

## **SUMMARY AND RECOMMENDATIONS OF SUBMISSION FROM THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION**

Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system. However, many government initiatives fail to optimise the potential of private hospitals to assist in the delivery of health system objectives and priorities.

One of the fundamental challenges faced by private hospitals is a tendency by policy makers at a Federal and State level to view the sector through the prism of private health insurance. This is both outdated and incorrect.

Australia has a health system that is largely funded by government (directly or indirectly), supported by private health insurance, that provides access to health services which are delivered predominately by private practitioners in private settings. Private hospitals treat 4 in every 10 hospital patients, however the extent to which private hospitals are engaged by State Health Departments in service planning or other joint activities, is highly variable.

- ✍ Private hospitals treat almost 40% of all hospital patients;
- ✍ Private hospitals treat over 1 million patients aged over 65 years;
- ✍ Each year public hospitals treat over 350,000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.
- ✍ Privately-insured patients account for about 10 per cent of public hospital admissions.

Private hospitals are not 'funded' by private health insurers and the Federal Government does not provide 30% of the 'funding' for private hospitals - all costs incurred in running a private hospital are the sole responsibility of the hospital's owners and operators. A recent analysis undertaken by the Department of Veterans' Affairs found that "the work that we have done basically suggest that we pay significantly lower prices in the private sector than we do in the public sector."

Regulation of private hospitals varies between jurisdictions.

An inefficient and inequitable compliance burden is imposed upon private hospitals through overlapping multiple reporting regimes.

There is no systematic approach to educating and training nurses, doctors and allied health professionals. 71% of private hospitals provide education and training for the health workforce at a cost of approximately \$35 million per annum, none of which comes from external sources. There have been significant barriers to the successful implementation of the Expanded Settings for Specialist Training program, beyond the control of private hospitals.

APHA has previously welcomed the development of a suite of indicators for measuring and reporting on the safety and quality of hospital and health services and looks forward to the recommendations of the National Health and Hospitals Commission (NHHC) on the indicators that will be collected nationally. In order to ensure confidence in the robustness and transparency of the new data collection, these indicators will necessarily need to be reported to a national entity that is equipped to independently analyse and report on the safety and quality of health services;

Currently, private hospitals report to a variety of entities on the safety and quality of their services. This is an ad hoc and wasteful series of multiple processes that have no capacity to either systematically monitor nor improve the safety and quality of private hospital services. In APHA's view, the reporting of data to a single national entity is the only means by which each of the purposes listed above for measuring and reporting on the safety and quality of private hospital services can be achieved.

## **RECOMMENDATIONS**

- 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&HC should establish what information and data is important for private hospitals to report and require that this information and data be reported once, nationally.**
- 3. Incorporate the private sector into national planning exercises as an active participant.**
- 4. Map exactly what health resources Australia has at its disposal and how best these may be deployed to meet health care needs.**
- 5.1 Impose a cap on private inpatient admissions on public hospitals in the next Australian Health Care Agreements, initially set at 10 per cent of total admissions for 2007-08, decreasing to five per cent at the end of the five-year AHCA.**
- 5.2 An alternative course of action to Recommendation 5.1 is to abolish the minimum benefit arrangements determined by the Minister for Health and Ageing under the Private Health Insurance (Benefit Requirements) Rules.**
- 6. Ensure that public hospitals, managers and government officials can be held accountable under the Trade Practices Act for any anti-competitive conduct in respect of private patients.**

- 7. Investigate mechanisms by which public hospitals may be incentivised to transfer privately insured patients presenting at public hospital Accident and Emergency Departments to appropriate private hospitals.**
- 8. Not disadvantage public patients by imposing AHCA grant funding penalties to punish inappropriate conduct around private patient elections.**
- 9. The scope of the next Australian Health Care Agreements should be broadened to enable national priorities to be addressed, including: the education and training needs of the health workforce; including the provision of clinical placements across the health system; and the establishment of a national framework for measuring and reporting on the safety and quality of health services. Similarly, the AHCA's should address the barriers to patient movement throughout the whole health system, not just those parts funded directly by the Commonwealth and State governments.**
- 10. Require that all University medical and nursing schools consult and collaborate with all hospitals (private and public) in their local catchments on the provision of clinical placements for students. These schools should be required to report publicly on their consultation process and to report details of how and where funding for clinical placements has been allocated.**
- 11. The Australian Government should require all regulators, funders and health insurance funds to acknowledge the compliance of a private hospital with the nationally agreed indicators and to not require any additional measurement and reporting. Indeed, if an additional indicator or set of indicators identified by a State Health Department or agency or a health insurance fund are so important that a private hospital is required to measure and report against it, then a case should be made for incorporation of the indicator(s) within the nationally agreed suite of indicators.**

# **SUBMISSION TO THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION**

## **The Australian Private Hospitals Sector**

### **Background**

Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services.

While some of the large acute medical/surgical private hospitals are virtually undistinguishable from their public sector counterparts in the range and type of services provided, for the most part, private hospitals are quite different from public hospitals in size and types of services offered. This is particularly evident in the mental health sector in which private facilities provide treatment for quite distinct conditions to those treated in the public sector. Indeed, the mental health area is a good example of the complementarity of the private and public sectors.

Much of the interaction by government with the private hospitals sector is premised around the view that the private sector is a type of ninth jurisdiction with a high degree of homogeneity, which is at odds with the reality of a dynamic and very diverse sector that comprises a wide range of facilities and ownership structures.

The bulk of health policy development in Australia is undertaken by individuals and agencies with little or no direct knowledge of the private hospitals sector and therefore many government initiatives fail to optimise the potential of private hospitals to assist in the delivery of health system objectives and priorities. Similarly, unfounded preconceptions and outdated views also limit the contribution of private hospitals to assist in the implementation of initiatives and the delivery of services. These shortcomings are a feature of decision-making at the national, State and Territory levels and are also a particular feature of much academic commentary.

For example, one of the fundamental challenges faced by private hospitals is a tendency by policy makers at a Federal and State level to view the sector through the prism of private health insurance. This is both outdated and incorrect.

Contrary to the views expressed by some commentators, the private hospitals sector does provide a comprehensive range of services; does treat older patients; does not merely provide 'profitable' services (whatever these may actually be); does provide training for medical, nursing and allied health staff; does provide safe and quality services; and does contribute significantly to the balance and sustainability of the Australian health system.

