Australian
Private Hospitals
Association

Introducing Competition and Informed Use Choice into Human Services

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Australian Private Hospitals Association ABN 82 008 623 809

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Introduction

The Australian Private Hospital Association welcomes the opportunity to respond to the Productivity Commission's Preliminary Findings Report published as part of its inquiry into Introducing Competition and Informed User Choice into Human Services.

The APHA strongly supports the Commission's view that public hospital and specialist palliative care services are amongst those services that could offer the greatest improvements in outcomes for consumers.

For some decades it has been recognized that Australia faces a major challenge, as the population ages and the burden of chronic disease increases, in meeting the demand for health services. This recognition has driven policy settings that support a strong private sector along side the public sector. Going forward, there is a need to ensure that strengths of both sectors are appropriately harnessed to ensure timely and equitable access to appropriate care.

This submission lays out:

- The potential benefits of contestability, user choice and competition in the provision of hospital sector and issues that need to be addressed to realise these benefits.
- The current extent of the private sector's role in providing public hospital services and hospital services to public patients in private hospitals.
- Issues regarding the private hospital sector's role in relation to palliative care services
- The extent to which the public and private sectors are already competitors and impact of competition of timely and equitable patient access.

Contestability, User Choice and Competition in the Hospital Sector

Contestability

The private sector has a strong record of participation in the provision of public hospital services and services to publically funded patients. While there have been instances when public-private partnerships have not achieved the outcomes anticipated by governments, there is now a range of highly successful partnerships including several which are of long standing. Many private hospitals are also involved in the provision of services on a contractual basis either as a long term contribution to public services in a given location or in response to immediate local demands. Contractual arrangements include detailed accountability arrangements including obligations with respect to efficiency and quality of service provision.

The APHA therefore contends that there is ample scope to expand the contestability of public hospital services and specialist palliative care to drive efficiency and quality in the provision of hospital services. Contestability can also increase the ease with which services can be expanded or redirected in response to service demands.

Specific examples of the delivery of public hospital services and services to public patients by the private sector and data showing the extent of this activity is discussed on page 3.

User Choice

The empowerment of consumers to exercise user choice in relation to health services is a complex issue. The exercise of choice may be constrained the availability of options (particularly in regional areas), the availability of information to enable informed choice, the availability of time to gather and assess information and the availability of the means to purchase services (either directly or through a third party payer).

Currently public hospital patients have comparatively little opportunity to exercise choice – at best they may have the opportunity to consider a limited range of treatment options in consultation with the clinicians to whom they have been assigned. Even when exercising their right to be admitted as a private patients, consumers often find that they are offered little real choice, ie they may find that they are still not able to choose their doctor. By contrast clients of the Department of Veteran's Affairs are able to choose their clinicians and their hospital from those approved by the Department.

One advantage of private health insurance is that it provides consumers with the means to exercise choice in their selection of specialist doctors and hospital. Privately insured patients electing to be treated in the private hospital system exercise choice in selecting their treating specialist (often with the assistance of their General Practitioner) and choice of hospital (mediated to some extent by the specialist and the consumer's health insurer). However, for some time now participation in private health insurance products providing hospital cover has stabilized around 47% and affordability of private health insurance is a growing concern to many consumers. Utilization of private health insurance is also largely skewed towards higher socio-economic groups.

Within the Australian health sector there is a need to address key challenges before user choice can operate in a way that is both economically sustainable and meaningful to consumers seeking good quality health outcomes. These challenges include:

- The need to give consideration to alternative mechanisms for providing less affluent consumers with the means and opportunity to exercise choice in health services.
- The need to address the problems of moral hazard inherent in both Medicare and private health insurance.

- The need to enable consumers to navigate around the blockages currently created by siloed funding mechanisms and service delivery models, for example, silos between hospital based and community based services.

Competition

To a limited extent competition has existed between providers of public hospital services for some years:

- competition between private providers for contracts to build and/or operate public hospitals
- competition between private providers for contracts to provide specified services to private patients

Less frequently there have been very discrete instances were public and private hospitals have competed against each other for funding to deliver specified services to public patients.

