CHAPTER 6

THE INTERFACE BETWEEN PRIVATE AND PUBLIC HOSPITALS

Introduction

6.1 Australia has had a long tradition of provision of health services by private providers to fee-paying private patients. There has also been provision of services for public patients by not-for-profit religious/charitable institutions. Until the late 1970s many private for-profit hospitals were small, often owned and run by medical practitioners. However, developments over recent times have seen an expansion of the operation of private for-profit operators with corporations entering the market. There has also been an impact on the private sector as new technologies emerge, more complex procedures are undertaken in private hospitals and the population ages. In addition, the private sector delivers services to some public patients under contract to governments and also provides clinical and non-clinical services to many public hospitals. This has resulted in a blurring of the boundaries between the public sector and the private sector.

6.2 This chapter provides an overview of the delivery of hospital services by the private sector and models of ownership, management and financing now in place in Australia. This is followed by a discussion of the impact of changes on private and public hospitals. The Committee has drawn on two recent papers for its overview of the private sector below: in December 1999, the Productivity Commission published a research paper on private hospitals in Australia and the Australian Competition & Consumer Commission (ACCC) reported to the Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance.[1]

Overview of the private sector

6.3 The private sector plays a significant role in the provision of health services in Australia. In 1998-99, there were 312 private hospitals providing treatment to both overnight and day patients and 190 freestanding day facilities.[2]

6.4 The services provided by private hospitals have been growing, particularly in the provision of day facilities. The following table provides an overview of activity and growth in the private sector.

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1 Productivity Commission 1999, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra, 1999; Australian Competition & Consumer Commission, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance*, ACCC, Canberra, 1999.

2 Australian Institute of Health and Welfare, *Australian hospital statistics 1998-99*, AIHW cat. No. HSE 11, Canberra, 2000, p.27.

Table 6.1: Profile of the private hospital sector, 1993-94 and 1998-99

	1993-94	1998-99
Private hospitals		
Establishments		
No of hospitals	329	312
Available beds	21 241	23 746
Private free standing day hospitals		
Establishments		
No of hospitals	111	190
Available beds	556	1 460
Private hospitals and free standing day hospitals		
Activity		
Separations ('000)	1 313	1 875
Same days separations (‘000)	568	1 028
Same days separations as a % of total	43.3	54.8
Separations per 1000 population	74.7	95.5
Patient days (‘000)	5 117	6 045
Average length of stay, all separations (days)	3.9	3.2
Average length of stay, excluding same day separations (days)	6.1	5.9
Private hospitals		
Financial data		
Total recurrent expenditure ($'000)	2 225 893	3 613 591
Total revenue ($'000)	2 491 674	3 797 681
Private free standing day hospitals		
Financial data		
Total recurrent expenditure ($'000)	61 092	137 480
Total revenue ($'000)	76 502	161 400

Source: Compiled from Australian Institute of Health and Welfare, *Australian hospital statistics 1997-98*, Canberra, AIHW, 1999, tables 3.1, 3.2 and 4.1 and *Australian hospital statistics 1998-99*, Canberra, AIHW, 2000, tables 3.1, 3.2 and 4.1.

6.5 Private hospital revenue has been increasing steadily over the last decade, with total revenue of more than $3 959 million in 1998-99.[3] Private acute and psychiatric hospital revenue grew by more than 40 per cent and free standing day hospital revenue grew in real terms by some 190 per cent during the period 1991-92 and 1997-98.[4]

6.6 The ACCC found that despite the dramatic increase in revenue there had not been a corresponding increase in private hospital profitability. Free standing day hospitals increased gross profit (revenue minus recurrent expenditure) from $10.1 million in 1991-92 to $23 million in 1997-98. Gross profit from private acute and psychiatric hospitals increased from $222 million to $285 million over the same period.[5] It has been reported that a number of private hospitals face a difficult financial position with pressure from private health funds to provide beds and services.[6]

6.7 The principle source of private hospital revenue is received from payment for patient services – about 92 per cent – while the remainder is derived from such things as investment income, accommodation and facility fees paid by doctors.[7] Patients in private hospitals may be fee-paying private patients, both those with private health insurance (76 per cent of separations) or self-funding (9 per cent); patients provided for by the Department of Veterans' Affairs (9 per cent); compensible patients (5 per cent); and public patients being provided services (2 per cent).[8]

6.8 In broad terms, in-hospital services to fee-paying patients with private health insurance are generally funded as follows:

Medical services – (including pathology/ diagnostic services)	Commonwealth: Medicare benefit of 75 per cent of the MBS schedule fee; Health insurance fund: health insurance benefit of 25 per cent of the MBS, although funds may pay more under contract or gap cover schemes; Patient: any gap due to the difference between fee charged by doctor for in-hospital medical services and combined Medicare and fund benefit;
Hospital services –	Health insurance fund: health fund benefit, often total cost depending on contractual arrangements;

3 Australian Bureau of Statistics, *Private Hospitals Australia 1999-00*, June 2000, p.27, Table 3.1.

4 Productivity Commission, p.30.

5 ACCC, p.63.

6 *The Sydney Morning Herald*, 'Four private hospitals go into receivership, and there's more on the critical list', 6.9.00.

7 ACCC, p.63.

8 Productivity Commission, p.22.

	Patient: any gap between fee charged by hospital and fund benefit;
Pharmaceuticals –	
PBS	Commonwealth: cost of pharmaceutical less patient contribution; Patient: contribution under the PBS, although the fund may pay the copayment under some types of cover;
non-PBS	Health insurance fund depending on type of cover.

As well, there may be additional expenses to the patient due to the type of cover purchased, including policies with front end deductibles, policies which do not cover non-PBS drugs or the full hospital charge (eg only cover private patients in public hospitals) and exclusionary policies.

6.9 There are four main ownership types in the private sector: for-profit group; for-profit independent; not-for-profit religious/charitable; and, other not-for-profit hospitals (includes bush nursing, community and memorial hospitals). The for-profit group and religious/charitable operators provide around 80 per cent of available beds in private acute care and psychiatric hospitals. The size of individual hospitals varies from very small (fewer than 25 beds) to major facilities with several hundred beds.[9] Large private hospitals are mostly located within metropolitan areas. Those in regional Australia are mostly very small and often not-for-profit hospitals.

6.10 Some private hospitals are co-located with public facilities. They may form a joint medical facility or precinct and may share some facilities. The co-located private hospitals vary in size from very small (10 to 20 beds) to medium size hospitals of 200 or more beds. However, the private hospital is not usually involved in the delivery of any public hospital services and they operate at arm's length.[10]

6.11 Co-location has become increasingly popular over the last decade. In 1999, there were approximately 32 co-located private hospitals operating in Australia. While there are some co-located not-for-profit hospitals, most recent examples involve the establishment of co-located for-profit hospitals. Expansion in this area is expected to continue, for example, five new co-located private hospitals were due to open in Queensland in 1999.[11]

6.12 Commonwealth legislation ensures that public hospitals that are co-located with private hospital facilities continue to provide access to a comprehensive range of services for public patients. The Minister for Health and Aged Care must consider a range of criteria listed in Ministerial guidelines set out in a disallowable instrument pursuant to subsection 23 EA(5) of the *Health Insurance Act 1973* before 'declaring'

9 Productivity Commission, p.xii.

10 Productivity Commission, p.9.

11 Submission No.38, p.37 (DHAC).

private hospital premises to enable payment of health insurance benefits for private patients treated in the facilities. Similar provisions under the *National Health Act 1953* apply to co-located day hospitals.

