

### **Assessment of Data Availability for the Analysis of Performance of Public and Private Hospitals.**

In May 2009, the Federal Government asked the Productivity Commission to undertake a Research Study to examine and report on the relative performance of the public and private hospital systems, and related data issues. As part of the study, the Commission was requested to consider:

- comparative hospital and medical costs for clinically similar procedures performed by public and private hospitals
- the rate of hospital-acquired infections by type, reported by public and private hospitals
- rates of fully-informed financial consent by privately-insured patients, out-of-pocket expenses for patients who do not give such consent, and best-practice examples where fully-informed financial consent is provided for every procedure
- other relevant performance indicators, including the ability of such indicators to inform comparisons of hospital performance and efficiency.

If any of the above tasks prove not fully possible because of conceptual problems or data limitations, the Government also asked the Productivity Commission to propose developments to improve the feasibility of future comparisons.

A draft report from the Study is due in October, with the final Report to be released in December 2009.

In order to provide an authoritative and independent source of analysis, APHA commissioned the National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra to examine a range of data sources and comment on some of the Commission's Terms of Reference. APHA believes that the report is a valuable addition to our knowledge about what data is collected, how it is used and what deficiencies and disconnections there are in the data.

Since its establishment in 1993, NATSEM at the University of Canberra has become Australia's premier microsimulation modelling centre. NATSEM is now widely regarded as one of the best sources of consultancy services in quantitative social and economic research and policy advice in Australia.

This document provides a brief summary of the analysis provided to APHA by NATSEM

#### **1. What NATSEM was asked to do**

APHA asked NATSEM to:

1. Review the possible hospital indicators which could be used;
2. Review the existing data sources to see the extent to which they can be used to compare the performance of public and private hospitals;

3. Look at the performance indicators which have been raised by the Productivity Commission; and
4. Consider how data collection and comparability issues could affect the legitimacy of making performance comparisons between the public and private hospitals.

## 2. Executive summary of NATSEM Report

1. The NATSEM report **examines a range of possible performance indicators that could be used to assess the comparative performance of hospitals.** It also examines whether the data exists in Australia to use such performance indicators.
2. The existing research in this area shows that a broad range of performance indicators have been proposed in the past. **However whichever indicators are used there are serious limitations and problems to their usefulness because of data coverage and comparability issues.**
3. Should a range of hospital performance indicators be used to compare the private and public sector the **National Hospital Cost Data Collection appears to be the best source of data.** However, because of the different cost structures and the way the data is collected, **it is difficult to draw definitive conclusions on the relative efficiency between the two sectors.**
4. It has been recently stated by the Federal Department of Health and Ageing (DOHA) that activity based on funding can enhance accountability in the delivery of hospital services by helping to drive efficiency and permit direct comparisons of the costs between hospitals and states, and eventually between public and private hospital sectors. However, **if such comparisons between the public and private sector are made they will need to be explicitly adjusted ('controlled') for the underlying differences between the two sectors.**
5. Quality of care issues are of high importance to the hospital sector, but **it is not possible to make comparisons between different sectors** as the existing data collections are incomplete. A more consolidated approach is required in this area.
6. **It is essential that performance indicators are developed to enable valid comparisons between the public and private hospital sector.** Despite there a broad range of data being collected, **at the present time comparisons cannot yet be validly performed.** Studies such as those being conducted by the Productivity Commission will hopefully lead to recommendations for more coordinated action on this front.

## 3. Hospital performance: A Brief Review

The performance of hospitals is usually thought of in terms of the effectiveness and efficiency of the hospital. More recently issues such as the quality of care being delivered, the equality of treatment on offer, and the sustainability of the workforce are starting to be considered by governments.

To assess the performance of hospitals the broader areas (domains) of hospital performance need to be initially worked out so that the details over what to measure (the performance indicators) and how to collect the data for these measurements can be established.