What is less well recognized is the fact that public and private hospitals are in competition with one another in the provision of services to several key cohorts:

- self-funded patients
- privately insured patients
- compensable patients
- clients of the Department of Veterans Affairs.

At present however the basis for competition is uneven resulting in some unintended consequences. The implications of this competition, particularly in relation to the largest cohort – privately insured patients is discussed on page 8.

The Private Sector's Role in Provision of Public Hospital Services

The APHA notes that there is already extensive experience within Australia with respect to competition and contestability in the provision of public hospital services. There are several examples were major public hospitals are being successfully run by private companies including:

- Joondalup Health Campus, Western Australia – a 660-bed outer metropolitan acute hospital treating 98,000 emergency presentations and 74,000 inpatient admissions per annum (15/16).
- Noosa Hospital – 96-bed acute hospital that treats 17,000 emergency presentations and 13,000 inpatients per annum
- Mildura Base Hospital – a 146-bed tertiary level regional teaching hospital, treating over 35,000 emergency presentations and 18,000 inpatient admissions per annum
- Peel Health Campus – a 128-bed regional hospital, treating over 43,000 emergency presentations and 12,000 inpatient admissions per annum
- Border Cancer Hospital, Albury NSW – a 30-bed plus 28-chemotherapy chair hospital which opened in September 2016.
- Northern Beaches Hospital currently under construction and due to open in 2018 with 488 hospital beds supported by a large integrated emergency department, state-of-the-art intensive care and critical care units and a modern inpatient mental health facility.

These examples, in addition to public hospitals run by the Catholic sector, are proof that the private hospital sector, both for profit and not-for-profit, has the ability to delivery safe and efficient public hospital services. These hospitals are subject to strict monitoring by the jurisdictions with which they are contracted.

Private hospitals also have a proven record in the provision of services to public patients – ie where the treatment of individual patients is contracted to a private hospital or private hospitals are contracted to provide a specified number of services. Statistics provided by the AHIW show that the percentage of services (separations) provided to public patients by the private hospital sector has been growing slowly from a low base. The actual extent of services provided in private hospitals is slightly higher because this data excludes services that in some States/Territories are deemed 'out-patient services' ie chemotherapy and renal dialysis. Private hospitals also provide two thirds of all services to clients of the Department of Veteran's Affairs.

	Public Hospitals	Private Hospitals	Total	% in Private Hospitals
Public Patients				
2010-11	4,491,588	104,951	4,596,539	2.3%
2011-12	4,658,853	110,131	4,768,984	2.3%
2012-13	4,607,839	119,236	4,727,075	2.5%
2013-14	4,701,799	131,135	4,832,934	2.7%
2014-15	4,949,069	155,252	5,104,321	3.0%
Veteran's Affairs				
2010-11	117,284	196,894	314,178	63%
2011-12	113,551	192,917	306,468	63%
2012-13	104,154	184,698	288,852	64%
2013-14	95,901	180,013	275,914	65%
2014-15	90,788	178,265	269,053	66%

Separations by principal source of funding public and private hospitals 2010-11to 2014-15, Admitted patient care 2014-15: Australian hospital statistics (AHIW 2016: 207)

The public hospital services provided by the private sector include services to patients in regional

areas. The following examples are defined in regional areas by the AHIW:

- Mildura Base Hospital - Outer Regional, Victoria
- Peel Health Campus - Inner Regional, Western Australia
- Border Cancer Hospital, Albury - Inner Regional, NSW

Specific services are provided on a contractual basis in many regional centres such as Bowral, Cairns and Bundaberg. According to the Australian Bureau of Statistics more than a fifth of private hospitals (acute and psychiatric) and around 13% of private hospital beds are in regional areas. As such private hospitals make a significant contribution to the provision of services in regional areas and are well placed to support the provision of more effective services to public patients in those locations.

The factors which have limited further expansion include:

- an apparent lack of awareness in some jurisdictions, where there has been limited, or no experience of successful public-private-partnerships, of the results which are achievable and the key success factors required for such ventures
- a reluctance on the part of jurisdictions and health districts to let tenders for extended periods of time or for more substantial quantums of service, and
- a tendency at the local level to only turn to the private sector when there is a need to meet immediate service shortfalls.