6.13 The services offered by the private sector have changed significantly over the last decade, particularly over the last five years. Although there are still differences in the casemix profile of public and private hospitals, the range of services in private hospitals has increased. Many more complex services are available with private hospitals now offering intensive care services, cardiac and oncology units. In 1981, there were only two intensive care unit (ICU) facilities in private hospitals. By 1997-98, there were 30 ICU, 21 coronary care units (CCU) and 33 combined ICU/CCUs. The number of private hospital accident and emergency units increased from none in 1981 to 27 in 1999.[12] However, there is still limited provision of some services in the private sector, for example, paediatric services, and no provision of some very specialised services such as transplants and burns units.[13]

6.14 The private sector dominates some areas of elective surgery. For some surgical procedures, the private sector is the primary provider:

- 71% of knee procedures;
- 68% of lens procedures;
- 66% of colonoscopy; and
- 59% of gastroscopy.[14]

6.15 The private sector has faced some significant developments in the 1990s:

- as noted above, with the growth of the private sector has come a greater diversity and complexity of the services offered, particularly for overnight patients;
- same day procedures are accounting for an increasing proportion of activity;
- changes in the relationship between private hospitals and health insurance funds, including contracting with hospitals by funds for services required by their members (known as hospital purchaser provider agreements (HPPAs)), have increased pressures on hospitals to deliver their services efficiently; and
- increasing delivery of services to public patients under a variety of contractual arrangements with government.

The interface between the private and public hospital sector

6.16 The interface between the private and public sectors arises through a variety of means:

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12 Submission No.18, p.7 (APHA).

13 Submission No.38, p.34 (DHAC); Submission No.63, p.29 (AHA, WHA & AAPTC).

14 Submission No.44, p.3 (Mayne Nickless Limited).

- informal links such as providers working across both sectors;
- outsourcing of clinical and non-clinical services in public hospitals;
- co-location of public and private hospitals;
- private hospitals purchasing services from the public sector;
- private provision of services for public patients; and
- privatisation of public hospitals.

Outsourcing

6.17 There are now many private contractors providing various clinical and non-clinical services to public hospitals. There is extensive contracting of services such as catering, cleaning, maintenance, laundry, car parks and security.

6.18 Increasingly governments are turning to the private sector for the provision of clinical services such as radiology and pathology. For example, the Queensland Government has entered into arrangements with private providers for services such as radiology and surgical services.[15] There are also examples of privatisation of outpatients' clinics, whereby hospital outpatients' clinics have been replaced by private clinics run by hospital specialists.

6.19 Services are contracted out for a variety of reasons including opportunities to reduce costs, improve quality of services provided and increase flexibility.

6.20 There are examples of public facilities which have been sold to private operators and which continue to provide some services to government under contract, for example the Repatriation General Hospital, Hollywood, WA and the Repatriation General Hospital, Greenslopes, Queensland. Access for veterans to these facilities continues through specific Hospital Services Agreements between the Department of Veterans' Affairs and the hospitals.

6.21 The 1998-2003 Australian Health Care Agreements allow for public hospital services to be provided in any appropriate environment, provided that the patient continues to receive care free of charge, on the basis of clinical need and within a clinically appropriate time. (See also paras 6.81-85)

Co-location

6.22 The interface between public and private hospitals also occurs with the co-location of private facilities with public hospitals. As stated above, co-location is increasingly occurring in Australia with more than 30 co-located private hospitals now in operation. (See also paras 6.88-95)

15 Submission No.41, p.31 (Queensland Government).

Private provision of public hospital services

6.23 In Australia there are now a number of arrangements which combine public and private sector involvement in ownership, management, delivery of services and financing of hospitals.

Joint ventures with religious groups

6.24 There has been a long tradition of private operators providing public hospital services. In the past, these have generally been provided by religious/charitable institutions. The first dates from 1857, when the Sisters of Charity established St Vincent's Hospital at Potts Point, Sydney, as a free hospital for all people. There are now more than 20 religious/charitable hospitals, including seven major teaching hospitals, providing about 3 000 beds for use by the public under arrangements with State and Territory governments.

6.25 Under these arrangements the institutions finance the construction and operation of facilities and the government pays them for treating public patients. There may be one management structure covering both the public and private components of the hospital and staff may be shared. However, the private hospital component is operated and licensed as a separate entity within the hospital complex.[16]

Franchised public hospital services

6.26 Franchising of public hospitals involves a state government contracting out the entire management of an existing public hospital to a private health care company, for example, Mersey Hospital in Tasmania was contracted to Health Care of Australia in 1995.

BOOT-type arrangements

6.27 BOO and BOOT arrangements involve private sector financing of the construction and operation of facilities for treating public patients. These arrangements allow the private sector to build and finance new public hospital facilities to treat public patients in return for the right to operate the facilities and receive patient payments from state governments.

- *BOO arrangements*: the private sector Builds, Owns and Operates a hospital facility. The state government purchases hospital services for a specified time (usually 20 to 25 years) after which ownership of the facility is retained by the private operator. Private facilities are also provided. For example, Port Macquarie Base Hospital, NSW, Latrobe Regional Hospital, Victoria, and Joondalup, WA;

16 Productivity Commission, p.8.

- *BOOT arrangements*: the same as a BOO arrangement, however, at the end of the contract period ownership is transferred to the state government, for example, Hawkesbury Hospital, NSW, Robina, Queensland, Noosa, Queensland;
- *BOLB arrangements*: the private sector Builds, Owns and Leases Back a hospital facility. The private operator constructs the hospital and leases it back to the public sector which runs the facility, for example Mount Gambier Hospital, South Australia.[17]

The impact of the change in the delivery of public hospital services

6.28 The private sector has expanded in all states and, as the Productivity Commission has stated, governments have sought increasingly to involve the private sector with the provision of health care. Factors contributing to this include (self imposed) funding constraints on governments which have limited their capacity to invest in new or to expand existing public hospital facilities and the perception that there would be cost savings and improvements in quality of care through greater private sector involvement.[18]

6.29 State Governments have used a combination of the models described above in their commercial dealings with the private sector. The Queensland Government stated that there were no privatised public hospitals in Queensland. It has instead pursued a partnership approach with the State retaining ultimate ownership of public health assets.

6.30 The Queensland Government saw direct benefits of its joint ventures including:

- reduction in duplication between private and public sectors which allows government to take advantage of excess private capacity and therefore meet unmet public sector demand;
- increased flexibility in service provision which allows the issue of unmet demand in the public sector to be addressed in a more effective manner; and
- sharing of infrastructure costs given the high cost of health capital.[19]

6.31 The West Australian Government also indicated that it was satisfied with the quality of service provided through a contract with a private hospital to provide services for public patients and that the services were being provided at a price that 'is more than comparable with the rest of the metropolitan area'.[20]

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17 Productivity Commission, pp. 6-7.

18 Productivity Commission, p.5.

19 Submission No.41, p.30 (Queensland Government).

20 *Committee Hansard*, 25.2.00, pp.278-9 (Health Department Western Australia).

6.32 DHAC and the Productivity Commission noted that those supporting the greater involvement of private sector management of public hospitals claim the following benefits:

- private sector operators have more ready access to capital for the construction of infrastructure;
- there is scope for private firms to exploit synergies from bundling construction, financing and hospital operations;
- the private sector can provide hospital services more efficiently than the public sector and thus there are better outcomes for limited public sector budgets;
- the use of private sector operators allows government to transfer risk of both capital expenditure and recurrent costs; and
- improvements in quality of care.[21]

6.33 Many witnesses pointed out that the Australian health care system was a blended one, with the private sector seen as performing an important complementary role to the public health care system. It was emphasised that the private sector should not be seen as a replacement for the public system.[22] Arguments were put to the Committee by those opposing moves towards further expansion of private sector provision of services for public patients, particularly through privatisation. These arguments included the differing motivation of each sector; uncertainty about the level of benefits; cost increases; equity considerations; and lack of reliable research.

