Australian
Private Hospitals
Association

Mr David Kalisch
Commissioner
Productivity Commission
LB 2 Collins Street East
MELBOURNE VIC 3000

Dear Mr Kalisch

On behalf of the Australian Private Hospitals Association (APHA), I attach a submission to the Productivity Commission's Research Study into the Performance of Public and Private Hospitals.

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 acute medical surgical hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

APHA is looking forward to the Commission's draft report and the opportunity to discuss the issues canvassed in it at the next roundtable in September.

Please contact me if APHA can assist further on this issue.

Yours sincerely

Michael Roff
CHIEF EXECUTIVE OFFICER
29 July 2009

AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

SUBMISSION TO THE PRODUCTIVITY COMMISSION RESEARCH STUDY INTO PUBLIC AND PRIVATE HOSPITALS

Introduction

In announcing the Research Study on 15 May 2009, the then Assistant Treasurer said, inter alia: "The Government is committed to improving transparency, accountability and performance reporting within the health system". (Hon. Chris Bowen MP, Media Release 15 May 2009). It would be perverse to dispute this stated goal, and APHA does not do so. Where arguments arise is around the definition and measures of efficiency that should be applied. The author(s) – unstated – of a Background Paper prepared for the National Health and Hospitals Reform Commission (NHHRC), adopted a fairly straight forward definition of economic efficiency, but noted tellingly that "[a] specified outcome may not be an efficient use of resources." (*The Australian Health Care System: the potential for efficiency gains – a review of the literature,* June 2009, p.4). This is quite correct and contains the nub of the issue. The paper goes on to sum up why: "Equity of access and outcomes are also important aspects of the health system".

It is from this issue of equity that much of the heat in discussions of the health system is generated.

"Equity" in health care is a very loaded term. It is often interpreted as "equal access to equal care for equal need". (For example, see Gavin Mooney, *Economics, medicine and health care,* 2003). However, who is the arbiter of need? Who sets the standards of equal care? And how should access be defined? Commonwealth, State and Territory Departments spend much time and resources in posing and answering these questions in regard to the public hospital sector. APHA contends that what is missing from such definitions and discussions is the explicit recognition that individuals should be able to exercise choice in heath care, which leads directly to a discussion of role of the private healthcare sector. Also absent is the explicit acknowledgement that individuals also make negative choices e.g. to smoke, to over-eat, to abuse alcohol or drugs, that can have a serious impact on their health and add to cost of hospital care, wherever that care is provided.

APHA believes that any discussion of the relative performance of the sectors can only be useful if it is devoid of ideology and comparisons or statements that are not based on evidence. For example, it was disappointing to read this statement in the Final Report of the NHHRC:

> "A growing tension between private and public provision
>
> One of the strengths of the Australian health system is that it has a combination of private and public financing as well as a competitive mix of private and public health care delivery. Nonetheless, there are signs that the competitive tension between private and public hospitals has become unbalanced. More and more, patients who can afford it are seeking planned surgical and procedural care in the private sector as they face long waiting lists and competing demands for emergency care in public hospitals. The attraction of better financial rewards and conditions in the private sector has resulted in surgeons and other proceduralists moving increasingly or exclusively to the private sector.
>
> There are increasing concerns that a two-tiered health system is evolving, in which people without private health insurance have unacceptable delays in access to some specialties such as cataract surgery and joint replacements." (*A Healthier Future for all Australians*, NHHRC Final Report, June 2009, p. 51)

No evidence is presented for these statements. The inference is left to be drawn: that it is somehow wrong for people who pay for the public hospital systems though their taxes, and then choose to pay again for private health insurance, to have access to the private care and treatment for which they have paid. This is unhelpful.

The Australian Private Hospitals Sector

Private hospitals are a vital partner, with the public sector, in Australia's health system. As the National Health and Hospitals Reform Commission observed in its draft report, released in February 2009:

"Australia's mix of public and private financing is generally regarded as one of the strengths of our health system. We believe that this balance should be maintained." (*A Healthier Future for all Australians*, Interim Report of the NHHRC, December 2008, p. 306).