It is also of concern to the APHA that recently there has been the expectation in some jurisdictions that the private sector will be willing and able to provide services as a substantial discount to the National Efficient Price. While there will be instances where the private sector is able to provide increased efficiencies, it is essential that price is only one criteria alongside guarantees of quality and accessibility.

If private hospitals are provided with greater certainty of public patient volumes over the medium term, greater efficiencies will be available than is possible in one-off short-term arrangements.

Recommendations

- Contestability in the provision of public hospital services needs to be increased by drawing on the learnings of successful public-private-partnerships for the management of public hospitals.

- Jurisdictions and local health districts need to be encouraged to consider allowing competitive tendering for the provision of public patient services on a longer term and more systematic basis.

Palliative Care Services

As observed in the Productivity Commission's Preliminary Findings Report, there is considerable variation in quality of care and access across different jurisdictions. Private hospitals are already active in the provision of palliative care. The private hospital sector currently accounts for 16% admissions to hospital-based palliative care services and an unknown number of 'acute care' admissions over and above this for which the purpose of admission is palliative care. Despite growth in demand there have been significant barriers to the private hospital sector responding further with either inpatient or community based services principally because of a lack of support from the private health insurance sector.

Some not-for-profit private hospitals have been able to develop integrated, multidisciplinary palliative care services, cross-subsidising them through other activities but funding mechanisms are needed that would enable private hospitals to innovate and expand the provision of community-based programs.

Private hospitals are obligated under the ACSQHC's National Safety and Quality Health Services Standards to ensure that a system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers. Hospital staff are frequently involved in providing information about care options and where possible facilitating transfers to suit consumers preferences. However the availability of suitable options and opportunities to transfer out of an acute hospital setting to hospice or community care varies considerably.

It is of particular concern that a lack of appropriate referral processes can mean that it is difficult for consumers discharged from private hospitals to access community-based palliative care. Some state funded services accept referrals from public hospitals but do not have similar links with private hospitals. Private patients can find themselves stranded, unable to pay for the services that would allow them to be cared for at home or in an appropriate care setting because such services are not covered by the private health insurance, and unable to access publicly funded services that would have been available to them had they been referred from a public hospital.

Recommendations

- The barriers which currently prevent private hospital providers from playing a greater role in the provision of in-patient and community based palliative care services need to be addressed.

- Unevenness in service availability and barriers to patient access need to be directly addressed including the barriers which prevent private hospital patients accessing community based palliative care where this is the preferred and clinically appropriate option.

Competition between Public and Private Hospitals

Although there is only limited competition between public and private hospitals in the provision of services for public patients, there are several patient cohorts for which competition between the two sectors is more common and more direct:

- Patients paying for their care using private health insurance
- Self-funded patients
- Patients whose care is covered by a workers compensation claim
- Patients whose care is covered by a motor vehicle third party personal claim
- Clients of the Department of Veterans Affairs.

Each of these cohorts has the capacity, to varying degrees, to exercise choice of health provider. Choice is available to the extent that providers offer the services required and the payer is willing (or obliged) to fund the chosen provider. The following table shows the distribution of these services between public and private hospital sectors on the basis of separations in 2014-15.

	Public Hospitals	Private Hospitals	Total	% in Public Hospitals
Private Health Insurance	814,702	3,456,176	4,270,878	19.1%
Self-Funded	49,331	286,403	335,734	14.7%
Workers Compensation	21,887	56,530	78,417	27.9%
Motor Vehicle TPPC [1]	27,779	6,686	34,465	80.6%
Dept of Veterans Affairs	90,788	178,265	269,053	33.7%
Other [2]	26,782	30,717	57,499	46.6%
Total	**1,031,269**	**4,014,777**	**5,046,046**	**20.4%**

Notes
1 Motor Vehicle TPPC are separations paid for through Motor Vehicle Third Party Personal Claims.
2 Other includes separations with a funding source of "Other compensation, Department of Defence, Correctional facilities, Other hospitals or public authority (without a public patient election status), Other, Health service budget – no charge raised due to hospital decision (in private hospitals) and not reported.