6.34 Many submissions supported a continuation of the primacy of the public sector and argued that the 'community role, quality and non-profitable services currently provided in public hospitals could be compromised or limited in the name of profit if public hospitals were privatised'.[23] Barwon Health, for example, stated:

> The other key point to emphasise in this topic is the distinctly different ethos of private and public providers, the former motivated by profit and dividends to shareholders, the latter serving the community stakeholder through equity of access and efficiency.[24]

This view was supported by AHA, WHA & AAPTC:

> It should be acknowledged that the private sector, including profit and not for profit organisations, will always seek a return on its investment…Most importantly the public sector is motivated not by profit but by access to care based on need…[The public sector] focus on equity is clearly resonant with

21 Submission No.38, p.37 (DHAC); Productivity Commission, p.5.

22 *Committee Hansard*, 22.3.00, p.429 (QNU).

23 CHERE, Discussion Paper 3: Key Issues, p.12.

24 Submission No.37, p.5 (Barwon Health).

> prevailing societal values and there appears little social or economic justification for diminution of its role in delivery of health care.[25].

6.35 Catholic Health stated that the interface between public and private hospitals is changing to meet demand and improve efficiency and that the Catholic health sector has participated in this approach and would 'ensure that issues of equity and access are monitored and understood so that issues of community benefit are not sacrificed for the need to ensure shareholder return'.[26]

6.36 Some commentators have argued that privatisation is an 'ideology or a belief structure'. The RACP, ACA and Health Issues Centre noted:

> …a privatised system is based on a free market, in which market forces determine supply and demand. A perfectly competitive market does not feature interference with the laws of supply and demand, such as government regulation. Such a system sees health as a commodity for which individuals must make their own choices in relation to consumption. This is contrary to the belief that health is a right, and that the community (and therefore government) has a responsibility to ensure that all its members have access to health and social services according to need.[27]

Efficiency gains and access to capital through privatisation

6.37 The major benefits claimed by the supporters of privatisation are increases in efficiency and access to capital. CHERE noted that the former is 'the standard economic rationale for privatisation in most industries, that is that the profit motive, assumed to be a driving force in the private sector, and competition would increase technical and allocative efficiency'.[28]

6.38 Evidence received by the Committee argued that this is in fact not the case, that costs in the private sector were higher, as operators need to make a profit and the number of services per patient are higher.[29] On the other hand, the RACP argued that it was not helpful to make blanket statements about public or private hospitals being more or less efficient. Rather, the key issues are about equity and access to quality care and opportunities for teaching, training and research, something that is rarely taken into account in arguments emphasising efficiency.[30]

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25 Submission No.63, p.36 (AHA, WHA, AAPTC).

26 Submission No.56, p.21 (Catholic Health Australia).

27 Submission No.45, p.26 (RACP, ACA, HIC).

28 CHERE, Discussion Paper No.3: Key Issues, p.11.

29 Submission No.17, p.9 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.20, p.17 (DRS); Submission No.45, p.28 (RACP, ACA, HIC).

30 *Committee Hansard*, 21.3.00, p.371 (RACP).

6.39 While it is acknowledged that there has been little data on the comparative efficiency of the private and the public sectors, some recent research may give an indication of a comparison of the two sectors.

6.40 A study by Stephen Duckett and Terri Jackson assessed the argument that the private sector is more efficient than the public sector.[31] They concluded that in the case of provision of hospital services the public sector is in fact more technically, allocatively and dynamically efficient than the private sector. Duckett and Jackson argued that past efficiency comparisons of public and private hospitals have been flawed because of the use of bed-day costs. However, changes to data mean that differential casemix of each sector can now be taken into account as well as costing discrepancies between the two sectors. These differences relate to medical services including pathology and imaging which in the private sector are not incorporated in hospital costs; pharmaceutical costs which are borne by patients in the private sector (reimbursed through the PBS); and, depreciation expenses which have not been well attributed in the public sector. They provided cost differences as follows.

Table 6.2: Estimated average cost per weighted separation, public hospital casemix, financial year 1996-97

	Public hospital costs	*Private hospital costs*
Unadjusted average cost per separation	$2 283	$2 058
Average cost per separation adjusted for discrepant elements*	$1 774	$1 941

*Discrepant elements removed are public medical, pathology, imaging and pharmacy costs and depreciation costs for the private sector. Costings use national public hospital DRG cost weights.
Source: Authors' estimates using National Cost Weight Study data

6.41 Duckett and Jackson concluded:

> These deficiencies in the data have fostered a longstanding but mistaken view that the private sector is more efficient than the public sector in providing hospital care. Even casemix data give this misleading result if costing discrepancies are not taken into account. Our analysis has shown that, when appropriate adjustments are made to these cost estimates, the public sector provides care at a lower cost per case, and thus there is no economic basis for directing additional expenditure to the private sector.[32]

6.42 The Centre for Health Program Evaluation (CHPE) submitted that the impact of privatisation depends upon the relative administrative efficiency of private and

31 Duckett, SJ, Jackson, TJ, The new health insurance rebate: an inefficient way of assisting public hospitals, *The Medical Journal of Australia*, Vol 172, May 2000, pp.439-42.

32 Duckett and Jackson, p.442.

public hospitals when the quality of care is similar; and the effect of private hospital status upon the type of service provided to the patient.

6.43 In relation to administrative efficiency, CHPE reported no reliable studies (to 1998) in the literature which demonstrated significant differences in administrative efficiency between public and private hospitals. It concluded 'in the absence of empirical evidence the case for the privatisation of public hospitals is weak and the likelihood of significant health sector benefits from this activity are correspondingly small'.[33]

6.44 In relation to the type of service provided, two studies were noted. The first, by Professor J Richardson and I Robertson, studied the likelihood of patients receiving a costly hi-tech procedure after hospitalisation with an acute myocardial infarction (AMI). It was found that those in private care were, at the end of eight weeks, 100 to 400 per cent more likely to receive a high technology, high cost procedure (angiography or a revascularisation) than patients treated in public hospitals. After 12 months a 100 per cent differential was preserved.

6.45 Professor Richardson stated that there was no indication of differences in quality of life from the study (or whether these results suggest overservicing in the private sector, or underservicing in the public sector or a mix of both). However, 'if there is no difference there then that simply means we are doing more [in the private sector] for the same outcomes. That is costly.'[34]

6.46 CHPE noted that as the reason for the difference 'is associated with the more permissive environment in the private sector (facilities being more readily available in order to attract private doctors), it is highly probable that the same differential pattern of service provision will occur in privatised public hospitals. Mechanisms have not yet been developed and implemented to regulate the type of procedures doctors choose to undertake in private hospitals.'[35]

6.47 The second study by Harper at the Monash Medical Centre examined the unit cost of coronary procedures in the public and private wards. The study found that private expenditures significantly exceeded public costs and 'perversely, because of the public reimbursement of medical and pharmaceutical costs, generated higher costs for public Medicare than if the patient had been admitted to the public hospital'.[36]

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33 Submission No.46, p.16 (CHPE).

34 *Committee Hansard*, 23.3.00, p.597-98 (CHPE).

