other two, more minor, issues.

Yours sincerely

Francis Sullivan
Secretary General

9 November 2009

ap:bh

D09/9745

AMA Comments on the Productivity Commission's draft report on the Performance of public and private hospital systems

Central office costs

We found the draft report to be somewhat ambiguous in relation to "central office costs", a term which in our view needs to be more clearly defined. We think that most readers of the draft report will "read down" the references to central office costs as being central office costs of the enterprise (that is, the individual hospital).

The NHCDC is based on enterprise level data. We share the Commission's concern that:

> *"... there appear to be inconsistencies in the extent to which central-office overheads are included in the NHCDC ..."* (Page 91)

> *"There are currently inconsistencies between jurisdictions/hospitals in the extent to which central-office overheads are reported to the NHCDC, and this is not clearly documented."* (Page 107)

It is obvious that where enterprises fail to allocate all level costs, then the DRG costs will be understated. We do not have any specific evidence to suggest that this is more likely to be a problem in one sector or the other. We consider this to be a material issue. We concur with both the way the issue is addressed in the draft report (the analysis and the findings) and we support the Commission's intention to further consider the estimation of hospital administration costs and central-office overheads for the final report.

We are concerned, however, that our submission has been misunderstood by the Commission. We sought to make the point that enterprise level data does not reflect the full cost to the community. In order to make a valid comparison of the costs incurred by the public and private hospital sectors, it is necessary also to take account of overhead costs that are external to the enterprises (the hospitals). These could be termed "**external overhead costs**". We recommend that the Commission give consideration to defining the "central office overheads" that are now addressed in the draft report. We think they are limited to "**internal overhead costs**" or else "**hospital-level central office overheads**".

Most importantly, we urge the Commission to consider including some material on "**external overhead costs**" in the final report.

In the case of the public hospital sector, those external overhead costs encompass a significant share of the cost of the State health departments, part of the costs of the Commonwealth health department, the costs of the area health authorities and the costs of other smaller agencies with specialized roles relating to the hospital sector. These costs are known to the governments incurring them but either not disclosed or poorly disclosed to the general public.

In the case of the private hospital sector, those external overhead costs encompass a small share of the cost of the State health departments, a very small share of the costs of the Commonwealth health department, and the overhead costs of the parent corporations or organizations (to the extent that they relate to the hospitals).

Some Catholic orders have operations spanning both public and private hospitals as well as residential aged care facilities and hospices. They may also have social service and other activities that are not part of the health sector per se. The allocation of external overheads can

be quite complex in some cases but in other cases—for example, the Calvary Hospitals run by the Little Company of Mary—each hospital owned by the order is highly autonomous. Thus, external overheads would be quite small.

We will say that any comparison of costs between the public and private hospital sectors that fails to take external overhead costs into account is invalid. The full costs to the community of acquiring the services will not be transparent.

We suspect that the rate of external overheads is significantly higher in the public sector but we do not have access to the empirical data. We are very disappointed that the draft report has not delved into external overheads costs and we express the hope that this will be rectified in the final report.

The "gold standard" would be an empirical analysis of the data which generated an "external overhead rate" for each sector. All enterprise level costings emanating from the NHCDC should be grossed up by the respective overhead rate to achieve a more valid cost comparison. We recognize the possibility that the jurisdictions may be extremely reluctant to have those external overhead costs placed under the microscope and may not co-operate with any data collection efforts. Were that the case, then of course it is a material fact which should be reported.

If there is any administrative fat in the private sector, then it is in the private insurance industry, not in the private hospital sector. The PHI insurers enjoy a comfortable oligopoly—strengthened by the consolidation within the industry—which puts them in a powerful position vis-a-vis consumers of health insurance. At the same time, while the legislative framework works to give them considerable market power over producers of hospital services, the private health insurers demand that the hospitals achieve productivity gains so as to reduce the real level of costs. However, they do not seem able to achieve any significant productivity gains in their own administrative operations.

In the draft report (at page 107), the Commission has noted that:

> *"Study participants noted that central-office overheads — such as for centralized procurement of supplies and provision of information-technology services — should also be included in cost comparisons as they are part of the cost of supplying hospital services."* (page 107).

We would like to see a text reference or a footnote recording that our submission raised a wider issue, that of external overhead costs.

Informed financial consent

The Commission has made a very balanced assessment of the issues around informed financial consent. There is one missing link. There is no discussion of the difficulties PHI fund members can experience in getting reliable and timely information from their health insurer as to their entitlements. This is part of the matrix of achieving excellence in informed financial consent.

The AMA has reservations about 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.

We doubt it will be the "magic bullet". As things stand, in a significant number of cases (about a third) of complaints about lack of informed financial consent, the doctor can produce documentary evidence of informed financial consent. There can be significant time lags between the giving of consent for the procedure, including informed financial consent, and the submission of a claim form. People forget. At the Commission's roundtable on 22 October 2009 the consumer representative highlighted that some people, having given informed financial consent, might not understand what they have consented to. Furthermore, the health insurers are not "trusted agents" in this matter. They have run a massive and highly misleading campaign on IFC, misconstruing and misrepresenting the data.

Significant effort has been made to ensuring that, in medical practices, obtaining informed financial consent from patients is a standard business practice. The challenges lie in encouraging other parties who are equally able to provide information to patients play their role: hospitals that have agreements with diagnostic imaging and pathology providers can make information about those fees available to patients on admission; health insurers can provide information to patients about the benefits they will pay. Patients need to be aware that a discussion about fees is a necessary part of the health care journey.

Indexation of Medicare Levy Surcharge thresholds

We have some reservations around draft finding 10.1:

Average weekly ordinary time earnings is the most appropriate indexation factor

The stated rationale is that AWOTE "*is more likely to maintain the Government's goal of the MLS being targeted at high income earners than if other indexation factors were used*". It may, in fact, have a different effect, that of redefining "high income earners" over time.

As the Commission itself notes in Table 10.2, AWOTE is a limited measure of earnings (excluding salary sacrifice, non-cash and other payments) and is subject to the effects of compositional change. The AMA recommends that the Commission consult further with the ABS, particularly in relation to the impact of compositional change.

There is a possible measure that the draft report does not discuss, the national accounts measure of average earnings (average non-farm compensation per employee, published in tables 40 and 41 of Australian National Accounts: National Income, Expenditure And Product, ABS Cat. No. 5206.0). Again, the AMA recommends that the Commission consult further with the ABS.

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