One such set of broader areas (domains) of hospital performance has been developed by the World Health Organisation

The six main areas (domains)
1 Clinical effectiveness
2 Production efficiency
3 Staff orientation
4 Responsive governance
5 Safety
6 Patient centeredness

**Figure 1 World Health Organisation - Performance Areas**

**Previous research carried out in United States and also in Germany has provided conflicting results as to what drives hospital performance.** Some research studies have found that cost and efficiency are influenced by both the size and ownership of hospitals. But the relationship is unclear; with some studies finding that larger hospitals are more efficient, but others finding smaller hospitals are more efficient. **Similarly, some studies have found public hospitals to be more efficient than private hospitals, but others have concluded the opposite.**

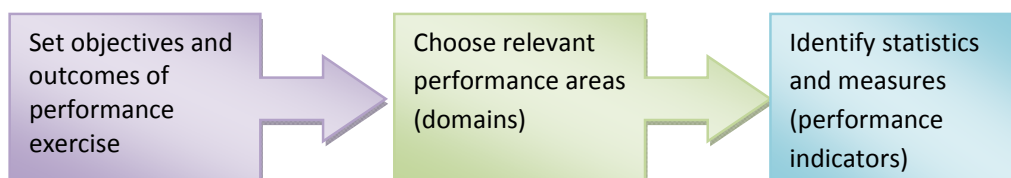
To explain these conflicting studies research has previously been carried out to find out why different researchers have been coming up with different answers. It was found that the results of such studies have been largely dependent on how the data has been collected, the region where it was collected, and the time period it was collected over.

For this reason it is **important to understand the context** when assessing the performance of both individual hospitals, and also groups of hospitals (such as public or private hospitals). The results of such assessment can say as much about how the data has been collected than about the performance of the hospital or hospital sector. This is because the regulatory, competitive and funding environment of hospitals, and also government policy and local demand, can impact as much on hospital performance as shown in performance indicators, than anything the hospital itself does.

### 3.1 Domains of hospital performance

When trying to establish which statistics and measures (performance indicators) to use to assess hospital performance, the relevant performance areas (domains) should first be identified. These performance areas (domains) are broad areas of performance for which a range of specific performance indicators can be developed. The performance areas (domains) chosen should reflect the desired objectives and outcomes of the hospital performance exercise being undertaken.

Figure 1 below outlines this process. This allows for a 'performance framework' for measuring the performance of hospitals to be created.



**Figure 2 – Creating a performance framework**

The detail of the performance framework, its performance areas and indicators, is open to interpretation by those implementing it. **The areas chosen and the specific statistics looked at will affect the stated performance levels of hospitals at the end of the exercise.** A variety of different performance frameworks have been developed elsewhere. In general these frameworks have a lot of commonalities, but as they have been developed with different overall objectives in mind they have their own specific emphases.

In reviewing the performance frameworks that have already been developed (see Figure 1), and in considering the Productivity Commission’s objectives and outcomes, the following common performance areas (domains) emerge that could potentially be used in an exercise to assess hospital performance.

Performance areas (domains) suggested for this exercise
1. Efficiency in the provision of hospital services
2. Quality of care in the treatment of patients
3. Accessibility of hospitals service
4. Sustainability of the sector

**Figure 3 Performance areas chosen for this exercise**

Once the performance areas (domains) have been decided upon the next step is to choose the performance indicators (such as the statistics and measures) that will be used to assess how hospitals are performing in each of these areas.

### 3.3 Levels of Performance Comparison

When assessing the performance of hospitals it is necessary to decide upon the level at which performance indicator should be taken. For example, the level could be the sector as a whole, public or private hospitals, the peer group the hospital resides in (such as size or type of treatment offered), or the individual hospital itself.

The level at which the performance hospitals are looked at should ideally be determined by the most relevant level for which performance indicators are available. When deciding upon the level at which to collect data for the performance indicators thought should be given as to the level at which actions would need to be taken in response to any perceived shortcomings.