## **Key Facts**

- ✍ Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system.
- ✍ Many government initiatives fail to optimise the potential of private hospitals to assist in the delivery of health system objectives and priorities.
- ✍ One of the fundamental challenges faced by private hospitals is a tendency by policy makers at a Federal and State level to view the sector through the prism of private health insurance. This is both outdated and incorrect.

## **Service provision and funding arrangements**

The Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the Private Health Insurance Administration Council all report a range of data on aspects of the hospital system, private and public. The Fact Sheet at Appendix 1 synthesises and analyses the latest available data to present an overview of the service provision and funding arrangements in the private hospitals sector. Selected highlights of the data include:

- ✍ Private hospitals treat almost 40% of all hospital patients;
- ✍ Private hospitals provide 32% of all hospital beds;
- ✍ Private hospitals perform 56% of all surgery;
- ✍ Private hospitals provide 69% of sameday mental health treatment and 43% of all hospital-based psychiatric care;
- ✍ Of the total 662 different procedures and treatments undertaken in Australian hospitals, private hospitals provide 658;
- ✍ Private hospitals treat over 1 million patients aged over 65 years;
- ✍ Private hospitals employ over 50,000 staff (FTE);
- ✍ Private hospitals invest over \$35 million of their own funds in the education and training of health professionals;
- ✍ An indication of the health system's inefficiency is that each year public hospitals treat over 350,000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.

There are six principal categories of patients treated by private hospitals:

- ✍ Privately insured
- ✍ Self-funded

- ✍ Department of Veterans' Affairs
- ✍ Workers compensation
- ✍ Motor vehicle third party personal claim
- ✍ Public patients

Of these, the privately insured category accounts for 77% of patients treated by private hospitals (a proportion of whom will make a personal financial contribution to their care under the conditions of their health insurance policy), which means that some 656,000 patient episodes in private hospitals are funded from sources other than private health insurance. Therefore, it is quite erroneous to claim that private hospitals are somehow 'funded' by private health insurers (a view held by insurers) or that the Federal Government provides 30% of the 'funding' for private hospitals (a view apparently held in some governmental and academic circles).

In fact, private hospitals are funded by their owners and operators. The services provided to patients treated in private hospitals are partially or fully subsidised from a variety of sources as per above, including private health insurance funds, the Department of Veterans' Affairs, third party insurers, State and Territory governments and out-of-pocket payments by patients.

There is no 'funding' from any of these sources to underwrite the maintenance, replacement or expansion of infrastructure in private hospitals, nor the day-to-day costs involved in running a private hospital such as nursing and allied health staff salaries, quality improvement activities and education, nor to meet the costs involved in the training of health and medical trainees (with the exception of positions funded under the Expanded Specialist Training Program). These and all other costs incurred in running a private hospital are the sole responsibility of the hospital's owners and operators.

In terms of efficiency, a recent analysis undertaken by the Department of Veterans' Affairs found that "the work that we have done basically suggest that we pay significantly lower prices in the private sector than we do in the public sector."

Aside from this work undertaken by the Department of Veterans' Affairs, APHA is not aware of any dataset that will allow the relative efficiency of different elements of the health care system to be evaluated and reported. Many assertions and preconceptions are held about the relative efficiency of, for example, private and public hospitals yet there is no comprehensive and objective data collection that will allow genuine comparisons to be made.

### **Key Facts**

- ✍ Private hospitals treat almost 40% of all hospital patients;
- ✍ Private hospitals treat over 1 million patients aged over 65 years;
- ✍ Each year public hospitals treat over 350,000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.

- ✍ Private hospitals are not ‘funded’ by private health insurers and the Federal Government does not provide 30% of the ‘funding’ for private hospitals - all costs incurred in running a private hospital are the sole responsibility of the hospital’s owners and operators;
- ✍ A recent analysis undertaken by the Department of Veterans’ Affairs found that “the work that we have done basically suggest that we pay significantly lower prices in the private sector than we do in the public sector.”

## **RECOMMENDATION**

**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.**

## **Addressing overlap and duplication including in regulation between the Commonwealth and States**

The regulation of private hospitals and the services they provide offers an apposite example of the overlap and duplication that so bedevils Australia’s health system.

Private hospitals are licensed by the States and Territories, although South Australia and Tasmania don’t license day hospitals, for reasons that are unclear to APHA. The licensing conditions (which vary from State to State) require private hospitals to meet a range of criteria, for example, around building regulations, provision of speciality services (intensive care etc) and safety and quality.

In order to be eligible for the payment of health insurance benefits and Medicare benefits (to patients and doctors) private hospitals must also apply to the Australian Government for a Medicare Provider Number and to be ‘declared’ as a private hospital by the Minister for Health and Ageing. This process requires private hospitals to meet an additional set of criteria. In some jurisdictions, such as Queensland, a State agency (Health Quality and Complaints Commission) establishes an additional set of requirements for private hospitals to meet.

In addition, quasi-regulation from the Australian Government imposed via the market power of private health insurance funds through their contractual arrangements with private hospitals, applies yet another layer of wasteful administrative hurdles for private hospitals.

Australia’s Health Ministers have recognised that overlap, duplication and multiple reporting requirements impose a compliance burden on private hospitals and have tasked the Australian Commission on Safety and Quality in Health Care to assess the

extent of the problem and to report back to Ministers as part of the second phase of the Commission's review of accreditation.

APHA has welcomed this initiative of Ministers and urges the NH&HRC to ensure that its consideration of system improvements is underpinned by the objective of rationalising the existing compliance burden rather than reinforcing (or worsening) the status quo.

### **Key Facts**

- ✍ Regulation of private hospitals varies between jurisdictions;
- ✍ An inefficient and inequitable compliance burden is imposed upon private hospitals through overlapping multiple reporting regimes;

### **RECOMMENDATION**

**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.**

## **Maximising a productive relationship between the public and private sectors**

One of the key obstacles to achieving greater coherency of Australia's balanced private and public health care system is the lack of understanding of how the health system is structured and operates.

In essence, Australia has a health system that is largely funded by government (directly or indirectly), supported by private health insurance, that provides access to health services which are delivered predominately by private practitioners in private settings.

Medicare is a system of universal public insurance which subsidises access for eligible Australian citizens to a range of health services, the bulk of which are provided by private medical and other health practitioners in private settings. A component of Medicare provides access for all eligible citizens to be treated free-of-charge in a public hospital by a medical workforce that comprises a mix of salaried employed doctors and contracted private Visiting Medical Officers who provide their services at a lower rate to State governments for the treatment of public patients in exchange for the right to treat private patients in public hospitals.