35 Submission No.46, p.17 (CHPE).

36 Submission No.46, p.16 (CHPE).

6.48 CHPE concluded:

- data suggests that private hospitals may be more likely to employ costly procedures and that the unit cost of such procedures may be significantly greater in the private sector;
- private hospital care may cost the public more than public care; and
- these results imply that the expansion of private hospitalisation and the privatisation of public hospitals may significantly increase the cost of health care.[37]

6.49 Similar research was cited by a number of the midwifery submissions which indicated that the rate of Caesarean section births is significantly higher in private hospitals.[38] Excluding Victoria and the Northern Territory, which did not have data on status in hospital, in 1995 the Caesarean rate of 24.8 percent for women who had private status in hospital was 51 percent higher than the rate of 16.4 percent for those with public status. This difference is partly attributable to a higher proportion of older women among those with private status.[39] The Victorian Branch of the Australian College of Midwives stated that a rate of Caesarean section births in excess of 15 per cent of all births in a region is above the maximum acceptable level (UNICEF 1997), and is an indicator of inappropriate use of obstetric services.[40]

6.50 Barwon Health noted that in a recent costing exercise, 'public hospital costs were found to be about the same after adjusting for competitive neutrality and comparing like with like. So there is no evidence that the private sector can manage hospitals more efficiently.'[41]

6.51 In its report on private hospitals, the Productivity Commission looked at three non-financial indicators of private hospital performance: hospital efficiency; service quality; and appropriateness of services provided.

6.52 For hospital efficiency the Commission evaluated cost efficiency, labour productivity and average length of stay. Findings included that:

- the casemix-adjusted costs per separation for all private acute care hospitals between 1993-94 and 1996-97 have fallen by 3 per cent, due mainly to a reduction in unit labour costs;

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37 Submission No.46, p.18 (CHPE).

38 See for example, Submission No.64, p.7 (Australian Midwifery Action Project); Submission No.75, p.10 (Australian College of Midwives (Vic)).

39 Australian Institute of Health and Welfare, *Australia's Mothers and Babies 1995*, 1998, p.17.

40 Submission No.75, p.10 (Australian College of Midwives (Vic)). See also *Committee Hansard*, 20.11.00, p.750 (Centre for Family Health and Midwifery).

41 Submission No.37, p.4 (Barwon Health).

- total unit costs in religious/charitable hospitals were considerably higher than in other ownership groups;
- costs per casemix-adjusted separation increase with hospital size, this may reflect the greater prominence of religious/charitable hospitals in the larger size categories although the Commission did not have access to data based on size;
- the smallest hospitals have relatively high labour costs. However, these are offset by lower non-labour costs; and
- both unadjusted and case-mix adjusted average length of stay (ALOS) fell during the 1990s, with ALOS for the top 15 DRGs in for-profit hospitals on average 5 to 6 per cent lower than for other ownership groups.

6.53 The Productivity Commission noted although for-profit hospitals may appear to be more efficient than the not-for-profit hospitals, other factors may explain the variations in efficiency. One reason is that the cost per separation and ALOS do not pick up differences in the complexity of cases within DRGs. With larger hospitals, often the religious/charitable hospitals, treating more complex cases within individual DRGs, costs will be higher. Larger hospitals may also devote proportionately more resources to non-clinical functions such as teaching and research, leading to higher costs per separation. It was also noted that the cost per separation and ALOS indicators do not make any allowance for variations in the quality of service delivered to patients.

6.54 The Commission indicated that there were broader influences on efficiency outcomes in the private sector. These included the regulatory and policy environment and the market relationships between the hospitals, doctors and health funds. In particular, changes in the relationship between health funds and private hospitals have strengthened the incentives for private hospitals to deliver their services efficiently.

6.55 In relation to quality of service, the Commission concluded that quality indicators 'paint a reasonably positive picture of quality in the private health industry'. However, the Commission noted that there were concerns with the use of quality indicators and the overall assessment of quality of care.

6.56 The Commission also addressed the issue of appropriateness of care and noted that studies had found that patients in private hospitals are more likely to receive a greater number of in-hospital medical services than they would have as private patients in public hospitals. The Commission noted the comments by Richardson that it is unknown whether these measures indicate overservicing in the private sector or underservicing in the public, or both.[42]

6.57 The Queensland Government provided the Committee with a comparison of the top 30 DRGs (by volume of patients) in both public and private hospitals. It was stated that, in general, the results indicate that:

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42 Productivity Commission, pp.45-58.

- overall, there was a zero difference between the average costs of public and private hospitals on a simple unweighted DRG by DRG basis;
- for core costs (salaries etc), public hospital costs were 14 per cent higher than private hospital costs;
- for over head costs (administration etc) public hospital costs were 31 per cent less than private hospital costs; and
- the different proportions of core and non-core costs in the total cost allow this outcome where the two components differ markedly but the overall difference is zero.[43]

It was noted that this was a simple comparison between two groups of hospitals and did not entirely control for differences in factors known to impact on costs such as teaching, tertiary or secondary status, location etc.

6.58 The other potential benefit of privatisation was that private hospitals have greater access to capital. Some submissions supported the involvement of the private sector in the development of public infrastructure on the grounds that the private sector could provide facilities at a time when governments were faced with tight fiscal circumstances.

6.59 However, CHERE noted that it is unclear whether this is a benefit, given governments can probably access capital at a cheaper rate than individual or groups of private hospitals. Collyer in her analysis of the privatisation of the Port Macquarie Base Hospital noted that the objective behind the privatisation was, in part, to address a shortage in available capital for the provision of public infrastructure. It was said that public finance was unavailable, given the constraints on global borrowing set by the Commonwealth. Collyer stated that this was never tested and it is possible that a loan may have been approved under Loans Council Guidelines.[44]

Potential costs

6.60 Evidence pointed to the complex nature of health services and the difficulties which that imposed on measuring benefits for public patients of expanded involvement of the private sector. It was argued that the public sector plays an important community role and as such provides numerous services that may not be profitable. For example, it was noted that the larger public teaching hospitals undertake many activities which go beyond routine clinical care, such as education, research and audit. Other services include many of the health services in rural and remote Australia. Other concerns were raised about ensuring equity and access to high quality care.

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43 Submission No.41, Additional Information, p.2 (Queensland Government).

44 CHERE, Discussion Paper 3, p.12; Collyer, F, 'Privatisation and the Public Purse: The Port Macquarie Base Hospital', *Just Policy*, No.10, July 1997.

Casemix

6.61 The Queensland Government noted that while private hospitals have extended the range and complexity of services offered, public hospitals still treat more complex and costly patients than in the private sector. Public hospitals also treat more medical cases and patients with chronic and complex conditions.[45] AHA, WHA & AAPTC also noted that while the private sector did some things very well, for example, ophthalmology, a range of services was not available in the private sector, for example, in the field of paediatrics and women's health, 'because they are not profitable services for the private sector'.[46]

6.62 The Royal Australasian College of Surgeons also stated that patients with complex or catastrophic illnesses are treated in the larger public hospitals and under present casemix funding, the costs usually result in a major loss. As a consequence, these patients would likely to be avoided by a privately managed private hospital.[47]

Education, training and research

6.63 Submissions noted that generally, undergraduate teaching, postgraduate training and quality assurance activities are not adequately funded in current hospital funding models and are often cross subsidised from other activities.[48] As a result, where services are privatisated these activities may not be recognised in contractual arrangements and therefore funded inadequately or not at all.

6.64 Concern was expressed that the private sector has generally failed to provide the same commitment to education and training as the public sector.[49] The DRS stated that 'despite claims of private institutions to be committed to education, their commitment rarely extends to the employment of adequate numbers of training registrars'.[50]

6.65 It was argued that the failure to provide adequate education opportunities is already causing difficulties and will result in serious shortages of appropriately trained staff in the future.[51] It was noted that privatisation of some services, particularly pathology and radiology, is removing training opportunities. The Royal Australasian College of Physicians stated that privatisation of ambulatory care facilities (usually

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45 Submission No.41, pp.30-1 (Queensland Government).