Private hospitals are, in some aspects similar to public ones. Some of the large acute medical/surgical private hospitals provide similar services to their public sector counterparts, including accident and emergency services. However, this applies largely in the densely populated metropolitan areas. For the most part, private hospitals are quite different from public hospitals in size and types of services offered. For example, private facilities in the mental health sector provide treatment for quite distinct conditions to those treated in the public sector. The majority of chemotherapy treatment for people with cancer is delivered in the private sector. Most of the rehabilitation for people who have had accidents, injuries or falls is provided in private hospitals, where patients needing in-hospital rehabilitation are transferred after surgery and recovery in the public or private sectors to a private rehabilitation hospital. And nearly all in-hospital specialist palliative care services for the dying are provided in private hospitals, especially in regional Australia.

The data below gives a snapshot.

There are **280 private hospitals and 272 day hospitals** in Australia, with **27,768 beds** – just under **33% of all hospital beds** in Australia.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

Private hospitals treat **40% of all patients in Australia.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

In 2007-08, private hospitals admitted **3.1 million patients**. In the same period, Australia's 742 public hospitals admitted 4.7 million patients.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

Private hospitals **perform the majority of surgery in Australia – 64%**.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

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 2007-2008*.

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

Knee replacements	66%	Procedures of the digestive system	62%
Hip replacements	54%	Musculoskeletal procedures	54%
Coronary angiography	52%	Chemotherapy	55%
Cardiovascular procedures	44%	Major malignant breast conditions	55%
Prostatectomies	64%		

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

Private hospitals also perform **48% of all cardiac valve procedures and provide 43% of all hospital-based psychiatric care**.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

Of the total **660 different procedures and treatments** undertaken in Australian hospitals, **private hospitals provide 653**.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-2008*.

In 2006-07, private hospitals treated some **453,000 accident and emergency cases**.

- Australian Bureau of Statistics, *Private Hospitals Australia 2006-07*.

Private hospitals treat over 1 million patients aged 65+ each year. This age group represented **36.75% of all private hospital admissions in 2006-07**, slightly higher than **public hospitals at 36%** over the same period.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-08*.

In 1997-98, patients aged 75 years and older comprised **16.8% of total admissions in private hospitals**, compared to **15.2% in public hospitals**. In 2007-08, patients aged 75 years and over comprised **22.2% of total admissions in private hospitals**, **whilst the proportion for public hospitals was 20.9%**.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 1997-98, 2007-08*.

In 2007-08, **5.2% of total private hospital treatments** were for patients aged 85 years and older. In public hospitals, **5.5% of total treatments** were for this age group.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-08*.

In 2007-08 **private hospitals treated 200,000 DVA patients**, (61.5% of all DVA-funded patients).

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-08*.

In 2007-08 **public hospitals treated 416,000 privately insured patients. In the same year, private hospitals treated 76,000 public patients.**

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-08*.

Private hospitals and day hospitals employ just over 49,000 full time equivalent staff.

- Australian Bureau of Statistics, *Private Hospitals Australia 2006-07.*

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.

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 2006-07, the most recent period for which this data is available, **public hospitals received a total $27 billion to treat 60% of hospital patients**. In 2006-07, **private hospitals received a total of $7.1 billion to treat 40% of patients**. Of this $7 billion, $5 billion (70%) came from private health insurers. $1.7 billion of this was tax-payer funded: the PHI rebate. The remaining $2.1 billion (30%) came from self-funded patients and other insurers, such as the Department of Veterans' Affairs.

- Australian Institute of Health and Welfare, *Health Expenditure Australia 2006-07*.

Some additional commentary on the 2006-2007 figures is provided below.

This data is important. It gives us important facts about what private hospitals do, and whom they treat. It does invite comparisons with the public sector. However, of itself, data like this – and there is plenty of it for both the public and private sectors – does not allow truly meaningful comparisons about performance to be made. Much more detailed examination of the data is needed, as set out in the Study's Terms of Reference, and the Commission's Issues Paper commenting on these.

The available data

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 the Terms of Reference. The report of this work is at **Attachment A**. 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.

NATSEM found, inter alia:

- There is a wide range of indicators that can be used to monitor aspects of hospital performance and the patient experience with the treatments they receive;

- There is a 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 is collected;

- While there is considerable data collected by hospitals, it is often not easily available or in the form that lends itself to comparative performance assessment.

These findings, whilst not surprising, are concerning. However, APHA contends that it is not beyond the capacities of the Commonwealth and State and Territory Governments, acting in concert with the private sector, to overcome the problems posed by this lack of information, as opposed to data.

In its submission to the NHHRC 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. It is a necessary pre-condition for true reform, for how else can the public actually know how its money is being spent?