The level at which the Productivity Commission is focussing is comparing hospital performance between the public and private sectors. The nationally consistent performance indicators which

would be needed for carrying out such comparisons might not yet have been developed for this level.

**After analysing all of the available data in the public domain NATSEM conclude that at the present time comparisons between the public and private hospital sector cannot yet be made.**

#### **4. Performance Indicators in the Hospital Sector**

The performance indicators chosen for each of the performance (areas) will be used to either:

- 1. Provide external accountability and verification of performance of private or public hospitals; and/or**
- 2. As a mechanism for internal quality improvement.**

This would normally be achieved by setting acceptable levels at which each performance indicator should normally be at, and then drawing attention to areas of poor performance. How and why performance varies can be considered with a view to improving on how the hospitals are operating in that sector.

There has been a widespread practice of developing and using performance indicators for assessment of hospitals. International reviews show that there are both commonalities as well as wide differences in the performance areas (domains) of the performance indicators. Performance areas, and their subsequent indicators, have tended to focus on clinical processes or outcomes, but some have also looked at the economic side of performance.

**A unified and definitive performance framework tailored for use throughout all Australian hospitals covering clinical, economic, access and equity, quality of care and other aspects of hospital performance has yet to be developed.** Examples of where performance frameworks have been used in Australia include:

- National Health Performance Committee (NHPC) *National Report on Health Sector Performance Indicators 2001*;
- Productivity Commission investigation of private hospitals, 1999;
- The Australian Council on Health care Standard (ACHS) *Australasian Clinical Indicators Report, 2009*.

Further to these national frameworks which have been used in the past, the States and Territories have also developed their own performance frameworks. However these vary considerably and as such they are not readily comparable.

Each of these different performance frameworks varies and different performance areas (domains) have been chosen in each of the frameworks. As such the performance indicators chosen to measure performance varies between the frameworks. **At present there are a variety of different frameworks that have been used but none of them are seen as the definitive framework for assessing hospital performance.** Many of the performance indicators which are used in these

frameworks would prove difficult to collect at the level the Productivity Commission would like to see.

Should a performance framework be developed to compare the performance between public and private hospitals it will need to be based on data which can feasibly be collected.

### 5. Possible Data Sources to Assess Hospital Performance

**There is a lack of comprehensive and suitable data available for measuring the performance of hospitals in Australia.** Whilst much data is collected that relates to performance, its collection is inconsistent as State level.

The data sources which are available are not in themselves primary collections, but are the combination of data provided by the States and Territory health departments.

This report has been through each of the datasets to try and identify limitations which would prevent them from being used within a performance framework. For each of the datasets the following were considered:

<b>Areas to investigate for dataset limitations</b>
<b>Period of time the data has been collected</b>
<b>Frequency with which it is updated</b>
<b>Accessibility of the data</b>
<b>Possibility of conducting more detailed analysis of the data than the publicly available reports</b>
<b>Scope of the collection</b>
<b>Relevant limitations</b>
<b>Types of data collected such as clinical items, financial details, administrative items or data relating to the quality of care</b>

**Figure 4 The main areas where thorough investigation of datasets was carried out in order to uncover possible limitations with the data**

The following table provides a summary of the main datasets and the potential issues that have been identified when using them for comparing public and private hospital performance.