46 Submission No.63, pp.33-4 (AHA, WHA, AAPTC).

47 Submission No.28, p.4 (RACS).

48 See for example, Submission No.49 p.1 (Faculty of Medicine, Monash University). See also Submission No.61, p.18 (Australian Physiotherapy Association).

49 *Committee Hansard,* 23.2.00, p.541 (Australian College of Health Service Executives).

50 Submission No.20, p.16 (DRS); see also *Committee Hansard,* 21.3.00, p.371 (RACP); *Committee Hansard,* 23.3.00, p.496 (Committee of Presidents of Medical Colleges), *Committee Hansard,* 23.3.00, p.541 (Australian College of Health Service Executives).

51 Submission No.28, p.4 (RACS); *Committee Hansard,* 23.2.00, pp.147-48 (Professor Roberton).

outpatients departments) has reduced training opportunities for physicians 'in a major way, leading to the re-evaluation of ambulatory care training by the RACP'.[52] Professor Roberton voiced concern for the training of medical students in a private environment where 'practitioners feel that they have a different responsibility and a greater constraint on their ability to discuss, to intellectualise, to think broadly as they are discussing matters with our trainees'.[53]

6.66 The Australian Healthcare Association also expressed concern over the future of research opportunities in the private sector. AHA stated that virtually all clinical medical research is conducted in the public sector:

> Despite the fact that the same clinicians may care for patients in the private and the public sector, it is much less common for research activities to be based in the private sector. This presumably relates to the nature of the reimbursement of clinicians in the private sector and the relative lack of support for such initiatives by private hospitals, health insurance funds and so forth.[54]

Equity and access to quality care

6.67 The RACP, ACA and HIC noted that 'in health care, the public sector has a crucial role in ensuring equity, that is ensuring access to good quality care for those in greatest need, commonly those with the least capacity to pay. It is also critical in ensuring geographic access'.[55]

6.68 Evidence was received that following changes to management arrangements, ie moves to the private provision of public services, difficulties had been experienced with services being reduced or closed. For example, it was stated that services have been closed at Latrobe Hospital 'in an argument that they are not being funded adequately through the private-public agreement'.[56] Concerns have also been expressed about the level, variety and quality of services provided at Modbury Hospital, SA, where a private company manages the public hospital. The hospital's 24-hour emergency surgery service had been reduced with some periods being covered by 'on-call' services.[57]

6.69 The changes to the level of service provision have significant implications for access to care. This is particularly so when the hospital in question is the only provider

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52 Submission No.45, p.28 (RACP, ACA, HIC).

53 *Committee Hansard*, 23.2.00, p.148 (Professor Roberton).

54 Submission No.63, Additional information, p.5 (AHA). See also Brooks, P. 'Privatisation of teaching hospitals', *Medical Journal of Australia*, 1999;Vol 170, pp.321-22.

55 Submission No.45, p.27 (RACP, ACA, HIC).

56 *Committee Hansard*, 23.3.00, p.537 (ANF (Vic)).

57 Submission No.65, p.13 (ANF (SA)); *Committee Hansard*, 23.2.00, p.175 (ANF(SA)).

for the region. This is the case for the Latrobe Hospital which replaced two public hospitals that were closed at Moe and Taralgon.

6.70 A further matter raised in relation to access to quality care concerned the changes in the public health sector workforce. Concerns were expressed that the supply of specialist medical staff in public hospitals may decline as a result of co-locations and expansion of the use of private hospitals. It was argued that this might lead to fewer specialists available to provide services in the public sector and thereby impact adversely on public sector waiting lists.[58] The increased reliance on part-time and casual hospital staff was also noted as an outcome of recent changes. It was argued that this increased pressures on staff and was detrimental to the quality of care.[59]

Financial viability

6.71 Concerns were also raised in evidence about the economic viability of some contracted out services and the impact of financial instability on the standard of care provided.[60] The AMA (Vic) pointed out that private operators in Victoria are funded in the same way as traditional Victorian public hospitals, which are the lowest cost providers of care in Australia. The AMA (Vic) considered that given this and the need for the private sector to deliver adequate returns on investment and that the for-profit sector does not have access to input tax exemptions, there are significant financial risks in the private sector operators, 'which given the nature of hospitals, cannot be quarantined to the operators. There would be risks to patients, staff and Government, if these competing pressures were not effectively managed'. The AMA (Vic) considered that the operating risks, in terms of the range and quality of services, are of such a magnitude, that they can only be safely borne by the public sector.[61] (See Box 2 for a discussion of Latrobe Regional Hospital.)

6.72 AHA, WHA & AAPTC also noted:

> Concerns now clearly exist as to whether these [co-locations] were sound business investment decisions. The returns on the high capital investment cost appear not to be sufficient to meet debt servicing and profit expectations. There are clear signs of the private sector wanting to increase its share of government funded work, arguably to improve its cash flow and enhance profitability.[62]

6.73 Catholic Health Australia also voiced a note of warning, stating that 'certainly a feature of more recent contracts is a risk shift to the owners and operators of the

58 Submission No.72, p.28 (Consumers' Health Forum of Australia). See also Submission No.45, p.28 (RACP, ACA, HIC).

59 Submission No.16, p.13 (QNU).

60 See for example, *Committee Hansard*, 22.3.00, p.433 (QNU).

61 Submission No.27, p.3 (AMA Vic).

62 Submission No.63, p.35 (AHA, WHA, AAPTC).

projects which has the potential to be unsustainable in the longer term. Competitive pressures may have also resulted in operators offering discounts on benchmark prices that are unsustainable in the long term'.[63]

Accountability issues

6.74 Concern was expressed about the possible lack of accountability arising from greater contracting with the private sector. It was argued that commercial-in-confidence contracts did not allow for full transparency.[64] Some submissions cited the example of Port Macquarie Base Hospital and Modbury Hospital where many details of the contracts entered into were unavailable due to commercial-in-confidence claims.[65] The Australian Nursing Federation (SA) stated:

> This cloak of secrecy is a major problem in an area of service delivery that impacts very directly on the health and welfare of the community and is paid through the public purse. It works to remove genuine public accountability for both economic efficiency but also for achieving appropriate standards of care and service to the community the hospital was intended to serve.[66]

Contracting and administration costs

6.75 DHAC noted that contracting also brings with it specific costs, which need to be factored into any analysis of potential savings. These costs include bargaining costs, opportunism costs, and transaction and monitoring costs.[67]

6.76 The RACP argued that in fact, the complexity of the arrangements may increase administrative costs, often to the detriment of clinical resources, and while the private sector may enjoy financial gains, the government continues to have the overall responsibility and financial risks.[68]

6.77 Together with the specific costs of contracts, there was also concern about the difficulties in defining in contracts all the services currently undertaken by public hospitals. In particular, submissions pointed to teaching and research activities and community services.

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63 Submission No.56, p.21 (Catholic Health Australia). See also *Committee Hansard*, 23.2.00, p.158 (SA Minister for Human Services).

64 Submission No.16, p.12 (QNU); Submission No.39, p.6 (ANF); Submission No.72, p.28 (Consumers' Health Forum of Australia); *Committee Hansard*, 21.3.00, p.373-74 (RACP).

65 Submission No.26, p.3 (Medical Consumers Association of NSW); Submission No.65, p.13 (ANF (SA)).

66 Submission No.65, p.13 (ANF (SA)).

67 Submission No.38, p.36 (DHAC).

68 Submission No.45, pp.28-9 (RACP, ACA, HIC).

Recent examples of private sector involvement in provision of public hospital services

6.78 There have been a number of reviews by State Parliamentary Committees and Auditors General of private sector provision of public services. These include the Port Macquarie Base Hospital (PMBH), the first arrangement whereby a private operator (Health Care of Australia) was contracted to provide public hospital services, Modbury Hospital in South Australia, Noosa and Robina Hospitals in Queensland, and Joondalup Hospital in Western Australia.

