australian nursing federation

Submission to Productivity Commission Discussion draft:

Public and Private Hospitals

November 2009

Gerardine (Ged) Kearney
Federal Secretary

Lee Thomas
Assistant Federal Secretary

Australian Nursing Federation
PO Box 4239 Kingston ACT 2604
T: 02 6232 6533
F: 02 6232 6610
E: anfcanberra@anf.org.au
http://www.anf.org.au

1. Introduction

The Australian Nursing Federation (ANF) is the largest professional and industrial organisation in Australia with Branches in each State and Territory and a membership of over 175,000 nurses and midwives.

The ANF has been pleased to participate in the two invitational roundtable discussions hosted by the Productivity Commission (the Commission), as well as the opportunity to provide an initial written submission and now a response to the recently released discussion draft paper.

The ANF congratulates the Commission on the production of the discussion draft *Public and Private Hospitals,* which has been prepared to enable further public consultation and input to the study on the performance of the public and private hospital systems. This document represents a significant body of work undertaken in a short period of time. In our submission of July 2009 to the Commission, the ANF voiced concerns that the timeframe for the study did not allow for collection of comparable data across public and private sectors, thus leading to findings which would be inconclusive and inaccurate but which might still be used by health policy makers and funders.

The ANF is pleased to see in the discussion draft that the Commission has noted the concerns of stakeholders to the extent that developments have been proposed that would improve future data collection and robustness of comparative analysis. While the Commission can not control the interpretations of the study findings by readers, nonetheless the ANF requests that the final report include stronger caveats on the existing results; and that the foremost outcome has been the highlighting of the need for data refinement and purpose of data analysis.

The commentary below makes some general observations on the discussion draft and provides supplementary information to the ANF submission forwarded to the Commission in July 2009.

2. Public and Private Hospitals

2. 1 General comments

Nurses and midwives, as the largest component of the health care workforce in Australia, and, as health professionals who work across both public and private sectors - in all geographical settings and in facilities of all sizes, have a keen interest in the well-being and sustainability of the public and private hospital systems.

Due to the nature of their practice, nurses and midwives are acutely aware of the differences in patient profile between public and private hospitals and therefore the complexities involved in comparative analysis in terms of efficiencies.

The ANF was not surprised to learn that the complexity and diversity of public and private hospitals has made a like-for-like comparison difficult for the Commission, nor that existing data collections and the short timeframe for the study have been found to be not well suited to achieving the aims of the project. Knowing that the foregoing would be the case, the ANF had been concerned that the inconclusive data might be used in policy decision-making for the hospital system, for funding purposes. It was therefore pleasing to read that the Commission has acknowledged the inconsistent data collection methods and missing information and stresses that "the resulting estimates should be considered experimental".

In its earlier submission to the Commission the ANF noted that the study aim of providing comparative data on the performance of the public and private hospital systems seemed somewhat premature, and that the short time frame allowed for the study would better lend itself to ascertaining deficiencies in current data and processes for improving data consistency. The most important outcome of the study thus far would seem to be confirmation of: the complexity of work undertaken in the hospital systems, the degree of difficulty for a comparative analysis across the public and private sectors, and acknowledgement that the deficits in data collection have resulted in inconclusive findings.

The ANF supports the fact that there does need to be on-going data collection to be able to give valuable information to the Australian public as a measure of accountability in the provision of health services - whether public or private. However, this information needs to be accurate and be able to produce sensible outcomes from which reasonable policies can be developed - acknowledging the very real differences between patient profiles and types of service and treatment offered by the public and private health systems.

The ANF welcomes the Commission's comments that the final report will include suggestions for future improvements for data collection.

2.2 The relative performance of public and private hospitals

2.2.1 Patient profile

It was pleasing to see that the Commission had taken on board the point made in the ANF submission about public hospitals treating highly complex cases which are more likely to be characterised by a relatively poor pre-existing health status, as follows:

> *The Australian Nursing Federation (ANF) described public hospital patients, in comparison to private patients, as possessing the following factors: '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'.*[1]

The Commission has rightly noted that this patient profile impacts on the resources required for treatment and consequently affects the apparent efficiency of the hospital if measured against another facility which has a different patient profile but is performing (on the face of it) similar procedures. The data collected in the study has confirmed what the ANF had said in its submission, that "the public hospital sector treats a disproportionately larger share of patients of relatively low socioeconomic status".[2] It should be noted too that it is not just the patient profile that differs between public and private hospitals, as just as importantly it is the type of service and treatments offered, such as dialysis, burns units, complex surgery (and the preparation for and recovery from this surgery) which differentiates the two systems.