Over time the percentage of motor vehicle third party personal claims and workers compensation claims treated in the public hospital sector has remained relatively constant. By contrast the percentage of separations for the Department of Veterans Affairs has fallen from 37.3% in 2010-11 to 33.7% 2014-15 and the percentage of separations funded through private health insurance has risen from 15.5% in 2010-11 to 19.1% in 2014-15. These trends raise questions as to whether choice and competition are resulting in optimal outcomes for both consumers and society as a whole.

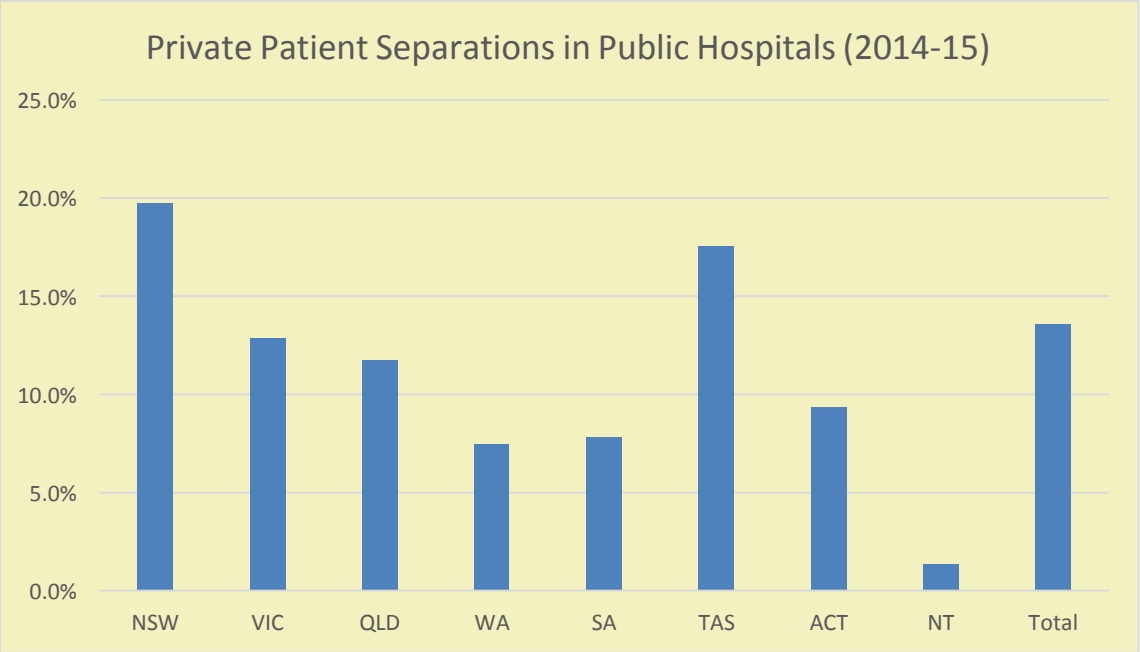
The trend for clients of the Department of Veterans Affairs is beneficial because the reduction in share of separations is matched by a reduction in absolute numbers of 26,496 separations between 2010-11 and 2014-15, freeing up public hospital resources for the care of public patients. It has also generally been the case, that the private sector has been able to deliver hospital services to DVA clients at a lower cost than the public hospital sector. Private hospitals providing services to DVA clients are subject to tight accountability arrangement with the Department. They are required to provide the Department with detailed information about the quality of the services that they provide. They are also required to receive specific approval for specialised programs such as rehabilitation programs and programs to treat veterans for post-traumatic stress disorder.

The rise in the number of patients in public hospitals that are funded through private health insurance however is of concern for a number of reasons. The one particular aspect of consumer choice is enshrined in the intergovernmental agreements regarding the funding of public hospitals is to ensure that all Medicare eligible consumers have the right to elect to be admitted to public hospitals as private patients. There is however no reciprocal guarantee of other choices such as

the option to be transferred to a private hospital (subject to clinical requirements). The number of public hospital separations has been rising rapidly at a time when participation in private health insurance is static meaning that additional factors are driving this trend.

Consequences of the Growth in Private Patients in Public Hospitals

The following chart shows the share of public hospital separations given over to private patients in each state.