Other comments

APHA offers some further observations which are relevant to the Commission's Terms of Reference.

Overall costs of health care

In 2006-2007, the latest period for which these figures are available, **$94 billion** was spent on health care in Australia. For hospital services, this figure breaks down as:

- $27 billion on **public hospital services**, of which $10.8 billion (40%) came from the Commonwealth, $14.3 billion from State and Territory Governments (53%) and $1.9 billion (7%) from private health insurance and self funded patients;

- $7.1 billion on **private hospital services,** of which $5 billion (70%) came from private health insurers and $2.1 billion from other sources including other insurers such as the Department of Veterans' Affairs;

- Of the $5 billion from private health insurers, **$1.7 billion** (34%) came from the PHI rebate.
    - Australian Institute of Health and Welfare, *State of our Hospitals*, June 2009

- Total Medicare Benefits paid to services to **private patients** treated in both public and private hospitals were $1.8 billion.
    - Medicare Australia
- Total PBS Benefits paid in 2006-2007 were $65 billion, of which $750 million is estimated to have been paid to patients in private facilities.
    - Medicare Australia and APHA estimate

In 2006-2007, private hospitals treated **2.96 million patients**, which represents 39% of all patients admitted to hospital that year. The cost to the Australian taxpayer was approximately **$4.25 billion**.

By comparison, public hospitals treated **4.64 million patients** (61%), at a cost to the taxpayer of **$27 billion**.

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006-07*.

Even allowing for the fact that public hospitals provide the majority of accident and emergency services and high cost treatments such as those provided for severe burns, this is a significant differential in cost.

Two other observations are relevant. The first is that in 2006-2007, 50% of public hospital separations were same day. 64.9% of private separations were same- day for this period. Same-day separations in both sectors increased over the previous year: 5.3% for the public sector and 4.4% for the private sector. Therefore, the cost differential to the taxpayer is not totally explained by differences in conditions treated, as there should significant correlation

between same –day costs. (Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006-07*).

Secondly, private hospitals fund their own capital expenditure, and also, as detailed later in this submission, significant clinical education and training. For profit private hospitals also pay tax, including FBT. None of these conditions apply to the public sector. Tax exemptions are not included in the figures above; one participant (not from the private sector) at the roundtable discussion held by the Commission in Canberra on 30 June commented that these were effectively "subsidies in the order of hundreds of millions of dollars to the States". To the APHA's knowledge, there is no readily available data on this.

The information above adds to the matrix of information about hospitals, and provokes questions, but unfortunately does not readily allow any conclusions to be drawn.

Capital Costs

As emphasised at the roundtable on 30 June, another difficult area for comparative analysis is capital costs. As the Commission observed in its Issues Paper, the cost of capital (depreciation and the user cost of capital) is implicitly included in the charge data for the Hospital Casemix Protocol, so that the cost of capital in the private hospital sector is accounted for. The public hospital sector differs in that not all States report depreciation costs to the Commonwealth's National Hospital Cost Data Collection (NHCDC). Nor is the value of public hospital assets included in the NHCDC. The Commission has stated that it intends to obtain the asset values of public hospitals from the States and Territories and then work out the UCC. It will be interesting to see how detailed the information is.

APHA can provide some recent data. A presentation given by the Queensland Department of Health in 2008 (see **Attachment B**) on the development of the new Queensland Children's Hospital indicates that the cost per bed for the 360 public hospitals beds is in the order of $3.055 million per bed or $14763 per sq. m. This compares with current costs from the acute private hospital sector in Queensland of around $5000 per. sq m. for high cost areas such as operating theatres and $3500 per sq. m. for areas such as patent wards/rooms and administrative offices. The differential is in the order of 250-300%.

APHA does not suggest why this significant differential in costs should exist. However, APHA does contend that the differential cannot be explained by the argument that some participants in the 30 June roundtable discussion seemed to be making: that capital costs in the public sector will always be higher because public hospitals are established for the "public good". This is simply an ideological assertion. APHA believes that on the face of it, these differing costs indicate the kind of "wastage" referred to by Bentley et al in their 2008 study of the US system. In particular, inefficient processes (in this case, procurement processes) and overly expensive inputs may well explain some of the higher public sector costs. (See Bentley, Effros, Palar and Keeler, "Waste in the US health care system: a conceptual framework, *Milbank Quarterly* 86, no. 4, 2008, pp. 629-659). Further, if private hospitals, both not- for-profit or for-profit, aim to contain capital costs, why is it not appropriate for the public sector, funded by the taxpayer, to seek to do the same with equal rigour?