Private health insurance provides choice and additional subsidies for consumers to assist them in accessing a range of health services. The Australian Government supports consumer choice through its 30% rebate which subsidises the private health

insurance premiums for a wide cross-section of Australian households, comprising almost 50% of the population.

As noted earlier, private hospitals treat 4 in every 10 hospital patients, however the extent to which private hospitals are engaged by State Health Departments in service planning or other joint activities, is highly variable.

Australia has a very good health system overall but one of its key shortcomings is that we very seldomly adopt a genuinely national approach to anything. Australia has any number of national strategies and plans, however, few if any, recognise the realities of Australia's health system and are genuinely national. Rather, these strategies are seldom more than agreements between governments.

Strategies agreed between the Australian and State and Territory governments are not national plans. Inevitably, these national plans are developed to operate within the funding and service provision silos that bedevil Australia's health system and therefore little more than incremental change is ever achieved.

In order to break the mould, the notion of partnership will need to be adopted by governments. Partnership encompasses but is not restricted to consultation and participation. A promising start would be to map exactly what health resources Australia has at its disposal and how best these may be deployed to meet health care needs. In the case of hospitals, an honest assessment of the reasons behind the disparity across jurisdictions in the treatment of private patients in public hospitals may provide some insights into the variability in access to services by public patients.

### **Key Facts**

- ✍ Australia has a health system that is largely funded by government (directly or indirectly), supported by private health insurance, that provides access to health services which are delivered predominately by private practitioners in private settings;
- ✍ Private hospitals treat 4 in every 10 hospital patients, however the extent to which private hospitals are engaged by State Health Departments in service planning or other joint activities, is highly variable.

### **RECOMMENDATION**

**3. Incorporate the private sector into national planning exercises as an active participant.**

**4. Map exactly what health resources Australia has at its disposal and how best these may be deployed to meet health care needs.**

### **Private patients in public hospitals**

According to the latest *State of Our Public Hospitals* report, almost 600,000 private patients were treated in public hospitals in 2005-06. Australian Institute of Health and

Welfare expenditure data for 2005-06 show that non-government spending in public hospitals was \$1.8 billion, a 20 per cent increase from the previous year. It is almost certain that this growth trend has continued since.

About 400,000 of these private patients were covered by private health insurance (PHI), equating to about 10 per cent of public hospital admissions. Beyond these, there are also veterans, patients covered by compensation and patients who self-insure.

The current Australian Health Care Agreements (AHCAs) do not prohibit public hospitals admitting privately-insured patients, nor limit the numbers of such patients in public hospitals. The AHCAs do provide, however, that patients must be able to elect their private or public status freely.

The APHA does not necessarily oppose privately-insured patients being treated in public hospitals. In a small number of cases, a public hospital may be the only local treatment alternative, or a patient's doctor may choose to admit the patient to a public hospital.

What concerns the APHA is the abundant evidence that States are encouraging public hospitals to do all they can to maximise their private patient revenue, to the point of placing undue inducements before patients to use their PHI. States can and do set private patient revenue targets for their public hospitals and, has been reported recently, some hospitals even go as far as to employ dedicated Patient Liaison Officers to persuade patients and their families to go private.

Indeed, there is sufficient anecdotal evidence to suggest that public hospitals offer a wide range of financial and other incentives to persuade patients to use their PHI. These include paying their medical gaps, and writing off health fund co-payments and excesses that an insured patient otherwise would incur under his or her policy. The rationale is that the cost of honouring such offers is actually considerably cheaper for the State than the whole cost of a public patient episode.

However, not all private patients in public hospitals are happy with their 'choice.' Federal Government sponsored surveys of consumers on their views on Informed Financial Consent, have been conducted in 2004, 2006 and 2007. Results from the 2006 survey (the 2007 results are yet to be released by the Government) indicated that more than 1 in 5 (21%) private patients in public hospitals "felt pressured to be private" or worse still believed that they were "not given [a] choice at all" when 'electing' to be a private patient in a public hospital. This increased from 18% in 2004. Indeed in 2006, 1 in every three private patients felt some form of pressure, or were not given a choice, when 'electing' to become a private patient in public hospital. This situation was also worse than that in 2004.

The current arrangements enable the States and Territories to both double-dip revenue and cost-shift by receiving payments from health insurance funds for the treatment of private patients in addition to the funding already received from the Australian Government for the treatment of all members of the jurisdiction's population should they require hospital care. This double-dip also imposes an extra cost on health insurers (now running at some \$500 million per year) which they must pass on to their

contributors through higher premiums. The double-dip also shifts extra costs to the Australian Government via additional payments under the Medicare Benefits Schedule.

In terms of the fair operation of the overall network of Australian public and private hospitals, there are two serious issues for the Commission to consider. Most importantly, every private patient in a public hospital occupies a bed and consumes resources that could have been used by a public patient. For someone on an elective surgery waiting list, each private patient admitted potentially makes his or her wait that much longer. No-one is suggesting that public patients are being denied life-saving treatment, but for many public elective patients their waits are not life-threatening but very uncomfortable and painful. Waits should not be prolonged unnecessarily just to admit more private patients.

New South Wales, which had almost half the share of private patients in public hospitals in 2005-06, in that year was a significant underperformer in the percentage of elective surgery admissions seen within the recommended time. These data alone indicate how public patients can be seriously disadvantaged if private revenue is chased at the expense of treating public patients.

The second serious issue is the artificial tilting of the playing field between public and private hospitals in competing for privately-insured patients. Whether or not they are for-profit, private hospitals operate on very tight margins. Public hospitals, however, can make generous offers to potential private patients, such as those outlined above, drawing on the economies of scale and scope of being part of a statewide network backed by the central State budget. This applies even in small States such as Tasmania. Private hospitals can't compete on that basis.

As in other areas of commercial activity, competition between the sectors must be free and fair. Where this is the case, APHA members are very happy to compete against public hospitals for private patients. As noted in this submission, in most parts of Australia, and for most Diagnostic Related Groups, people can gain access to high-quality private hospitals as good as or better than the leading public hospitals in their States.