The number of separations involved in each State is as follows:

State	2014/15
New South Wales	358,022
Victoria	204,375
Queensland	141,350
Western Australia	44,770
South Australia	33,024
Tasmania	20,996
Australian Capital Territory	10,335
Northern Territory	1,830

What is even more alarming is data recently published by the National Hospital Performance Authority (NHPA) suggests that at some public hospitals the percentage of private patient admissions is far higher. A table showing those hospitals with a proportion of private patients above the national average is provided on the following page. These figures do not represent the total percentage of private patients admitted to each hospital because some admissions were excluded from NHPA's analysis for methodological reasons. Even so, many of the percentages are sufficiently high to raise concern about the extent to which private patient election is being driven by directives to maximise revenue rather than patients freely exercising informed choice.

It is also notable that the majority of hospitals listed below are in metropolitan locations where private hospitals provide the full range of services, with the exception of those few services such as complex trauma and organ transplant which are generally only available in large public hospitals. Even for those regional hospitals that do admit relatively high percentages of private patients, these percentages are significantly lower than those found in many metropolitan hospitals. Finally, the significant variation between states strongly suggests that levels of private patient admission are strongly determined by deliberate marketing and may in some cases be the result of behaviour that could potentially be described as pressure and even bullying (see below).

Public Hospitals With Percentages of Private Patients Higher Than The National Average

Campbelltown Hospital	Major metropolitan	NSW	14%
Liverpool Hospital	Major metropolitan	NSW	14%
Shellharbour Hospital	Large metropolitan	NSW	14%
Westmead Hospital	Major metropolitan	NSW	16%
Wyong Hospital	Major metropolitan	NSW	16%
Canterbury Hospital	Large metropolitan	NSW	16%
Gosford Hospital	Major metropolitan	NSW	21%
Wollongong Hospital	Major metropolitan	NSW	21%
Ryde Hospital	Large metropolitan	NSW	21%
Prince of Wales Hospital	Major metropolitan	NSW	25%
Concord Hospital	Major metropolitan	NSW	26%
Royal Prince Alfred Hospital	Major metropolitan	NSW	26%
St George Hospital NSW	Major metropolitan	NSW	27%
John Hunter Hospital	Major metropolitan	NSW	29%
Hornsby Ku-ring-gai Hospital	Major metropolitan	NSW	33%
Royal North Shore Hospital	Major metropolitan	NSW	34%
St Vincents Hospital	Major metropolitan	NSW	35%
Mona Vale Hospital	Large metropolitan	NSW	35%
Manly Hospital	Large metropolitan	NSW	38%
Sutherland Hospital	Major metropolitan	NSW	41%
Lismore Hospital	Major regional	NSW	14%
Port Macquarie Hospital	Major regional	NSW	14%
Grafton Base Hospital	Large regional	NSW	15%
Dubbo Hospital	Major regional	NSW	16%
Bathurst Hospital	Large regional	NSW	16%
Shoalhaven Hospital	Major regional	NSW	18%
Coffs Harbour Hospital	Major regional	NSW	19%
Wagga Wagga Hospital	Major regional	NSW	19%
Tamworth Hospital	Major regional	NSW	20%
Orange Health Service	Major regional	NSW	22%
Goulburn Hospital	Large regional	NSW	27%
The Prince Charles Hospital	Major metropolitan	Qld	21%
Bundaberg Base Hospital	Major regional	Qld	14%
Toowoomba Hospital	Major regional	Qld	16%
Hervey Bay Hospital	Major regional	Qld	18%
Rockhampton Hospital	Major regional	Qld	21%
Mackay Base Hospital	Major regional	Qld	24%
Frankston Hospital	Major metropolitan	Vic	14%
St Vincent's Hospital [Fitzroy]	Major metropolitan	Vic	14%
Angliss Hospital	Large metropolitan	Vic	15%
Geelong Hospital	Major metropolitan	Vic	16%
Box Hill Hospital	Major metropolitan	Vic	17%
Royal Melbourne Hospital [Parkville]	Major metropolitan	Vic	18%
Austin Hospital [Heidelberg]	Major metropolitan	Vic	19%
Maroondah Hospital [East Ringwood]	Major metropolitan	Vic	20%
The Bendigo Hospital	Major regional	Vic	15%
Goulburn Valley Health [Shepparton]	Major regional	Vic	16%
Ballarat Health Services [Base Campus]	Major regional	Vic	22%
Wimmera Base Hospital [Horsham]	Large regional	Vic	27%
Sir Charles Gairdner Hospital	Major metropolitan	WA	15%
Albany Hospital	Large regional	WA	17%
Launceston General Hospital	Major regional	Tas	17%
Royal Hobart Hospital	Major regional	Tas	23%