6.79 The reviews identified a range of deficiencies in the contractual arrangements entered into including problems with data and modelling used to compare private and public options; lack of tangible benefits to the state; limited government control over quality; cost overruns; poor contracting management and increased risk for the state. In the case of one parliamentary committee, it was found that commercial-confidence provisions prevented it from concluding its inquiry.

6.80 While these reviews have uncovered major problems with contracting, it was pointed out to the Committee that more recent contracts have included improved arrangements for funding and the types of services provided.[69]

69 Submission No.45, p.29 (RACP, ACA, HIC).

Box 1: Modbury Hospital, South Australia

In 1995, the South Australian Government signed a contract with Healthscope Ltd to manage the Modbury Public Hospital for a period of 10 years with an option to extend the term in addition to the construction of a private hospital on land close to the public hospital. The hospital pays a service fee to Healthscope which is set annually for the management of the public hospital.

In July 1996, the Legislative Council Select Committee on the Proposed Privatization of Modbury Hospital tabled an Interim Report. The Committee reported that it had been unable to obtain information from Healthscope, the Health Commission and the Modbury Hospital Board.

By 1997, Healthscope had raised a number of matters of concern with the contract including continued losses. It was alleged that the contract price was insufficient to enable it to support the long term completion of the contract.

In 1997, Coopers & Lybrand were engaged to report on matters concerning the contract and identified a number of key deficiencies in the contract management process and in the original management agreement.

In 1997 the contract was substantially amended and re-executed after the Government decided that it would be acting against the public interest in not proceeding to amend the contract. It was estimated that the renegotiated contract reversed losses of around $2 million in 1996-97.

The SA Auditor General, in its audit of the Hospital contract in 1997, reported that difficulties had arisen between 1995 and 1997 between the Government and Healthscope over a number of ambiguities in the original management agreement. Further, Healthscope considered that it should be funded on the basis of the same principle as other public hospitals, but as the management agreement did not provide for this, the SA Health Commission refused to provide funds on this basis. Substantial problems also appeared to have occurred because the amount of money the parties had agreed would be paid to Healthscope under the management agreement was allegedly insufficient to allow Healthscope to make a profit.

The Auditor General also noted that the management agreement did not provide any guarantees from Healthscope and there were deficiencies in the Government management of the contract. The Auditor General concluded that the Modbury Hospital contract provided an example of some of the difficulties associated with contracting out and that the Government had a non-delegable duty of care in matters of the provision of public health. The Auditor General also noted that the original and amending contracts would be disclosed.

Concerns continue to be expressed about the level, variety and quality of services provided at the Hospital. For example, the ANF (SA) reported that the Hospital's 24-hour emergency surgery service had been reduced with some services being provided by on-call services. The ANF (SA) stated that it believed that there was not a drop in user rates of the service, but that Healthscope had sought this as a cost-saving device.

Source: SA Auditor General, Report on Summary of Confidential Government Contract under s41A of the Public Finance and Audit Act 1987 Modbury Hospital: Audit Commentary and Recommendations, 1997-98; Submission No.65, p.13 (ANF (SA)); Submission No.16, p.12 (Queensland Nurses Union), Committee Hansard, 23.2.00, p.183.

Box 2: Latrobe Regional Hospital

Latrobe Regional Hospital was opened after the closure of public hospitals as Moe and Taralgon. Australian Hospital Care (Latrobe) Pty Ltd, a wholly owned subsidiary of Australian Hospital Care Pty Ltd, was contracted by the Department of Human Services to build, own and operate the new hospital, with exclusive rights to provide public hospital services in the region for a period of 20 years.

The contract was not made public. In 1999, the Victorian Civil and Administrative Appeals Tribunal ordered that the then Government release the contract. The Government appealed to the Supreme Court.

In October 2000, Australian Hospital Care announced that the Latrobe Hospital would be transferred to the Victorian Government on 31 October. Australian Hospital Care had reported a loss of $6.2 million in 1999 for the hospital and was forecast to lose $2.7 million in the current year (until the transfer to the Government). The company had written off its $17 million investment in the hospital. The Victorian Minister for Health, The Hon John Thwaites, stated that 'the losses incurred by Australian Hospital Care meant it could no longer guarantee the hospital's standard of care'.

Under the transfer arrangement, Australian Hospital Care will be released from its contract in return for dropping legal action against the Government, selling its $12.6 million stake in the hospital building for $6.6 million and giving the Government a cash payment of about $1 million.

Australian Hospital Care stated that under the terms of the contract signed with the previous Victorian Government, the company had incurred heavy losses and were 'unviable'.

Source: Rollings, A, 'La Trobe hospital returns to public control', The Age, 24 October 2000; Victorian Legislative Assembly, Debates, 14.5.99, p.1111.

Box 3: Port Macquarie Hospital, NSW

In 1990, the NSW Health Department sought ways to provide a new hospital at Port Macquarie. The Department compared the costs of a new public hospital with those of allowing the private sector to build and operate a public hospital. Under the private option it was expected that the new facility would cost $15 million less and that operational costs over 20 year would also be $46 million less than for public sector operation.

This assessment was examined by the NSW Public Accounts Committee. It concluded that there was no significant difference in operational costs of providing patient care either through the private or the public sector. It recommended that the private sector should be allowed to build the hospital, but that the NSW Government should keep the delivery of hospital services in public hands by leasing the hospital from the private sector.

The PAC recommendations were not accepted. In 1992, the then NSW Government contracted Health Care of Australia (HCOA) to construct and manage a new privately operated 161 bed public hospital in Port Macquarie. Under the arrangement, the hospital is owned by Port Macquarie Base Hospital Limited, which is leased to HCOA. The buildings will revert to HCOA after 20 years. HCOA is contracted to provide public hospital services to public patients under a 20 year contract. In exchange, the NSW Health Department pays the private operator an annual service charge for the treatment of public patients (the service charge is calculated on a set fee per service, which is equivalent to the top cover private hospital rebate). In addition, the Department pays an availability charge to ensure the hospital remains available for public patients. This was the first such arrangement in Australia.

The NSW Auditor General reported in 1996 that the final costs had increased significantly over those contained in the tender documents. In addition, the Health Department did not have accurate costing systems to identify reliably the costs of operating an individual hospital at a particular level of service delivery. Thus the output of the model of public sector operation it had used to compare with the private sector was basically a ‘best guess’ estimate.

The Auditor General also found that the cost of capital construction of the hospital would be totally met by the State under the annual availability charge paid to the HCOA over the 20 year period, but that the State does not receive the hospital at the end of the term, unless it purchases it at market value. The Auditor concluded that the cost of financing the hospital through the private sector was substantially higher than it would have been through the public sector.

In 1996, the then NSW Minister for Health reported that the running costs of the Hospital were between $4.5 million to $6.5 million more than running a public hospital of the same size providing the same services.

Collyer concluded ‘the privatisation strategy has transferred, and continues to transfer, significant public funds from the public sector into the private sector. Private hospital operators, previously relying on patient contributions and health insurance company payments, can now rely more heavily on public funds for the financing of profitable patient services’.

Sources: Collyer, F, Privatisation and the Public Purse: The Port Macquarie Base Hospital, Just Policy, No. 10 June 1997; NSW Auditor, NSW Auditor General’s Report for 1996, vol.1.; Radio National, Background Briefing, 20 October 1996.

Box 4: Joondalup Health Campus, Western Australia

In 1996, the Western Australian Government contracted Mayne Nickless Ltd to provide public hospital services at what had previously been known as Wanneroo Hospital. Under the contract, Mayne Nickless was to rebuild, manage and operate a combined private and public hospital (70 private beds and 265 public beds). It also provides emergency facilities, operating theatres, a medical centre as well as providing for the construction of new community health facilities which will be leased and operated by the public sector.