The APHA believes that some relatively straightforward changes can be made to achieve a fairer competition for private patients between public and private hospitals. Firstly, there should be a cap on the proportion of private patient admissions in public hospitals, encouraging them to stop chasing private revenue and concentrate on their core business of looking after public patients in a safe and timely manner. The next AHCA should limit the proportion of private patient admissions to no more than 10 per cent of total public hospital admissions in each State for 2007-08 (as a base year) for the first year of the new AHCA in 2009-10. This would decrease progressively to five per cent in the last year. Progressive tightening would avoid sudden funding crises in individual hospitals.

Alternatively, the Commission could recommend that the Government abolish the minimum benefit arrangements determined by the Minister for Health and Ageing under the Private Health Insurance (Benefit Requirements) Rules. Such a measure would cease the automatic and inflationary (on health insurance premiums) practice

that assures public hospitals of additional payments for the treatment of private patients.

Secondly, any “shield of the Crown” protection for State governments and public hospitals in respect of the commercial act of admitting private patients is wrong. Unfair inducements offered to patients by State authorities or individual public hospitals should be outlawed expressly as anti-competitive practices under Part IV of the Trade Practices Act as well as in the next AHCA. Such unfair inducements include payment by the public hospital of excesses and co-payments that may apply under a person’s health insurance policy and provision of a private room to a privately insured patient on other than clinical grounds. As a further disincentive, managers, officials and public hospital board members who are parties to such practices should be liable to personal penalties under the TPA or other Commonwealth legislation for sanctioning anti-competitive behaviour.

As detailed above, current settings provide incentives for public hospitals to ‘chase and retain’ private patients at the expense of public patients stranded on elective surgery waiting lists. An alternative approach would be to provide incentives for more efficient use of public and private resources by encouraging public hospitals to transfer insured patients to private hospitals.

Finally, the APHA believes that financial penalties imposed on AHCA grants to the States are not appropriate as sanctions against this type of conduct. Such penalties are not only impractical to apply, but they would unfairly deprive thousands of innocent public patients of funding for their procedures, and also impose still more pressure on public waiting lists. That is unconscionable in our view. If the public and the private sectors are to work better together in the future, maximising their cooperation in the best interests of their communities, addressing these issues fairly is both good policy and good sense.

### **Key Facts**

- ✍ Privately-insured patients account for about 10 per cent of public hospital admissions.
- ✍ Often these admissions are obtained by persuading patients to disclose and use their private health insurance, and there is strong evidence that many hospitals are aggressive in pursuing private elections, including offering a range of financial and other incentives to patients.

### **RECOMMENDATIONS**

**5.1 Impose a cap on private inpatient admissions on public hospitals in the next Australian Health Care Agreements, initially set at 10 per cent of total admissions for 2007-08, decreasing to five per cent at the end of the five-year AHCA.**

- 5.2 An alternative course of action to Recommendation 5.1 is to abolish the minimum benefit arrangements determined by the Minister for Health and Ageing under the Private Health Insurance (Benefit Requirements) Rules.**
- 6. Ensure that public hospitals, managers and government officials can be held accountable under the Trade Practices Act for any anti-competitive conduct in respect of private patients.**
- 7. Investigate mechanisms by which privately insured patients presenting to public hospital Accident and Emergency Departments may be transferred to appropriate private hospitals.**
- 8. Not disadvantage public patients by imposing AHCA grant funding penalties to punish inappropriate conduct around private patient elections.**

***Beyond the Blame game: Accountability and performance benchmarks for the next Australian Health Care Agreements, a report by the National Health and Hospitals Reform Commission***

Although this report is ostensibly concerned with the next Australian Health Care Agreements (AHCAs), part of the document is devoted to discussions around the health care system, particularly the Principles to guide reform. In these circumstances, it is disappointing that the NH&HRC has interpreted its initial task so literally and so narrowly. It is not at all clear to APHA why the next AHCAs should be concerned solely with funding flows between the Commonwealth and the State governments and thereby continue the silo-based approach to health care provision. Indeed, the NH&HRC itself acknowledges the necessity to look beyond the current AHCA framework:

*“Addressing the challenges needs concerted action by Commonwealth and state governments, involving the public and private sectors, hospital and community services, and crossing traditional funding boundaries (such as the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme). **Although the AHCAs haven’t had that scope in the past, health system reform needs to harness all the potential levers.**”* (page 18 – emphasis added).

However, when it comes to proposing ways forward for the future, the NH&HRC appears unable to look beyond current day constraints. For example, the NH&HRC proposes a ‘new’ accountability framework as:

*“...we have assumed for the purpose of performance benchmarks that state governments will be accountable for public hospitals, mental health, maternal and child health services, and public health services, while the Commonwealth Government will be accountable for aged care. We have assigned responsibility and accountability to the Commonwealth Government for prevention and Indigenous health on the basis of the need for national leadership in these areas.”* (pages 22-23)

Surprisingly, the NH&HRC is silent on the interfaces between the different parts of the system, which is where consumers face most difficulties and which are arguably the most glaring shortcomings of the current arrangements. Indeed, the NH&HRC has effectively proposed ‘silos of accountability’, which could well exacerbate current problems in relation to interfaces within the continuum of care. While all interfaces are problematic, the public/private interfaces create many difficulties for private hospitals and their patients. For example, discharging a patient from a private acute mental health facility into a public community mental health service is virtually impossible and despite years of representations and assurances, APHA is not aware of a single patient that has been able to move from a private hospital bed into a transition care place.

Similarly, transition care beds would appear to fall between the cracks of the ‘silos of accountability’ recommended by the NH&HRC.

Transition care places (which the Government has undertaken to double from 2,000 to 4,000) are funded by the Commonwealth and administered by the States. Although access to transition care is intended to be available for all Australians according to need, States have effectively blocked access for any patient being discharged from a private hospital.

It is difficult to see how such an iniquitous and discriminatory practice will be remedied by the NH&HRC’s proposals.

The next AHCAs offer an important opportunity to consider a range of national issues, including: the needs of the health workforce of the future; establishing a national framework for measuring and reporting on the safety and quality of health services; and dismantling the artificial barriers to patients moving seamlessly through the health system. There is nothing in the NHHRC’s initial report that will assist in any of these tasks and if not remedied, the report represent a missed opportunity for reform.