Agency responsible for amalgamating data from State/Territory/PHI	Data collections	Issues of relevance when using data set
<p><b>Department for Health and Ageing (DOHA)</b></p> <p><b>Nine sizeable data collections that provide a comprehensive range of public/private comparative performance indicators.</b></p> <p><b>Data ranges from surgery waiting times, emergency care details, outpatient care services and various levels of establishment expenditure</b></p>	<ul style="list-style-type: none"> <li>• National Hospital Cost Data Collection (NHDCDC)</li> <li>• National Admitted Patient Care Data Set</li> <li>• Elective Surgery Waiting Times Additions and Removals</li> <li>• Elective Surgery Waiting Times Census</li> <li>• Non-admitted Patient Emergency Care</li> <li>• Outpatient Care Dataset</li> <li>• Public Hospital Establishment Collection (PHEC)</li> <li>• The Hospital Casemix Protocol (HCP) data collection</li> <li>• Private Hospital Data Bureau</li> </ul>	<p><b>Linkable sets</b> There is a potential to be able to link the datasets together using patient identifier numbers</p> <p><b>Datasets most relevant to hospital and medical costing comparisons: NHDCDC and HCP</b> The NHDCDC contains cost and activity data from both public and private acute care hospitals. The most recent published results (2006-07) were based on responses from 47% of all public hospitals and 36% of all private hospitals, taking in 86% and 59% of public and private acute separations respectively. The HCP contains data collected as part of private health insurance regulation. It includes information on patient demographics, clinical information, hospital charges, medical information, medical charges, prosthetic items and charges, health fund benefits and consumer out of pocket expenses. Data is collated at the patient, provider and insurer level. The PHEC data set contains establishment data on staff type, salaries, non-salary expenditure, revenue and other HR indicators. However a private sector equivalent is not publically-available. This would need to be established to make cross-sector comparisons at this level.</p> <p><b>Issues associated with carrying out private-public hospital expenditure comparisons</b> <u>Time series analysis</u> –<b>Contains no private hospital data for period 2003-04 to 2006-07.</b> Less than 50% of private hospital separations data are covered between 1996-97 to 2002-03. The HCP does contain some substitutable private hospital cost data covering this period, but does not cover care where payment is made directly by the patient, or by the DVA. Furthermore, NHDCDC data contains data hospital on expenditure/costs whereas HCP contains amounts charged to patients and benefits paid by insurers. <u>Cost-components</u> –The range of <b>costs incurred across the two sectors are inherently different.</b> For example, “Ward Medical” cost component differences between public and private hospitals are primarily due to the low number of salaried medical officers employed in the private sector in contrast to the public sector. Imaging and Pathology differences between the two sectors are considerable since they are generally outsourced by the private sector, yet performed within the public hospital. <u>Accessibility</u> – All publically available data is de-identified and presented in aggregate format. Permission from the supplying organisations would be required to disaggregate the data. This would need to occur to compare data between private and public hospitals with similar functionality <u>Data collection and processing</u> – There are significant data collection issues with the data at present. These include insufficient detail in breakdown of costs in General Ledgers; inconsistency in general ledger reporting; inaccurate ward transfer data; inability to link ward transfer data with patient records; tracking of patients who visit operating theatres or specialist areas; PHDB contains many incomplete patient records; PHDB data does not contain the most up to date information. <b>Significant resources would have to be diverted to improve on the existing data collection standards.</b> Reporting issues are partially addressed through NHCA but private hospitals are outside the scope of these agreements</p>