The State pays the operator service and availability charges for a period of 20 years, after which time the public facilities will revert to the control of the State. The private facilities revert to the State after 40 years.

The WA Government stated that by transferring capital expenditure to the private sector, a net present value saving of $21 million would be provided compared to public sector provision. This was based on a benchmarking exercise which put the cost of public provision of the new hospital at $51 million. However, by June 1997 the operator's costs had increased by 56 per cent on the original estimate of capital costs of the project to $42.4 million.

In 1997, the WA Auditor General conducted a performance examination and reported that:

- there were doubts about the validity of the benchmarking exercise that the Department of Health had conducted and that 'the benchmark figure used by the Department to estimate the capital saving has a number of limitations so that there is no reliable estimate of the extent of any savings';
- the benchmarking exercise did not reflect costs savings that might have been expected if a competitive public sector bid had been developed and did not take into account the value and utility of the existing hospital buildings;
- the contract price did not provide any direct savings in service prices; and
- the contract resulted in additional risks to the State including reduced flexibility and lack of competition for new services and facilities; limited contractual control over the quality of services; financial incentives for the operator to influence admission, treatment and discharge patterns; and potential overpayments because of incorrect coding of treatments.

The Auditor General concluded that there was 'not reliable information to establish that the contract provides net tangible benefits to the State relative to the public sector alternative from either services or facilities'.

Source: WA Office of the Auditor General, 'Performance Examination - Private Care for Public Patients - The Joondalup Health Campus', Report No.9, November 1997; Centre for Development and Innovation in Health at www.cdih.org.au/marketpplace/case.htm; Submission No.45, p.29 (RACP, ACA, HIC).

Provision of services for public patients in private hospitals

6.81 The 1998-2003 Australian Health Care Agreements allow for public hospital services to be provided in any appropriate environment, provided the patient continues to receive care in line with the AHCAs principles. That is, eligible persons must be given the choice to receive public hospital services free of charge as public patients, on the basis of clinical need regardless of geographical location.

6.82 DHAC stated that the 'Commonwealth's focus is on public hospital services rather than public hospitals, provided that:

- arrangements do not result in the transfer of costs from State Budgets to other parties such as consumers, health funds or the Commonwealth; and
- levels of public patient access to free hospital services are not compromised'.[70]

6.83 A number of arguments were put to the Committee about the difficulties of placing public patients in private hospitals as well as some unintended consequences of such a move. It was argued that those taking out private health insurance did so because they wanted choice of doctor, ready access to care and the quality of the private hospital infrastructure. If public patients were treated in private hospitals, private patients may question the need for health insurance, as public patients would also have access to the benefits of the private system at no cost. As a consequence, the Commonwealth Government policies aimed at improving private health insurance uptake would be eroded.[71]

6.84 It was also noted that the same difficulties of demonstrating the benefits of private provision of public hospital services arise in the case of a public patient in a private hospital. The private provider would have to demonstrate a comparative advantage in the provision of the service and the public sector would have to develop the means to monitor services purchased.

6.85 The Australian Private Hospitals Association (APHA) suggested that there was a need for contracting guidelines to be developed where governments sought to contract services for public patients in private hospitals. APHA pointed to a number of disincentives to the expansion of services for public patients in private hospitals:

- current financing arrangements: medical costs are the major cost differences between private and public hospitals. For private hospital services with large volumes, medical practitioners are often willing to negotiate their fees but not to as low as the sessional rates received in public hospitals. 'For this reason, it is unlikely that large numbers of public patients will be treated in private hospitals';

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70 Submission No.38, p.38 (DHAC).

71 Submission No.18, p.8 (APHA); Submission No.27, p.3 (AMA (Vic)); Submission No.37, p.5 (Barwon Health); Submission No.55, p.29 (AHIA); Submission No.86, p.3 (Australian Association of Surgeons).

- 'discounting': often under HPPAs a hospital offering a price to a non-insured patient that is lower than the contracted price with a health insurance fund, is required to offer the same price to the contracting fund; and
- transparency of contracts: contracts between a hospital and a public health department 'would essentially be on the public record. This may discourage some hospitals, reliant on their contractual arrangements with insurers, from accepting a contract with a public health department.'[72]

Competition between the private and public sectors

6.86 The Productivity Commission considered the level of competition between the public and private sectors for insured private patients. The Commission found that with many private hospitals now offering services and treatments that were previously only available at major teaching hospitals, there was competition for private patients. The commonality in the leading DRG groups for insured patients treated in public and private hospitals was a further indication of the scope for some competition between the two sectors: four of the top 10 DRGs for insured patients are common to public and private acute care hospitals.[73]

6.87 The Commission found that in competing for private patients public hospitals face both advantages and disadvantages due to regulatory/policy arrangements:

- *Advantages:* private hospitals face costs from the bed licensing system; accommodation charges for private patients in public hospitals are set at a default rate, which have not generally covered costs;
- *Disadvantages:* the capacity of public hospitals to actively compete for private patients is constrained as they do not have access to capital market funding for refurbishment of facilities and they have not been able to give private patients preference over public patients; the financial incentive for them to treat more private patients or to seek to negotiate accommodation benefits with health funds that more closely reflect costs may be limited as this might lead to lower levels of Commonwealth funding.

Co-location

6.88 As stated earlier, the number of co-located facilities is increasing. It is argued that major benefits arise from co-location of private facilities on public hospital sites through complementary provision of services and economies of scale. These included benefits from:

- reduction in the duplication of services and facilities between the private and public sectors;

72 Submission No.18, p.8 (APHA).

73 Productivity Commission, p.92.

- increased flexibility in service provision;
- increased efficiencies from sharing the infrastructure costs given the high costs of health capital as well as operating efficiencies by the sharing of facilities such as pathology, radiology, laundry, catering and parking;
- increased ability to recruit and/or retain senior staff in co-located facilities who are able to work across the public and private facilities. As well as contributing to the quality of patient care, this may increase the viability of teaching services, allow public hospitals to install better technology and assist in nursing recruitment;
- increased competition among providers and institutions by creating markets where none might have otherwise existed;
- provision of revenue to the public sector through the leasing and sharing of capital infrastructure and the contracting of services into the private facility;
- provision of backup for each sector. Co-locations occur at major teaching hospitals and this can provide a degree of comfort for the private sector in knowing that hi-tech tertiary care is available on-site if difficult cases arise. In addition, specialists may prefer to work in conditions that enable them to interact with their peers and to have access to a wider range of cases; and
- greater opportunities to provide additional private services in rural locations which may be unable to support a separately sited private hospital.[74]

6.89 Barwon Health provided evidence of the benefits of co-location of facilities in Geelong where a decease in waiting lists and opportunities to purchase services for public patients has arisen:

> For example, in the emergency department if a person comes in with private health insurance, they have got the option of being transferred immediately across through the tunnel into the co-located hospital or remaining with the public system…I think what we have been successful in doing is shifting the emphasis of our facilities onto what I believe they are there for—that is, the proper care of public patients. That has had an enormous impact on our ability to admit public patients, to reduce our waiting list and to increase the turnover of elective work.
>
> ...There have been many occasions over the last 18 months where, for patients that we have had difficulties admitting in an acceptable time frame, we have actually contracted with a co-located hospital to treat those patients…On many other occasions where we have been faced with cancelling major surgery, we have been able to buy intensive care beds from a co-located hospital and then bring the patients back as quickly as we can.

