



australian
nursing federation

Submission to Productivity Commission Commissioned study on performance of public and private hospital systems

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1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia.

With a membership of over 170,000 nurses and midwives, members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The core business for the ANF is the industrial and professional representation of our members and the professions of nursing and midwifery.

The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, social justice, immigration, foreign affairs and law reform.

The ANF was pleased to be invited to participate in the roundtable discussion hosted by the Productivity Commission in June 2009, which was an initial phase in the commissioned study into the performance of public and private hospital systems. The ANF now welcomes the opportunity to provide comment on the issues paper released in June 2009, and looks forward to the release of the draft report scheduled for late September 2009.

2. The nursing and midwifery professions

Nurses and midwives form the largest health profession in Australia, providing health care to people across their lifespan.

Nurses and midwives are the most geographically dispersed health professionals in Australia, working across the public and private sectors in: homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

There is a combined total of 244,360 registered and enrolled nurses actually employed in nursing in Australia, with 18,297 of these being registered midwives.¹ Nurses and midwives comprise over 55% of the entire health workforce.²

Nursing and midwifery are therefore key professions to engage in achieving the aim of Australia as the healthiest country by 2020.

3. Performance of Public and Private Hospital System

3.1 Overview of Commissioned Study

The ANF welcomes the opportunity to provide input to the study which the Productivity Commission has been commissioned to undertake into the performance of public and private hospital systems in Australia. The submission to follow refers to the Issues paper released in June 2009 titled *Performance of Public and Private Hospital Systems*.

It is noted that the Commission has been asked to examine and report on the relative performance of the public and private hospital systems, and related data issues, under the following Terms of Reference (in brief):

- a) comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals,
- b) the rate of hospital-acquired infections, by type, reported by public and private hospitals,
- c) rates of fully informed financial consent for privately insured patients treated as private patients in both public and private hospitals,
- d) other relevant performance indicators, including the ability of such indicators to inform comparisons of hospital performance and efficiency,
- e) If any of the foregoing tasks prove not fully possible because of conceptual problems and data limitations, the Commission should propose any developments that would improve the feasibility of future comparisons.³

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

3.2 General comments

The ANF is concerned at the incredibly short timeframe that has been allocated to this study and has misgivings then for the quality and applicability of the resultant data and report. Acknowledging that the study represents a significant and important body of work, with a substantial amount of information being sought, the ANF urges consideration be given to seeking an extension of the completion date. From the discussion at the roundtable it is obvious that this view is shared by people who have considerable experience in the field of hospital data collection and analysis.

The Productivity Commission's issues paper refers to the Government's commitment to improving transparency, accountability and performance reporting within the health system. This is laudable and what the citizens of this country deserve and would want their Government to be serious about. However, that commitment needs to incorporate a

sense of the need to develop supporting frameworks such as standardised reporting datasets, agreed definitions, realistic timeframes, and feedback mechanisms, applicable across the public and private sectors.

A recent research paper by the Parliamentary Library, *Does the Commonwealth have constitutional power to take over the administration of public hospitals?*⁴ refers to the Australian Labor Party's pre-election plans regarding public hospitals, and in particular

*It will include additional funding to state and territory governments if they achieve agreed reform milestones - similar to the system of competition policy payments designed to reward those States that improve their performance. This will introduce a significant change and incentive to our health system - rewarding states and territories for reforms based on improved health outcomes not simply inputs.*⁵

The ANF is of course supportive of a process which provides incentives to hospitals where they can clearly demonstrate improved health outcomes (and not simply inputs). What the ANF would not be supportive of, is if the Government were to use any results from this rushed study currently being undertaken by the Productivity Commission, for basing performance and therefore funding levels for public hospitals.

The ANF considers that the study aim of providing comparative data on the performance of the public and private hospital systems is somewhat premature. The short time frame allowed for the study would better lend itself to ascertaining what data is needed, where this data is currently available, or if not available now, what processes are required to obtain the information, how comparable is the data, what needs to be done to refine the data to enable a greater (and more accurate) degree of comparability, and the development of a shared understanding across both sectors about the data requirements - in short, to establish objective and measurable performance criteria. The ANF urges the Productivity Commission to rethink the study purpose and resolve to advise the Government of the building blocks needed for the commissioned study (as outlined above) and a timeframe for a more rigorous and considered study to commence.