Agency responsible for amalgamating data from State/Territory/PHI	Data collections	Issues of relevance when using data set
<b>Australian Institute of Health and Welfare</b>	<ul style="list-style-type: none"> <li>National Hospital Morbidity Database (NHMD)</li> <li>National Public Hospital Establishments data collection</li> <li>Health Expenditure data cubes</li> <li>Mental Health Admitted Patients data cubes</li> <li>National Elective Surgery Waiting Times data collection</li> </ul>	<p><b>National Hospital Morbidity Database</b> The NHMD is a comprehensive census of hospital separations across both the public and private sectors. It is open to time series analysis, but cost-data is not available which restricts analysis to epidemiological and administrative metrics. Further analysis from the published data requires permission from the relevant State or Territory, or from the Private Hospital concerned. The data does not contain unique patient identifiers which makes it difficult to identify what can be said about the performance of hospitals on a patient basis.</p> <p><b>National Public Hospital Establishments Data Collection</b> The NPHE data collection is a census of public hospitals collecting details on capacity, staffing and limited financial information. The publically available data is only available by State and Territory which prevents analysis between establishments. Given the scope of the Productivity Commission inquiry this data collection would only be relevant if comparable data on private hospitals could be contained.</p> <p><b>National Elective Surgery Waiting times Data Collection</b> The NESWTDC reports on the number of people awaiting treatment for elective procedures. The collection goes back to 1995-96 but is limited to the public sector, and so is of limited relevance when comparing public and private hospitals.</p> <p><b>Medical Indemnity National Collection</b> The MINC was developed to monitor the costs of health-care litigation. This collection could be used as a surrogate indicator of quality and safety. The MINC provides data on the number, nature, incidence and costs of public sector medical indemnity claims. Data has been collected since 2003 from the public sector, and from 2006 from the private sector. However, private hospital insurance claims – claims against hospitals as opposed to claims against individual practitioners – were not in the scope of the MINC. Should the private sector data become available and include private hospitals it would be possible to use MINC to investigate difference in performance between public and private hospitals.</p>
<b>Australian Bureau of Statistics</b>	<ul style="list-style-type: none"> <li>Private Health Establishment: Acute and Psychiatric Hospitals Data Report</li> <li>Private Health Establishments: Free Standing Day Hospital Facilities Data Report</li> </ul>	<p><b>The Private Hospitals Collection</b> maintained by ABS contains details about the facilities, activities and finances of all private hospitals. The collection extends back to 1992-93. The data collected is very broad and there is only limited information on the financial performance of private hospitals. Data is only available at the state level.</p>
<b>Australian Council of Healthcare Standards</b>	<ul style="list-style-type: none"> <li>Clinical Indicator Program</li> </ul>	<p>The <b>Clinical Indicator Program (CIP)</b> contains a large number of clinical indicators, ranging across 23 different areas, and includes 47 which measure health care-associated infections linked to specific procedures. The data appears to be the most comprehensive collection on hospital-acquired infections and covers both public and</p>

Agency responsible for amalgamating data from State/Territory/PHI	Data collections	Issues of relevance when using data set
<b>Private Health Insurance Administration Council</b>	<ul style="list-style-type: none"> <li>• Quarterly statistics hospital and general statistics treatment</li> <li>• Quarterly gap payment and medical benefit statistics</li> <li>• PHIAC A, B, 3, 4</li> <li>• Hospitals and general treatment insurance: statistics trends in policies and insured persons</li> <li>• Hospital and general treatment insurance: statistical trends in benefits paid</li> <li>• Annual private health insurance membership survey</li> </ul>	<p>private hospitals. However the sample size is small and participation is voluntary.</p> <p>The Private Health Insurance Administration Council (PHIAC) collects and maintains a number of nation-wide databases, summaries of which are published quarterly or annually. Data is published at the state or national level. The data concern the number of policies and insured persons covered by private health insurance for hospital treatment and general treatment and the proportion of the population these insured persons represent. The outcome and output data from the PHIAC collection bear little or no direct relevance to the measurement of hospital performance as envisaged within the terms of reference of the Productivity Commission (2009).</p>
<b>Other data relation to quality of care (custodian)</b>	<ul style="list-style-type: none"> <li>• Australian Commission for Safety and Quality in Health Care report</li> </ul>	

## 5.1 Observations on the available data

The necessary data collections do already exist to report on many of the potential performance indicators commonly used to assess hospital performance. **In particular for the Productivity Commission study, the NHCDC contains the cost of complexity weighted separations (i.e. separations by AR-DRG). However, a closer inspection of the data shows that at the moment the data is not comparable between the public and the private sector – or even within groups within the same sector.**

## 6. Cost Structures and Relative Performance

One of the most significant reasons for the non-comparability of cost data between the two sectors is that **the charging practices used by hospitals are the cause of superficial differences in costs, not the actual performance of the hospital.** The public sector has a far higher proportion of salaried medical staff whereas the private sector has a higher proportion of visiting medical officers. This means that essentially identical services can be provided to the patient, but because of differences to the way costs are assigned, charged and recovered treatment costs can vary significantly for the same procedure. For this reason it is not necessarily appropriate to directly compare costs in this way.