One factor that should be considered – although the data to do so would be very difficult to extract - is the fact that, to the best of APHA's knowledge, the cost per bed for new public hospital infrastructure does not include the costs of those parts of the large State Health bureaucracies that are involved in running the public hospital system. Private hospital costs explicitly include such administration costs. It would be useful to be able make cost comparisons that factored in true total costs.

Safety and Quality

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. We note that the final Report of the National Health and Hospitals Commission (NHHRC), has recommended that "…data on safety and quality should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement…" (NHHRC Final Report 2009, Recommendation 32). However, there is as yet no national agreement on what this data should be.

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 neither 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.

APHA has embarked on a pilot project that is collecting data on key indicators from private hospitals, both members and non-members. These indicators have been previously provided to the Commission. If successful, it is intended to roll out the indicator collection to all APHA members. Reports will be sent to hospitals to allow them to compare their performance with others in their peer group and to drive improvements in safety and quality by sharing information and learning from it. APHA believes that the issue of national indicators is an urgent one, and by, embarking on its own collection, aims to provide further impetus to the work being undertaken at the national level.

Clinical training and education

One of the aspects of public hospitals often referred to as "unique" is the role they play in clinical education and training. There is no dispute that this is a very important role. Participants at the Roundtable in June referred to it and there were comments made that this was a factor in attracting and retaining good quality clinical staff in the public sector.

The fact that the private hospital sector provides significant clinical education and training is usually ignored. At **Attachment C** is a report prepared for APHA in 2005: *The education and training of health and medical professionals in private hospitals and day surgeries.* The report shows that the private hospital sector makes a significant commitment to education and training, with 71% of private hospitals offering programs to medical, nursing and allied health staff and students in 2004.

This report, funded by the APHA, is the most recent national study available. However, at **Attachment D** is the report from Ramsay Health Care on undergraduate clinical placements in Ramsay Hospitals for 2008-2009. In that period, Ramsay's 62 hospitals provided training and education to 755 undergraduate medical students and 4545 undergraduate nursing students (all categories). No hospital estimated a drop-off of activity in 2009-2010; 55.75% of hospitals estimated that student intake numbers would increase.

Other points to note about the Ramsay Report are:

- It is based on a 100% response rate;
- This training is not funded by Governments;
- The report, and the survey, has been made available to the National Health Workforce Taskforce; and
- To the APHA's knowledge, there is no similar retrospective report available for any public hospital or Area Health Group.

The last point provokes an obvious question: given the often-stated importance of the role of the public hospital sector in clinical education and training, why does the sector not collect data and report publicly for both undergraduates and postgraduates?

Informed financial consent (IFC)

A good example of the IFC standards which private hospitals must meet is provided by the Second Tier Benefit application process. To be eligible for second tier benefits, hospitals must provide to their patients information on:

- The hospital charges in dollar amounts;
- The health insurer benefit in dollar amounts; and
- Any out of pocket costs the patient will incur.

The hospital is permitted to advise the patient that these costs are estimates and can vary due to circumstances one the patient is admitted e.g. length of stay. However, the hospital must clearly state its own charges and the insurer benefit payable, and the patient must agree in writing.

An example of a Second Tier Benefit application form is at **Attachment E**.

Private hospitals aim to give patients the fullest information they can about out of pocket costs. Not only is this in the best interests of the patient and his/her family or carer, it also reduces the administrative burden on hospitals. In regard to in-hospital services, a patient may have out-of-pocket costs if:

- They are covered by a health insurance policy that has an excess;
- They are covered by a policy that has a co-payment for a hospital stay e.g. $x per day for a specified period
- They are a maternity patient and the hospital charges a booking fee;

- They are self-insured.

The hospital will ascertain the patient's level of cover with their health fund before admission, and normally advise the patient prior to admission of their out of pocket costs (if the admission is urgent it is not always possible to do this in advance, so the hospital follows up as soon as practicable). The hospital also asks the patient or the fund contributor to agree in writing to these costs. Most hospitals require payment prior to admission.

Private hospitals do not administer out of pocket expenses that may be incurred in regard to pathology, radiology, treating doctor and anaesthesia. However, hospitals advise patients to talk to their doctor about these expenses, so that they are as fully informed as possible prior to admission.