Source: NHPA: Costs of acute admitted patients in public hospitals 2013-14 supporting data http://www.myhospitals.gov.au/about-the-data/download-data, April 2016

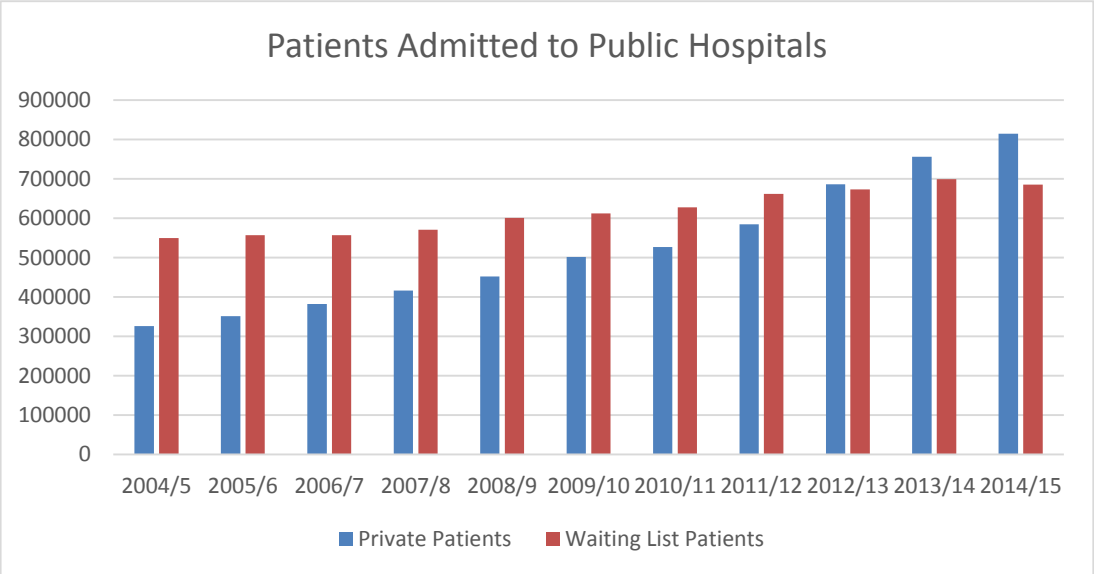
Under current arrangements consumers are entitled to indicate their election upon or as close as practicable to, their admission to a public hospital. In doing so, those who hold private health insurance are able to use that insurance to cover the expenses charged by the public hospital and treating clinician. The public hospital and treating clinician in turn are able to charge both the Commonwealth Government and the consumer's health insurer, thereby accessing revenue/income in addition to that paid through government funding for public hospitals. The use of deliberate strategies to recruit private patients is evidenced by:

- Brochures given to patients
- The explicit and systematic use of 'nudge theory' techniques to increase the rate of election by patients
- Specification of revenue targets.

From a policy perspective, this practice is giving rise to a number of issues of concern:

- Public hospitals and treating clinicians are inherently conflicted in inviting consumer to 'elect' private patient admission because they stand to gain financially from the election either through revenue to the hospital, revenue to trust funds held for use by clinicians or personal income.
- Public hospitals are using public funds to gain an unfair advantage in competing for private patients. Public hospitals are using public funds to employ staff whose specific role it is to recruit private patients. Public hospitals are using public funds to incentivise patients to elect to be treated as a private patients by for example, waiving of out-of-pocket costs and providing 'free' services and gifts.
- Publically funded infrastructure is being use to provide subsidized services to private patients at a time when there are insufficient services to meet the needs of public patients. These private patients account for more than 2.8 million patient days for the year, equivalent to a capacity of over 7,000 beds. (APRA, Year ending 30 June 2016).