## **RECOMMENDATION**

**9. The scope of the next Australian Health Care Agreements should be broadened to enable national priorities to be addressed, including: the education and training needs of the health workforce; including the provision of clinical placements across the health system; and the establishment of a national framework for measuring and reporting on the safety and quality of health services. Similarly, the AHCAs should address the barriers to patient movement throughout the whole health system, not just those parts funded directly by the Commonwealth and State governments.**

## **Providing a well qualified and sustainable Health Workforce**

Education and training of the health workforce is an excellent example of policy failure over many years. Other than the program discussed below, there is no systematic approach to educating and training nurses, doctors and allied health professionals. This problem is particularly evident in the lack of consultation,

cohesion and co-ordination between universities and private hospitals in the provision of clinical placements. As with all generalities, there are exceptions, but these tend to be ad hoc and a result of considerable effort by particular individuals rather than evidence of a consistent approach to training.

There is some considerable irony in the contention in the NH&HRC's report (Beyond the Blame Game) that:

*“Schools of nursing and allied health professions are constrained in their ability to expand to meet workforce needs because of the difficulty of finding appropriate clinical placements.”* (page 17)

A number of private hospitals have encountered barriers and in some cases outright opposition from certain schools of nursing when attempting to engage in serious discussions on the provision of clinical placements in the private sector.

### **Expanded Settings for Specialists Training Program**

In July 2006, the Council of Australian Governments (COAG) agreed that by January 2008, the Commonwealth and the States and Territories would establish a system for medical specialist trainees to undertake rotations through an expanded range of settings beyond traditional public teaching hospitals, which could include a range of public settings (including regional, rural and ambulatory settings), the private sector (hospitals and practices), community settings and non-clinical (for example, simulated learning) environments.

The Australian Government has established the Expanded Settings for Specialist Training Program to support the implementation of this COAG decision. The program aims to provide trainees with access to an expanded range of training experiences that better match specialist practice.

A survey conducted for the Australian Private Hospitals Association in 2005 found that 71% of private hospitals provide education and training for the health workforce at a cost of approximately \$35 million per annum, none of which comes from external sources. The majority of hospitals expressed an interest in increasing their role in education and training but cited the lack of external funding as the key barrier.

While many private hospitals have keenly sought (and some have received) funded training allocations under the Expanded Settings for Specialist Training program, it is apparent there have been significant barriers to the successful implementation of the program, beyond the control of private hospitals, principle amongst which are;

- ✍ Differences between the States and Territories in their understanding and acceptance of the program which has led (in several jurisdictions at least) to delays in the approval of training places in the private sector,
- ✍ The need to clarify insurance arrangements for both trainees and the private hospital/practice; and,

- ✍ Relatively complex processes that have led to delays by some specialist colleges in the approval of training posts.

APHA believes that the recent establishment of state-based Working Groups to facilitate successful applications and deal with local issues arising under the program, both geographical and sectoral, will assist in alleviating the difficulties experienced to date and ultimately lead to the enhanced implementation of this program, necessarily with the continued support of the Australian Government.

### **Key Facts**

- ✍ There is no systematic approach to educating and training nurses, doctors and allied health professionals;
- ✍ 71% of private hospitals provide education and training for the health workforce at a cost of approximately \$35 million per annum, none of which comes from external sources;
- ✍ there have been significant barriers to the successful implementation of the Expanded Settings for Specialist Training program, beyond the control of private hospitals

### **RECOMMENDATION**

**10. Require that all University medical and nursing schools consult and collaborate with all hospitals (private and public) in their local catchments on the provision of clinical placements for students. These schools should be required to report publicly on their consultation process and to report details of how and where funding for clinical placements has been allocated.**

## **Safety and Quality**

The Australian Private Hospitals Association (APHA) has previously welcomed the development of a suite of indicators for measuring and reporting on the safety and quality of hospital and health services and looks forward to the recommendations of the National Health and Hospitals Commission (NH&HRC) on the indicators that will be collected nationally.

In order to ensure confidence in the robustness and transparency of the new data collection, these indicators will necessarily need to be reported to a national entity that is equipped to independently analyse and report on the safety and quality of health services.

### **Measurement and reporting of the safety and quality of services in private hospitals**

Currently, private hospitals report to a variety of entities on the safety and quality of their services. This is an ad hoc and wasteful series of multiple processes that have no

capacity to either systematically monitor nor improve the safety and quality of private hospital services.

These overlapping processes are imposed by State and Territory licensing regimes, private health insurance fund and Department of Veterans' Affairs contracting arrangements, accreditation agencies and State-based safety and quality agencies that have all developed their own sets of measuring and reporting frameworks with which private hospitals must comply. There is a high degree of variability in the amount of feedback provided to private hospitals from private health insurers and State and Territory Health Departments from these data collections. This variability is a shortcoming of the present arrangements which (Queensland and Western Australia excepted) do not enable a systemic approach to promoting organisational learning. This is regrettable given the substantial effort committed by private hospitals in collecting and reporting the data.

Several exercises are currently underway that aim to identify sets of indicators that can be reported nationally across the health system. APHA fully supports the national collection and reporting of data on the safety and quality of health services, including services provided in private hospitals. In order to be as efficient and effective as possible, this national process will necessarily require the identification of a central agency to which the different elements of the health system will report. The Australian Commission on Safety and Quality in Health Care would seem well placed to undertake this role.

### **Purposes of measuring and reporting on the safety and quality of health services**

A number of interlinked purposes can be identified for the measurement and reporting of safety and quality indicators, all of which require a national perspective. These include:

- ✍ Monitoring the safety and quality of services
- ✍ Improving the safety and quality of services
- ✍ Accountability
- ✍ Transparency
- ✍ Independence
- ✍ Consistency of data reporting and analysis
- ✍ Informing the public on the safety and quality of services

### **Methods of reporting on the safety and quality of health services**

#### **1. Reporting to a national entity**

In APHA's view, the reporting of data to a single national entity is the only means by which each of the purposes listed above for measuring and reporting on the safety and quality of private hospital services can be achieved.

A national system of reporting will enable feedback to hospitals and thus facilitate benchmarking and organisational learning, leading to systematic quality improvement. In addition, a national system of reporting is also the only mechanism

by which to reduce the duplication and overlap that has been identified by Health Ministers as an area of concern for private hospitals.

National reporting is the only means by which national objectives can be achieved; the only mechanism that will ensure a consistent and systematic approach is adopted; and the only way in which data collection and reporting can be achieved efficiently and effectively. As noted earlier, the Australian Commission on Safety and Quality in Health Care would seem well placed to undertake this role.