2.2.2 Competition

It is the position of the ANF that all Australians must have access to high quality health services, regardless of whether they are delivered in the public or private sector. The public health system must provide equity of access to free at the point of delivery health care for all Australians. The private health sector has a legitimate and important role as an alternate choice for those who are able to and wish to exercise such a choice. It is the view of the ANF that the public and private hospital systems must not be set up to compete with each other. As stated in our original submission, there are models where the relationship between the two systems is cooperative, with the private system being a supplement, or complementary to, the public system. The notion of 'competition' does not sit well with systems which have demonstrated differences in clientele profiles, types of services and treatments offered, and also because of the strong teaching and research component of the public hospital system.

2.3 Indexing the Medicare Levy Surcharge income thresholds

The ANF reiterates what was stated in our previous submission that we strongly support a universal health insurance system to enable equity of access to all necessary health

services for all Australians. We consider that the most equitable way to achieve this is for people who can afford to do so to contribute more to the health system through taxation - in this instance, through increasing the Medicare levy.

In our submission the ANF advised the Commission to consider either the Average Weekly Total Earnings (AWTE) or the Average Weekly Ordinary Time Earnings (AWOTE) as the most appropriate indexation factor for the Medicare Levy Surcharge (MLS) thresholds, as "these measures most accurately reflect changes in earnings."[3]

The ANF was pleased to note that the Commission's findings supported AWOTE as being the indexation factor for the MLS thresholds most likely to "maintain the Government's goal of the MLS being targeted at high income earners than if other indexation factors were used."[4]

2.4 Labour productivity as an indicator of performance

There is mention in the discussion draft that private hospitals appear to operate relatively leaner staffing levels than public hospitals. The ANF is concerned that the inference will be that the private sector is necessarily more efficient in doing so and that public hospitals may be overstaffed. As the discussion draft rightly says "a relatively high ration of medical and nursing staff to patients may provide a higher level of personal care to patients at levels that are clinically appropriate".[5]

A conclusion on efficiency measures based on labour data must include a detailed analysis of variables such as skills mix of staff, acuity of persons requiring care, type of service and/or treatment being provided, and the teaching and research obligations of the hospital. The ANF considers that the current study does not have the time or data capability of making such judgements.

Numerous international and national studies have provided evidence of the pattern of staffing required in order for safe care to be delivered which will give optimal health outcomes. These can be found in the ANF publication *Ensuring quality, safety, and positive patient outcomes - Why investing in nursing makes $ense* (available at: http://www.anf.org.au)

2.5 Remote/very remote hospitals

The discussion draft includes statistics on remote and very remote hospitals and makes the point that there are no private hospitals in remote and very remote regions. A participant to the second roundtable discussion contended that in a study on both public and private hospitals, this component should be removed. The ANF supports the removal of the remote and very remote hospitals data from the study. A simple statement could be included which notes that these regions are not included as there are no private hospitals beyond outer regional areas.

Conclusion

The ANF welcomes the opportunity to provide advice to the Productivity Commission's study into the performance of public and private hospital systems and thanks the Commission for noting issues raised in our submission of July 2009 .

Given the cautions raised in our original submission about undertaking a comparative study of this nature in a short timeframe and in an environment of inconsistent data, the ANF is pleased to that the Commission has considered the resulting estimates from the study on hospital and medical costs as 'experimental'.

The ANF has also welcomed the Commission's finding of

> *A common theme throughout this report is that improvements could be made to data collections to improve the feasibility of future comparisons. Foreshadowed changes - such as strengthened national reporting under the new National Healthcare Agreement (NHA) between the Australian, State and Territory Governments - will help in this regard. However, more improvements could be made, such as adopting consistent national reporting of costs and infections across both public and private hospitals.*[6]

It is right and proper that health care facilities be accountable for the services they provide to the Australian community but any analysis of those services, and particularly comparative analysis, should be through the collection of data which is consistent across the sectors.

The ANF looks forward to reading the final report from the Productivity Commission towards the end of 2009.

References

1 Australian Government. *Productivity Commission Discussion Draft: Public and Private Hospitals*. October 2009. Available at: http://www.pc.gov.au/projects/study/hospitals p. 24.

2 Ibid. p.23.

3 Ibid. p. 204.

4 Ibid. p. 209.

5 Ibid. p. 132.

6 Ibid. p. xxxii.