As shown in the chart below, the number of public hospital separations per year is now higher than the number of separations for patients from public waiting lists. Patients who cannot afford private health insurance and are hence reliant on public waiting lists are being disadvantaged. The drive by public hospitals to increase 'other source' revenue means that patients who could otherwise be discharged or transferred to private hospitals are admitted to the public hospital system. This trend further entrenches inequity in access to health services for those unable to afford private health insurance.



(Source: AIHW, Admitted patient care 2014-15: Australian hospital statistics. This is the most recent data available).

Over the past decade, the number of waiting list admissions per 1,000 population increased by 0.7 hospitalisations per 1,000 population, however, the average waiting times for public elective surgery increased from 29 days in 2004–05, to 36 days in 2014–15.

The APHA is concerned the drive by public hospitals to increase 'other source' revenue may also be giving rise to practices compromising the rights of patients seeking treatment in public hospitals. These practices would include the following:

- Undue pressure applied to patients seeking admission as a public patient to use their private health insurance.
- Undue pressure on patients presenting at an emergency department to use their private health insurance on admission to the hospital.
- Failure to provide informed financial consent, including patients not being aware they were signing an election to be treated as a private patient.
- 'Conversion' of patients from public to private post admission (note that election is supposed to be exercised prior to, at, or as soon as possible after admission).
- Pursuit of patients post-discharge to retrospectively elect to use their private health insurance
- Lack of, or insufficient provision of, information to enable a patient to consider care options and make an informed choice.
- Denial of a patient request to transfer to a private facility.
- 'Mixed lists' whereby patients are induced to seek admission as a private patient in order to queue-jump at the expense of public patients.

The scale of the issue is illustrated by the following data:

- The most recent data available indicates private patients (ie, patients paying for their care using private health insurance) in public hospitals now account for 17.5% of all privately insured episodes of care annually (APRA, Year ending 30 June 2016).
- Private health insurers paid public hospitals over $1.05billion for the year ending 30 June 2016 exclusive of benefits for prostheses or fees to clinicians. (APRA, Year ending 30 June 2016).
- Nationally in 2014/15, privately insured patients accounted for 814,702 separations, or 13.6% of all separations in public hospitals, up from 13.2% for the previous year and up 6 percentage points over the last decade.(AHIW, Hospital Statistics 2014-15, April 2016, and Hospital Statistics 2013-14, April 2015)

APHA has received anecdotal accounts of cases where public hospitals appear to have acted contrary to the spirit of the National Healthcare Agreement:

- Patients being pressured to elect for private admission while family members have stepped away from the bedside for a short time.
- Patients being emotionally blackmailed with threats that a facility will close if they do not elect to be admitted as a private patient. Public hospitals persuading a patient to retrospectively elect to be a private patient.
- Public hospitals writing to patients post-discharge inviting them to retrospectively elect to have the admission recorded as a private patient admission.
- Patients being forced to wait for a transfer and/or being told that no private hospital bed is available when this is not the case.

- Patients being told that the private hospital doctor is on leave/not available when this is not the case.

- Patients being told that the private hospital does not admit seriously ill patients when this is not the case.

- Patient preference for a transfer to a private hospital at which they have been a regular patient has been ignored.

- Patients being forced to pay the cost of ambulance transfer from a public hospital to a private hospital even though they have private health insurance and ambulance cover.

- Patients being persuaded to elect as a private patient and then directed down a public sector care plan without being advised of their alternatives including private sector options through which they could access the required treatment in a significantly shorter timeframe.

- Patients' requests to be taken their private emergency department of choice are refused by ambulance services even though the hospital in question is formally recognised as being able to take cardiac patients.

Specific accounts of pressure being applied to patients have been obtained in a range of circumstances including psychiatric patients, patients admitted through emergency departments and cardiac patients.

Recommendations

- Public hospitals should no longer be allowed to use public funds to provide inducements such as fee waivers, 'free' services or gifts to persuade patients to elect admission as a private patient.

- Public patients in situations of duress such as emergency departments and psychiatric wards should be protected from undue pressure to elect private patient admission.

- Public hospitals should be required to act within both the letter and the spirit the National Healthcare Agreement.