A mechanism of achieving compliance across private hospitals (and public hospitals if required) is to link the reporting of safety and quality to the process of 'declaration of a hospital by the Minister for Health and Ageing. This process is a requirement of the *Private Health Insurance Act 2007*.

APHA fully supports the identification of an agreed set of indicators that can be collected and reported nationally. This does not mean 'national' agreement on a course of action that is then delivered and monitored in a disparate fashion by each health insurance fund or each State and Territory jurisdiction. This would be an unacceptable outcome which would achieve little more than entrenching the current system's inadequacies.

APHA believes that the Australian Government should require all regulators, funders and health insurance funds to acknowledge the compliance of a private hospital with the nationally agreed indicators and to not require any additional measurement and reporting. Indeed, if an additional indicator or set of indicators identified by a State Health Department or agency or a health insurance fund are so important that a private hospital is required to measure and report against it, then a case should be made for incorporation of the indicator(s) within the nationally agreed suite of indicators.

APHA believes that such an approach by the Australian Government would deal very quickly with duplication by placing the onus on the regulator, funder or health insurance fund to justify why additional measurement and reporting beyond the nationally agreed set of indicators is required.

## **2. Reporting to or through private health insurance funds**

Contrasting with the systematic approach outlined above, a number of disadvantages can be identified around the national reporting of the safety and quality of private hospital services to or through private health insurance funds.

(a) As noted above, private hospitals currently report a wide range of data on the safety and quality of their services to multiple entities, each with its own suite of requirements. Within this wasteful and multiple series of frameworks, each private health insurance fund has developed its own set of reporting requirements, which are incorporated into hospital-health insurer contracts. These contracts have commercial-in-confidence status and the safety and quality components are driven by so-called accountability requirements, rather than being used as a mechanism to engineer quality improvement. These in-confidence contractual arrangements do not easily

lend themselves to transparency or consistency, which are two vital requirements for a national system of measurement and reporting on the safety and quality of services.

(b) Although a vast array of data is reported by private hospitals to private health insurance funds, none of this data is fed back to the hospitals to enable benchmarking or organisational learning.

(c) For consistency, data on the 360,000 privately insured episodes that occur in public hospitals would need to be reported by the States and Territories to or through private health insurers.

(d) Health insurance funds do not have a strong track record under their current legislative requirements for reporting on private hospital services though the Hospital Casemix Protocol (HCP). A recent analysis undertaken by the Department of Health and Ageing's Acute Care Division noted that the timeliness and accuracy of the HCP data submission process (data provided by hospitals through health insurance funds to the Commonwealth) was far inferior to that of the Private Hospital Data Bureau (data provided directly from private hospitals to the Commonwealth) and that inconsistent performance by several health insurers had resulted in the completeness of the HCP collection falling to 57% of episodes in 2006-07, down from 90% in 2005-06, with deadlines not being met by all insurers.

(e) Due to the imbalance in the market power of health insurers and most private hospitals, a percentage of private hospitals will not be in a contractual relationship with any or all health insurers, and it is unclear where data would be reported by these private hospitals.

(f) Together, Medicare (and in 77% of patient episodes), private health insurance funds pay benefits for the services provided by medical practitioners in private hospitals. None of these payments are paid directly to private hospitals. It is unclear exactly what is proposed for clinician-related data if reporting is imposed to or through health insurance funds. For example, will clinicians report some data to Medicare (100% of episodes) and some to private health insurance funds (77% of episodes)?

(g) Health insurance funds do not have a proven record of working cooperatively and indeed as competitors, this is not surprising. It is unclear therefore what mechanisms will be available for the national collection and analysis of data, particularly in view of the points made above in relation to the HCP data collection.

(h) Due to the disparate nature of health insurance funds, national reporting on safety and quality measures by private hospitals to or through health insurers would be both ineffective and inefficient.

At best, only the accountability purpose will be met by private hospitals reporting to or through private health insurance funds. There will be no capacity for system-wide monitoring of private hospital services, no systematic process for informing the public on the safety and quality of services nor will there be any possibility of improvement in the safety and quality of private hospital services through benchmarking and organisational learning.

### 3. Reporting to or through the State and Territory Health Departments

Many of the shortcomings identified above are also relevant to a discussion of reporting by private hospitals to or through the States and Territories.

(a) Private hospitals currently report a range of data to State and Territory Health Departments, usually as part of licensing requirements. The data collected varies across each jurisdiction.

(b) There are differences across jurisdictions in their licensing practices for private hospitals. For example, South Australia and Tasmania do not currently license day hospitals.

(c) Although a vast array of data is reported by private hospitals to State and Territory Health Departments, there is considerable variability in the data that is fed back to the hospitals to enable benchmarking or organisational learning.

Again, at best only the accountability purpose will be met by private hospitals reporting to or through State and Territory Health Departments. There will be no capacity for system-wide monitoring of private hospital services, no systematic process for informing the public on the safety and quality of services nor will there be any possibility of improvement in the safety and quality of private hospital services through benchmarking and organisational learning.

#### Key Facts

- ✍ APHA has previously welcomed the development of a suite of indicators for measuring and reporting on the safety and quality of hospital and health services and looks forward to the recommendations of the National Health and Hospitals Commission (NHHRC) on the indicators that will be collected nationally;
- ✍ In order to ensure confidence in the robustness and transparency of the new data collection, these indicators will necessarily need to be reported to a national entity that is equipped to independently analyse and report on the safety and quality of health services;
- ✍ Currently, private hospitals report to a variety of entities on the safety and quality of their services. This is an ad hoc and wasteful series of multiple processes that have no capacity to either systematically monitor nor improve the safety and quality of private hospital services;
- ✍ In APHA's view, the reporting of data to a single national entity is the only means by which each of the purposes listed above for measuring and reporting on the safety and quality of private hospital services can be achieved.

## **RECOMMENDATION**

**11. The Australian Government should require all regulators, funders and health insurance funds to acknowledge the compliance of a private hospital with the nationally agreed indicators and to not require any additional measurement and reporting. Indeed, if an additional indicator or set of indicators identified by a State Health Department or agency or a health insurance fund are so important that a private hospital is required to measure and report against it, then a case should be made for incorporation of the indicator(s) within the nationally agreed suite of indicators.**

### **The Australian Private Hospitals Association**

The Australian Private Hospitals Association (APHA) is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes medical/surgical hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Accreditation by an industry recognised and approved accreditation agency is a prerequisite for membership of APHA.