3.3 Public and private hospital systems

The ANF supports a public health care system which is available to all, and a viable private health sector for those who wish to utilise it and can afford to do so. These systems must not be set up to compete with each other. There are models where the relationship can be cooperative, with the private system being a supplement to the public system. The longstanding commitment by successive Australian Governments to universal health care must prevail.

The ANF position statement on public and private health services states:

All Australians must have access to high quality health services, which may be delivered in either the public or private sector.

A public health system is strongly supported as it provides equity of access to free public health care for all Australians. The provision of private health services is and should remain complementary to a viable and effective public health system.

The provision of all public and private health services should be subject to Government regulation and accountability, should meet acceptable health outcome standards, and be planned in the context of the total needs and requirements of the population using the health service.⁶

While the ANF sees merit in examining issues of efficiency in hospitals in terms of accountability to the community for the large funding investments into their operations, there must be an acknowledgement of differing environments between public and private sectors. Public hospitals accommodate a mix of elective cases (many of whom are high-risk patients with multiple co-morbidities) while also responding to emergency driven demand from the community. Private hospitals have much greater ability to modulate their workload of largely pre-booked cases and have more scope in screening for lower-risk cases. It is essential that this widely differing case mix be taken into account in the study on comparative efficiency between public and private hospital systems.

This difference is highlighted in the Australian Institute of Health and Welfare's recently released *Australian hospital statistics 2007-08*⁷ where it says that public and private hospitals have different service profiles: elective surgical cases accounted for 62% of private hospital separations in 2007-08 whereas in public hospitals, surgical elective cases accounted for 30% of separations in 2007-08; and an increasing proportion of admissions over the years have been for same-day care - 50% in public hospitals in 2007-08, and 66% in private hospitals. In addition, the rate of private elective surgical separations was highest for those with the most advantaged socioeconomic status group whereas in the public sector the rate of public elective surgical separations was lowest for those in the most advantaged socioeconomic status group and highest for those with the most disadvantaged socioeconomic status.

3.4 Comparative efficiency

The ANF notes that the Commission may opt to measure the output of hospitals as opposed to patient outcomes, due to the constraints of time for the study. The ANF is concerned about taking this option for reasons of expediency and ease of measurement purposes. This will only lead to conclusions of efficiency in terms of numbers of patients through the service, for what will appear to be clinically similar procedures, but will overlook the complexity of the cases included which has a great impact on a hospital's ability to

be efficient. A hospital can be effective in terms of managing highly complex cases and achieving a good outcome for the person at the end of their hospitalisation but appear to have been 'inefficient' when measured against another facility, if there were factors such as old age, co-morbidities and/chronic conditions leading to extended hospital stay. As the Issues paper quite rightly identifies "measuring performance in terms of outputs has the disadvantage that it does not directly quantify the degree to which a hospital achieves its primary purpose - to improve health outcomes". This is exactly why the Productivity Commission needs to advise the Government that the limitations of the current study will not reveal meaningful results, and that a longer term which allows for tracking of patient health after hospital discharge to measure outcomes, is what is required. The ANF cautions that policy decisions can not, and should not, be based on this current study.

3.5 Indicators of performance

3.5.1 Clinically similar procedures

The ANF is concerned about the notion of comparing 'clinically similar procedures' unless there is a very clear definition outlining exactly what is being compared. Procedures may be similar in nature but difference will be in the profile of the patients undergoing the procedure. Variables include: older age, co-morbidities, chronic conditions, presence of life-style/surgical risk factors such as smoking, obesity, pre-existing mental illness, or general health status related to socioeconomic status. Patients with any of these are generally more prevalent in the public hospital system.

3.5.2 Occupational mix of the hospital workforce

The proportion of registered nurses and enrolled nurses in the nursing skill mix of the Australian health care sector has declined in recent decades. These changes to the mix of workers doing nursing work have occurred with little evaluation of the effect on patient care or outcomes.