### 6.1 Comparing Performance on the Basis of Competitive Neutrality

Competitive neutrality involves comparing the public and private sector on the basis that they face the same tax, incentive and regulatory environment. Where such neutrality does not exist there is a need to account for this so that valid comparisons between the two sectors can be made. There are two important areas where such neutrality does not exist at present and these are the user cost of capital and taxes.

The for-profit private sector incurs 'opportunity costs' of the capital it has to borrow and this cannot in itself be taken as indicative of higher costs and evidence of relative inefficiency. Whilst the public sector and the not-for-profit private hospitals may incur such costs this is not explicitly documented or known. This makes fair comparisons between and within the sectors very difficult to make, and makes comparisons using HCP data inappropriate.

The different sectors face different tax regimes, and this can change frequently as the various tax codes are amended. This has the potential to impact upon any standardised data capture regime which is developed to measure the efficiency of the two sectors. The Productivity Commission itself has already concluded that it is impossible to know the extent to which input tax exemptions have been used to underwrite inefficiencies in not-for-profit hospitals, or to bolster their competitiveness.

## 7. Participation in Data Collections

The NHCDC has been identified as the most viable source for comparative cost data. However at the moment this only covers 47% of public hospitals and 36% of private hospitals. This represents 85% of acute separations in public hospitals, and 59% in private hospitals. For this reason there are currently major issues as to how representative the current sample is, and at present this is undiscussed in the commentary which accompanies the data. **At the present time the data could not be used with full confidence as it is not known whether or not the sample is representative of the sector.**

A larger proportion of hospitals would need to contribute towards the NHDC to create a comprehensive picture of costs in the two sectors. However there would be practical difficulties in achieving this, such as the cost of collecting the additional data and the commercial sensitivities of hospitals in providing such data.

**It would be desirable for protocols to be established that enable more comprehensive data to be provided to a coordinating agency.** This should be carried out in a manner that appropriately recognises the resourcing implications and confidentiality considerations of all the responding entities.

#### 8. Unique Patient Identifiers

One of the significant problems identified with the various data collections is that not all **patients can be traced through the whole system**. This means that the use of hospitals and patient experience within hospitals cannot typically be traced beyond single episodes of care. The introduction of individual patient electronic health records could be a mechanism for establishing this capacity. As this inhibits the efficient operation of the hospital sector in Australia the productivity commission may wish to consider relative costs and benefits of establishing this.

#### 9. Selected Performance Indicators and the Available Data

Common performance areas (domains) relevant to a performance framework that could be used in the Australian context would cover the following:

- Economic efficiency, often focussing on the complexity adjusted cost
- Quality of care issues
- Accessibility of hospital services
- Patient satisfaction
- Workforce sustainability

When developing performance indicators to assess each of the above, there can be a tension between measuring patient outcomes and measuring the outputs of a hospital. Positive patient outcomes (quality treatment and care) are clearly the underlying objective of interest in the provision of hospital services, but it can often be the case that outputs (for example, the number of times a treatment was carried out, or the cost of particular treatment) are more easily measured. In considering this some of the possible performance indicators are discussed below.

##### 9.1 Efficiency Performance Indicators

The first item in the terms of the Productivity Commission study is to consider comparative costs for clinically similar procedures performed by public and private sectors. This tends to be assessed in terms of:

- Casemix-adjusted cost separations; and
- Some measure relating to length of stay per separation.

## 9.2 Average Cost for Selected DRGs

Within these performance indicators, it is important to adjust for the differing clinical complexity and this is typically achieved by comparing at the DRG level. This ensures that episodes of care being compared are of comparable complexity and resource usage intensity. However the cost data provided by hospitals is subject to a number of caveats that make comparisons between public and private hospitals problematic.