## APPENDIX A

### Private Hospitals and the Australian Health System

#### *Provision of Services*

Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services. The private hospitals sector is very diverse and includes a wide range of facilities and ownership structures.

While some of the large acute medical/surgical private hospitals are virtually undistinguishable from their public sector counterparts in the range and type of services provided, for the most part, private hospitals are quite different from public hospitals in size and types of services offered. This is very evident in the mental health sector in which private facilities provide treatment for quite distinct conditions to those treated in the public sector. Indeed, the mental health area is a good example of the complementarity of the private and public sectors.

Contrary to the views expressed by some commentators, the private hospitals sector DOES provide a comprehensive range of services; DOES treat older patients; DOES NOT merely provide ‘profitable’ services (whatever these may actually be); DOES provide training for medical staff; DOES provide safe and quality services; and DOES contribute significantly to the balance and sustainability of the Australian health system, as is illustrated by the data below.

- ◆ Private hospitals treat almost **40% of all patients in Australia**.  
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.
- ◆ In 2005-06, private hospitals admitted **2,846,000 patients, up 17.0%** on the previous four years.  
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.
- ◆ Private hospitals **perform the majority of surgery in Australia – 56%**.  
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.
- ◆ Of the **top 10** (in volume) treatments provided by both public and private hospitals, **five are identical procedures – with private hospitals performing the majority in four of the five**.  
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.

- ◆ **Numerous complex procedures and treatments** – traditionally associated solely with public hospitals – **now see private hospitals doing the bulk of work, for example:**

Sameday alcohol use, disorder and dependence services	92%	Major eye procedures	69%
Obesity Procedures	85%	Cerebral palsy, muscular dystrophy and neuropathy	66%
Sleep apnoea	83%	Other major joint replacement and limb reattachment	64%
Knee procedures	77%	Hip replacements	55%
Sinus, mastoid and complex middle ear procedures	70%	Chemotherapy	55%
Mental health treatment, sameday	69%	Major malignant breast conditions	55%

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.

- ◆ Private hospitals also perform **46% of all cardiac valve procedures and provide 43% of all hospital-based psychiatric care.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.

- ◆ Of the total **662 different procedures and treatments** undertaken in Australian hospitals, **private hospitals provide 658.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.

- ◆ In 2005-06, private hospitals treated some **423,000 accident and emergency cases.**

- Australian Bureau of Statistics, *Private Hospitals Australia 2005-06*.

- ◆ **Private hospitals treat over 1 million patients aged 65+ each year.** This age group represented **36% of all private hospital admissions in 2005-06,** commensurate with **public hospitals at 35%** over the same period.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-06*.

- ◆ In 1995-96, patients aged 75 years and older comprised **14.6% of total admissions in private hospitals,** compared to **13.9% in public hospitals.** In 2005-06, patients aged 75 years and over comprised **20% of total admissions in private hospitals, the same proportion as in public hospitals.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 1995-96, 2005-06*.

- ◆ In 2005-06, **4.6% of total private hospital treatments** were for patients aged 85 years and older. In public hospitals, **5.1% of total treatments** were for this age group.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-06*.

- ◆ In 2005-06 **private hospitals treated 186,000 DVA patients,** while **public hospitals treated 135,000 DVA patients.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-06*.

- ◆ In 2005-06 **public hospitals treated 351,000 privately insured patients. In the same year, private hospitals treated 100,000 public patients.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-06*.

## *Infrastructure*

- ◆ There are **284 private hospitals** in Australia, with **25,252 beds** – around **32% of all hospital beds** in Australia. There are 252 free standing day surgeries.  
- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2005-2006*.
- ◆ Since 2001-02, **private hospital capital investment** has fallen by 17% (from \$446,990,000 to \$370,132,000). **Day surgery capital investment dropped 39%** (from \$27,285,000 to \$17,235,000). These figures starkly reflect the failure of health insurance companies to pass on successive premium increases to health care providers.  
- Australian Bureau of Statistics, *Private Hospitals Australia 2005-06*.

## *Employment and Training*

- ◆ Over the past decade, **full-time equivalent staff in private hospitals** has increased by 22% to **47,770**. **Full-time equivalent staff in day surgeries** has increased by 150% to **2,231**.  
- Australian Bureau of Statistics, *Private Hospitals Australia 2005-06*.
- ◆ Australia's **private hospitals invest \$35,000,000 a year** in the education and training of surgeons, doctors, nurses and other health care professionals. Of this philanthropic investment in the nation's future medical workforce, private hospitals receive **no funding from governments or private health funds**.  
- Allen Consulting Group, *Education & Training in Private Hospitals*, 2005.