The application of economic principles from outside the health sector have been applied to health with no consequent evaluation of the purported efficiencies of reducing nursing staffing levels or altering skill mix.

Altering the skill mix by reducing the proportions of the most highly educated nurses in health care settings can have catastrophic and expensive results.

Altering the skill mix of nursing staff is a practice which is clearly motivated by desire among service providers to drive down one of their major recurrent costs, that of nurse staffing. However, this can increase costs to the health service provider and to taxpayers. It also imposes costs on the recipients of care and to nurses themselves. Having the right mix of qualified and experienced nurses available to monitor patients' conditions and intervene to prevent the development of complications, deterioration of illness and to promote recovery is vital.

A recent Australian study found skill mix was a significant predictor of patient outcomes. Reinforcing the findings of other international studies, a skill mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers, gastrointestinal bleeding, sepsis, shock, physiologic/metabolic derangements, pulmonary failure and failure to rescue. The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients: one extra registered nurse per day would reduce the incidence of sepsis by eight per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing hours increase.⁸

3.6 Indexation of Medicare Levy Surcharge thresholds

The Medicare levy surcharge (MLS) was introduced by the Howard Government following their election in 1996. The Medicare Levy Amendment Act (MLAA) introduced a one per cent Medicare levy surcharge for individuals with a taxable income above \$50,000 and families with combined taxable incomes more than \$100,000 who did not have private hospital insurance cover for themselves and all their dependants.^{9,10}

The surcharge is in addition to the standard Medicare Levy of 1.5%, which is paid by most Australian taxpayers. The expressed intentions for the MLS were to provide an incentive for higher income earners not to rely on the Medicare system and to take out private health insurance.¹¹

A number of changes were made to the MLS in 2008, which included provision for annual increases in the thresholds by means of indexation.

*The primary purpose for indexing the MLS thresholds is to ensure that the policy remains targeted at the 'high' income group for which it was intended. The income target group is defined by the level at which the thresholds are set, and the focus on this group is maintained over time via indexation. Without automatic indexation, the MLS would become less effective over time in targeting high income earners.*¹²

The ANF strongly supports a universal health insurance system to enable equity of access to all necessary health services for all Australians. The most equitable way for people who can afford to do so, is to contribute more to the health system through taxation - that is, increasing the Medicare levy.

The ANF considers that the proposed changes to health insurance cover, including those to index the MLS thresholds, will mean that citizens on higher incomes will be able to fulfil their responsibility as members of a civil society. The ANF considers that the most appropriate indexation factor for the MLS thresholds should be either the Average Weekly Total Earnings (AWTE) or the Average Weekly Ordinary Time Earnings (AWOTE) as these more accurately reflect, and in a timely manner, changes in earnings.

3.7 Improving the feasibility of future comparisons

It is noted that the Commission has leeway to "propose developments to improve the feasibility of future comparisons", should any of the study tasks not found to be possible due to "conceptual problems or data limitations". The ANF considers however, that there is great potential for comparative analysis from data collected to present fallacious results due to lack of standardisation of information, and for this to be used in a damaging manner by lobbyists, politicians, the media and particular community groups.

The ANF is greatly concerned for the morale of health professionals if data, brought together in an unsatisfactory timeframe for comparative purposes, leads to ill-founded results of particular sections of the public health sector.

Conclusion

The ANF welcomes the opportunity to participate in the consultative process for the Productivity Commission's study into the performance of public and private hospital systems.

While the ANF endorses the need for the Australian Government to be committed to improving transparency, accountability and performance reporting within the health system, we caution against undertaking a comparative study which has an ill-conceived timeframe for completion.

A study of this nature should be developed, in consultation with the public and private hospital sector and the broader community, which incorporates the standardised and agreed datasets and definitions. A shared understanding of data required will lead to meaningful comparative data, of robust quality, able to be used to make necessary improvements to the public and private hospital systems for the benefit of the Australian community.

The ANF looks forward to receipt of the draft report from the Productivity Commission towards the end of September 2009 and continued participation in the study.

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