In examining the relative cost of treatment by looking at the average cost per DRG it is neither consistently higher nor lower in either the public or private sector. For the reasons already outlined, such as the cost structure and the way different costs are allocated in the public and private sectors, these cost differences may say less about the efficiency of a hospital and more about how the data has been collected. Even when looking at the average cost per DRG within the public sector there is a far broader range of costs.

**While the casemix-adjusted cost separations are an interesting set of comparative metrics, as a performance indicator it is not clear what can be definitively inferred in terms of the relative performance between these groups of hospitals.** For this reason definitive conclusions cannot be drawn from this data.

## 9.3 Average length of stay

**The differences in the relative average length of stay (ALOS) between groups of hospitals could be attributable to differences in clinical practices, quality of care, and profile of the patient population or administrative efficiency.** This highlights the danger of looking at any given metric in isolation from other aspects of hospital performance.

## 9.4 Quality of Care Performance Indicators

The second item in the terms of reference of the Productivity Commission study is to consider the rate of hospital-acquired infections, by type, reported by public and private hospitals. This will be provided by states and territories under the new National Healthcare Agreement, and existing data provided to the Government by private hospitals.

Hospital-acquired infections are only one performance indicator for monitoring and assessing quality and safety of hospital care. There are a range of other indicators such as mortality rates, unplanned re-admissions or return to care, rates of adverse events, therapeutic accidents, or medication errors. These already exist under existing frameworks such as the national health Performance Framework.

## 9.5 Other Performance Indicators

A wide range of performance indicators have been discussed in this report and these could be used to monitor different aspects of hospital performance and patient experience. A common theme throughout has been the general lack of data that is either complete in its coverage or able to be validly compared between the public and private sector in the form that it is collected. **A considerable amount of data is collected by hospitals, but this is often either not available or in a form that lends itself to comparative performance assessment.**

Many of the performance indicators are primarily, if not exclusively, related to the public sector. Whilst other performance indicators are based viewed at the whole-of-sector level (public and private combined).

#### **10. NATSEM's Conclusion**

This report provides a survey of a range of possible performance indicators for hospitals, and in particular the availability of data to support these indicators. A range of data collections were surveyed as possible sources for the comparison of relative performance between public and private hospital sectors. These collections have limitations in terms of the coverage provided or the extent to which meaningful comparisons can be validly made between the performance of the public and private hospital sectors.

The national Hospital Cost Data Collection appears to be the best source of data to compare clinically similar services between the two sectors. However, the different cost structures between the two sectors make it difficult to draw definitive conclusions on the relative efficiency between the two sectors. Furthermore, the difficulties of comparing the two sectors on the basis of a competitively neutral environment have yet to be resolved, making comparisons between the two sectors using this data extremely problematic.

Safety and quality are very important throughout the hospital sector. At the present time the existing data collections are incomplete. The Productivity Commission study will specifically consider hospital-acquired infections, while individual State and Territory governments collect data according to their own criteria. There is a need for a more consolidated approach to data collection in this area.

A set of performance indicators that enable valid comparisons to be made between hospitals in the public and private sector is essential. Despite the broad range of data being collected such comparisons cannot yet be validly performed. It is hoped that the Productivity Commission will recommend the need for more coordinated action in this area.

#### **11. APHA's recommendation**

In its submission to the National Health and Hospitals Reform Commission in 2008 APHA advocated:

“1. Robust data is the foundation of sound policy-making. The Australian Institute of Health and Welfare should be tasked with developing a data collection that will enable the relative efficiency of different elements of the health care system to be evaluated and reported annually.

2. The starting point for reform is to rationalise the existing plethora of regulation and reporting requirements imposed on private hospitals. The NH&HRC should establish what information and data is important for private hospitals to report and require that this information and data be reported once, nationally.”

APHA believes that this reform would save the taxpayer significant dollars and free up hospital resources in both sectors