## *Funding and Efficiency*

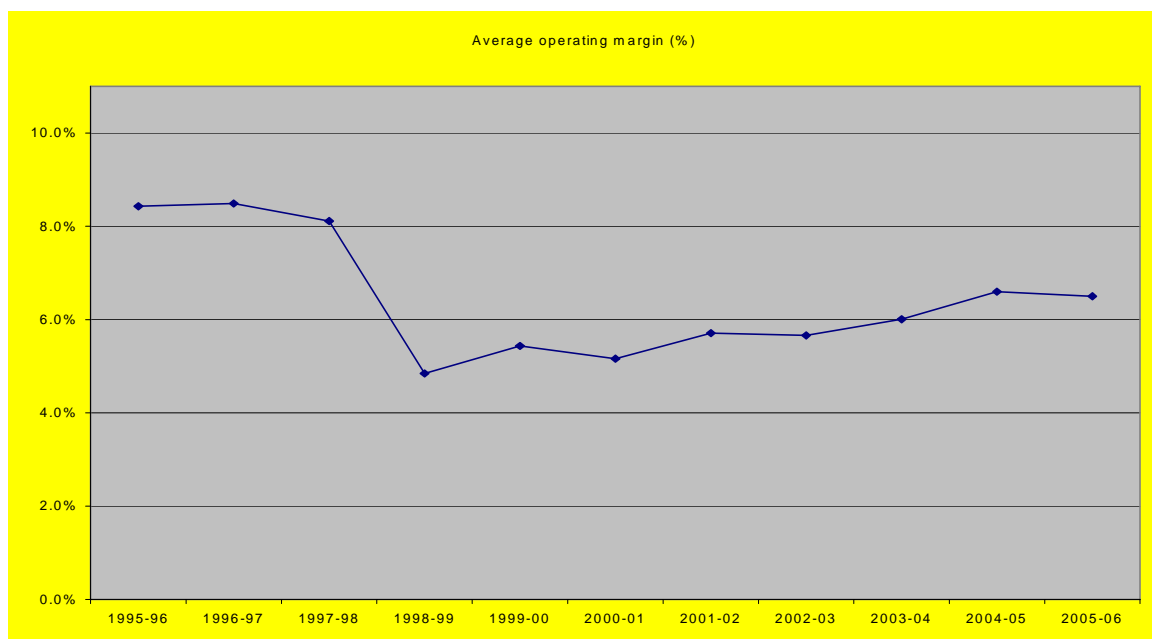
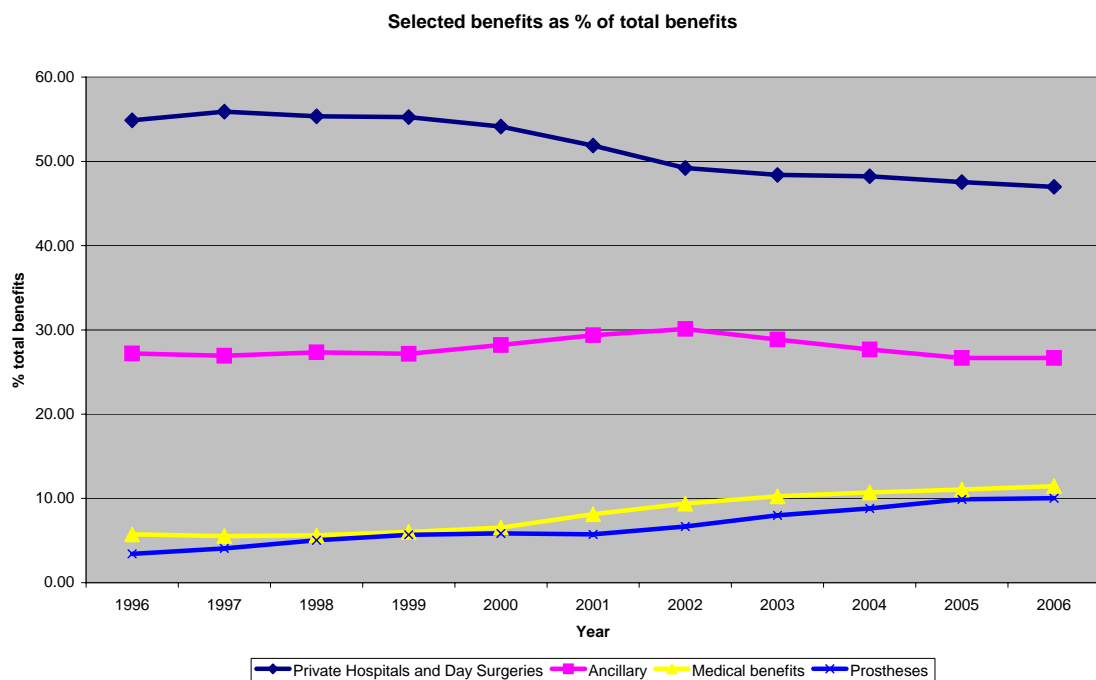
Private hospitals are funded by their owners and operators. The services provided to patients treated in private hospitals are partially or fully subsidised from a variety of sources, including private health insurance funds, the Department of Veterans' Affairs, Medicare, the PBS, and third party insurers.

- ◆ In 2005-06, **public hospitals received a total \$24.4 billion to treat 60% of hospital patients**. In 2005-06, **private hospitals received a total of \$6.7 billion to treat 40% of patients**.  
- Australian Institute of Health and Welfare, *Health Expenditure Australia 2005-06*.

- ◆ On the surface at least, these figures would seem to support the view presented by the Department of Veterans' Affairs to the House of Representatives Standing Committee on Health and Ageing on 4 September 2006 that: ***“the work we have done basically suggests that we pay significantly lower prices in the private sector than we do in the public sector.”***

- House of Representatives, Standing Committee on Health and Ageing, Reference: Health Funding, 4/9/06.

However, despite, or perhaps because of this fact, the funding provided by private health insurance funds for the treatment of their members in private hospitals is failing to meet the costs of the provision of that care. Indications of this situation can be found in the tables below.



## *Safety and Quality of Services*

APHA and private hospitals are proud of the standard of services provided in the sector. Regardless of whether they are operated on a for-profit or not-for-profit basis, private hospitals operate in a competitive environment. One of the key ways in which private hospitals seek to compete with each other and with the public sector is on the quality of their services. There is therefore a very strong imperative to maintain a high standard of safety and quality of services. This fact is not well understood by many people outside the sector, including private health insurance funds. However, the goal of quality services never has an end point and continuous improvement and benchmarking are essential ongoing activities.

APHA is most concerned about the duplication and overlap and accompanying compliance burden that characterises the measurement and reporting around the safety and quality of services in private hospitals. State and Territory licensing regimes, private health insurance fund contracting arrangements, accreditation agencies and State-based safety and quality agencies have all developed their own sets of measuring and reporting frameworks with which private hospitals must comply. This is wasteful and does little, if anything, to actually assure patient safety.

The Australian Council on Healthcare Standards has released 2 reports on the accreditation performance of public and private hospitals. In the latest report:

14 private hospitals were recognised for their leading practices by being awarded at least one Outstanding Achievement (OA) rating. This represents 58% of all hospitals recognised in this way. These OA ratings were awarded against a range of criteria, including:

- ✍ Care planning and delivery
- ✍ Infection control system
- ✍ Consumer participation in health services
- ✍ Consumer rights and responsibilities
- ✍ Governance structures

Australian Council on Healthcare Standards, *National Report on Accreditation Performance 2003-2006*.

## *Private patients in public hospitals*

One area in which private hospitals and public hospitals compete directly is in the treatment of private patients.

- ◆ **Public hospitals received nearly \$400 million in benefits from private health insurance funds in 2005-06, with New South Wales receiving more than 50% of the payments.**

- PHIAC, *Operations of the Registered Health Benefits Organisations*, 2005-06.

- ◆ However, waiting times for public patients to receive elective surgery are also increasing. **Government figures indicate that in 2004-05 only 82% of elective surgery admissions were seen within the recommended time.**

- *State of Our Public Hospitals June 2007 report.*

## *About APHA*

APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes medical/surgical hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Accreditation is a prerequisite for membership of APHA.

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