74 Submission No.32, p.2 (Dr G Masters); Submission No.38, p.38 (DHAC); Submission No.41, p.31 (Qld Government); Submission No.63, pp.34-5 (AHA, WHA & AAPTC); *Committee Hansard*, 11.11.99, p.100 (Australian Association of Paediatric Teaching Centres); Productivity Commission, p.9.

> It has been an arrangement where it has certainly assisted us in coping with peak workload pressures, and it has obviously been of assistance to them in smoothing out their workload. There are many other cases where we work to mutual advantage. They were able to access our specialised medical staff and also our specialised facilities…
>
> We have approximately 18 to 20 pricing agreements for services that we have between us. It has certainly worked to our mutual advantage in a whole range of ways for us.[75]

6.90 However, some concerns were also expressed about the co-location of private facilities on public hospital sites.[76] In particular, the opportunity to cost shift was raised. This could occur if services that were accessed by public patients in a public hospital, at State Government expense, were provided, after co-location, by the private hospital. In this case, the Commonwealth would incur some of the expense for the medical services involved.

6.91 DHAC noted that legislative provisions are in place to ensure that the public hospital involved continues to provide access to a comprehensive range of services for public patients. Before 'declaring' the private hospital premises to enable payment of health insurance benefits for private patients treated in the facility, the Minister for Health and Aged Care must also take into account the co-location's effect on:

- access to services for public patients and the patient's right to choose to be treated as a public patient;
- whether the co-location would result in a transfer of costs; and
- whether the hospital will supply information in order for the Commonwealth to monitor access, adequacy and costs of treatments.[77]

6.92 The Productivity Commission noted that these provisions 'are principally designed to reduce the Commonwealth's exposure to cost shifting'.[78]

6.93 While there may be cost savings to State Governments through the co-location of facilities, there may also be loss of private patient revenue in public hospitals. As noted in the previous chapter, the fall in revenue from private patients in public hospitals has been marked and has impacted adversely on hospitals' ability to provide services. Co-location of private and public facilities may exacerbate this trend.

6.94 DHAC noted the potential impact on private patient revenue but stated:

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75 *Committee Hansard*, 23.3.00, pp.563-54 (Barwon Health).

76 Submission No.17, p.10 (Public Hospitals, Health and Medicare Alliance of Queensland).

77 Submission No.38, p.37 (DHAC).

78 Productivity Commission, p.9.

> However, the relationship between this marginal revenue and the marginal cost of services to private patients is not clear. In some instances the marginal revenue forgone as private patient numbers in public hospital decline has been offset by non-patient revenue (such as lease payments) raised from private hospital operators participating in co-location initiatives.[79]

6.95 The Australian Nursing Federation (SA) also offered a specific example of problems arising from the co-location of a public and private hospital. The ANF (SA) stated that the co-located private hospital at the Flinders Medical Centre was guaranteed a significant volume of public day surgery, cardiac investigations and some other work. As a result, limitations have been imposed on Flinders Medical Centre to make decisions about managing its own budget and activity. When Flinders was faced with a budget reduction, it had very little capacity for adjustment as 'the contract with the private hospital meant that it was required to make those payments regardless of whether the public sector had the services carried out or not'.[80]

Evaluation of changes to provision of services

6.96 While there has been a number of reviews of specific cases of privatisation, the Committee heard that there was no wide ranging evaluation of the increasing trend of private delivery of public services. The Department of Health and Aged Care noted that the arguments used by those supporting privatisation are still to be evaluated as most of the initiatives 'are very recent'.[81]

6.97 However, other commentators voiced stronger concerns about the lack of evaluation in the light of government policy promoting greater private sector involvement. Professor J Richardson stated:

> Concerning public use of private hospitals, the broader issue here is whether or not we get a better deal if the public uses private hospitals. The unknown factor here is whether or not that is of any benefit at all. We simply do not know the quality and the costs of the public versus the private hospitals. In fact, because of the lack of research in this area we have engaged right around Australia in privatisation with virtually no evidence to suggest that that will actually give the benefits that are claimed.[82]

6.98 The lack of research and evaluation also has implications for government's ability to assess the benefits to the public of changes in service arrangements. The Productivity Commission stated:

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79 Submission No.38, p.38 (DHAC).

80 Submission No.65, p.14 (ANF (SA))

81 Submission No.38 p.37 (DHAC).

82 *Committee Hansard*, 23.3.00, p.597 (Professor J Richardson)

> The increasing role of the private sector in the delivery of public patient services also puts a much greater premium on governments having access to good information on the quality of services and clinical outcomes in both public and private hospitals. In addition, further research and evaluation of policy experimentation will be necessary to help determine which forms of private sector involvement are best suited to particular circumstances.[83]

6.99 The Productivity Commission also noted that the Victorian Health Services Policy Review, in a comparison of a number of approaches to increased private sector involvement in the delivery of public services, had concluded that there was a need for further evaluation:

> …we believe that there is insufficient evidence at this stage to support the wholesale tendering of public patient services in Victoria…The next few years should provide rich evidence of the success or otherwise of that model of service delivery as privately operated hospitals are established and placed under the social microscope. Further, tendering under that model should await the outcome of rigorous evaluation.[84]

6.100 In its analysis for the Committee of research needs, CHERE stated that the following matters need to be examined in relation to the interface between public and private sectors:

- quality - development of performance measures for ongoing monitoring of quality;
- comparative performance - comparison of overall performance and performance in particular areas; and
- identification of potential relationships between the two sectors and appraisal, demonstration projects and evaluation.

Conclusions

6.101 Recent initiatives by State and Territory Governments have seen a blurring of the roles of private and public sectors. Whilst there has been a long history of the provision of public services by private providers, those providers have in the past been religious/charitable institutions operating jointly with government. However, governments are now pursuing a variety of other models of delivery of public services. Many different services are involved ranging from the outsourcing of certain clinical and non-clinical services to the total management and provision of a large public hospital. For-profit organisations, including large corporations, are now providing public services under a variety of contractual arrangements.

6.102 The Committee received evidence from those who supported the greater involvement of private operators and from those who did not. Many of those who did

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83 Productivity Commission, p.114.

84 Quoted by the Productivity Commission, p.114.

not support the current trend emphasised the lack of clear benefits for public patients and the lack of research in this area.

6.103 It is this lack of research and evidence of benefits that is of major concern to the Committee. It appears governments have embarked on the path of increased privatisation without the benefit of rigorous analysis of the benefits and costs. Individual examples of privatisation have highlighted many problems which have resulted in costs rather than savings to the public purse. In part, these may have been due to problems arising from poor contracting arrangements. However, there is a fundamental lack of data and research about the comparative merits of the models proposed.

6.104 Some research was provided to the Committee which may call into question the benefits put forward in support of privatisation. For example, the analysis by Duckett and Jackson suggests that one of the main arguments for privatisation – the greater efficiency of the private sector – cannot be maintained.

6.105 The Committee also recognises that the private sector is not homogeneous and that certain types of care may well be more efficiently provided through the private sector. This adds to the complexity of any comparative analysis as does difficulties of costing many of the services provided in public hospitals. For example, a vigorous public health system also provides many benefits to health care through training, education and research. As well, public hospitals provide a range of community services. These activities are difficult to cost and appear, on the evidence received, more difficult to establish in a for-profit environment.

6.106 The Committee concludes that research is required into the comparative performance of the public and private sectors to appraise and evaluate measures of efficiency and effectiveness before further privatisation takes place.

Recommendation 23: That independent research be commissioned by the Department of Health and Aged Care to examine the strengths and weaknesses of current examples of co-location and cooperative sharing of resources between nearby public and private hospitals.

Recommendation 24: In view of the difficulties currently being experienced at several privately managed public hospitals, the Committee RECOMMENDS that no further privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services.