Catholic Health Australia

Operating efficient public and private hospitals:
CHA submission to the Productivity Commission

27 July 2009

Executive Summary

This submission makes three key points:

1) It is impossible to accurately compare public and private hospital costs and efficiencies of their operation in the absence of consistent data to be able to do so. Any outcomes of such an exercise should be understood within this context;

2) Noting the problems caused by absence of comparable data, there are however indications that those hospitals run by non-government organisations are more efficient on average than those run by State/Territory Governments; and

3) This study provides the opportunity to develop the robust data sets needed to identify the underlying reasons for differences in hospital efficiency – whether be management structures divorced from the patient bed-side, different funding mechanisms or simply the inherent inefficiencies of large health bureaucracies.

Australia's private and public hospitals are a key part of Australia's health system - with the community contributing $34 billion in annual expenditure or around 3.5% of GDP for hospital treatment. It is important that both sectors operate as efficiently as possible and there are many lessons that each sector can learn from the other in terms of maximising efficiency.

Current data collections - in particular those that relate to costs - have contributed to improved performance by allowing hospitals to compare themselves with their peers.

Current data collections are not, however, well set up to enable robust comparisons to be made between the public and private sectors. This is the result of differences in costing methodologies and cost structures (for example public hospitals usually employ their medical workforce, whereas in the private sector the medical workforce normally comprises independent contractors who are separate entities to the hospital) and funding mechanisms.

Whilst existing datasets may be useful in allowing comparisons to be made between peer groups within sectors, CHA has serious doubts that valid comparisons can be made across different jurisdictions within the public sector - let alone between the public and private sectors. We would certainly question whether this could be done in any robust sense within the six-month timeframe the Productivity Commission has been given. It is CHA's view that the six months should be used to identify how the costing comparisons across the sectors should be undertaken, what datasets would be required, and what resources would be needed to undertake a study that would result in reliable information.

Given that the National Hospital Cost Data Collection (NHCDC) in particular was not set up with the objective of comparing public costs against private, there are serious issues related to the available data in terms of quality, representativeness and consistency of definitions.

There are also differences between public and private sector " products".

The private product is distinct from the public product in the sense that patients who elect to receive private treatment have already made a full, compulsory contribution to the public hospital system through their taxes as part of the universal Medicare coverage. This means that patients need to be convinced to spend additional money in order to receive private treatment.

There are a range of reasons people may choose to do this, including:

- Having a choice of provider (doctor and/or hospital),
- Faster access to treatment, and

- The opportunity to choose treatment in a setting that meets the patient's spiritual requirements at a time of illness and vulnerability.

The private hospital sector is providing an increasing proportion of total hospital services in many different specialty groups, particularly in the areas of Cardiac medical, Cardiac Interventional, Oncology, Obstetrics, Orthopaedics and Gastroenterology. It is important for the future of Australia's health system to create robust, consistent, national datasets that allow comparisons between sectors. This study provides an opportunity to proactively plan and improve on existing data sets and identify what needs to be done in order to have nationally consistent cross-sectoral data.

The private sector itself is also not homogenous. It varies from small specialised, doctor-run day surgeries through to large tertiary level hospitals – often run by not for profit groups, particularly Catholic hospitals. In some respects the work of these large Catholic hospitals - with their involvement in teaching and research as well as in treating highly complex medical and surgical patients - will have much in common with the large public hospitals. Their cost structures are likely to reflect these more complex roles.

Catholic hospitals also have a mission focus which is often reflected in providing a wider range of treatments, such as palliative care, than might be the case than if the hospital was purely focussed on profit maximisation. It also means that some Catholic hospitals are located in geographic regions which might not necessarily be attractive to for-profit operators.

In relation to safety and quality data, as distinct from funding issues, there are datasets that are currently collected by bodies such as the Australian Council on Healthcare Standards (ACHS) (useful - although limited in scope by its voluntary nature) as well as a number of the jurisdictions (especially in Queensland and Western Australia) that would allow comparisons to be made across the public and private sectors. The mandatory nature of the collections in these jurisdictions provide a strong basis for appropriate cross-sectoral comparisons. The Australian Commission on Safety and Quality in Health Care is well placed to provide guidance in this regard.

Caution must be exercised in the interpretation of some proposed data sets, such as re-admissions within 28 days, which may or may not relate to the performance of a hospital and may occur in the normal course of a chronic condition. Some patients who are admitted to different hospitals may not be captured at all as a "re-admission". Any such indicators should also be evidence-based indicators of clinical performance and efficiency.

In relation to informed financial consent, CHA considers it is an important right for patients to be given, where possible, an estimate of the amount of likely out-of-pocket costs that will be incurred in undertaking a therapeutic procedure. Ideally this information should be provided in circumstances that allow patients to make a genuine choice about whether or not to proceed and with which provider.

Whilst private hospitals generally have a good record in ensuring that patients are well advised in advance of likely out-of-pocket costs for the hospital component of their treatment, there are continuing issues in relation to the various medical components of their treatment. These vary by specialty group; the current data collected by IPSOS provides a sound basis to enable continuing work with the various medical specialty groups to increase rates of informed financial consent. CHA supports the potential role that IT and E-health solutions such as Eclipse may be able to provide in coordinating complex data from differing health providers and private health insurers and presenting that information to patients in a timely and readily understandable format.

In relation to the indexation of the Medicare Levy Surcharge Thresholds, CHA does not propose the adoption of a particular index other than noting that it is important that whatever index is chosen, it provides a reasonable representation of movements in income levels.

Key Recommendations

- CHA recommends the creation of an Office of Hospital Cost Data be established within the current Commonwealth Department of Health and Ageing, with responsibility to oversee the creation of a national robust and consistent hospital cost data set and collect information across all jurisdictions as well as the private sector – with governance comprising representatives from both sectors.

- As the Commonwealth moves to activity-based funding for public hospitals, CHA proposes that Commonwealth funding to the States be made contingent upon the States and Territories contributing future data that is high quality and consistent in format and definition, ie. in a form that would enable the Commission to undertake studies such as this one.

- Given the demonstrated propensity for gaming and manipulation of data within the health sector, CHA also proposes the establishment of an independent data audit agency with the power and ability to audit data submitted to hospital cost data collections in all jurisdictions and the private sector.

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About Catholic Health Australia

Twenty-one public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Introduction

CHA welcomes the opportunity to provide a submission to the Productivity Commission study of the efficiency of Australian public and private hospitals. CHA represents 75 Catholic private and public hospitals across all States and the ACT. In terms of coverage, this represents around 26% of private beds and 5% of public beds nationally. The comments below are therefore based on the observations and experiences of a significant component of the hospital sector. A list of CHA member hospitals is attached at Appendix 1.

Prior to commenting on the specific terms of reference and questions, CHA believes the study needs to be placed in context.

Australia's public and private hospitals are a key part of Australia's health system. The health system itself can be seen as comprising a continuum of services which extend from individuals engaging in positive health behaviours, primary health care, hospitals providing therapeutic treatment, other community care services including palliative care services and long-term residential care - particularly for the elderly.

The performance of the whole health system relies on the effective contribution of all parts of the system. Similarly the performance of any of the individual components of the system relies on the performance of the other parts and cannot be divorced from these parts.

For example, hospitals can be well-run and operate with the most modern equipment and highest infection control standards. However this would matter little if the health education and immigration systems fail to deliver appropriate numbers of highly skilled health professionals required for hospitals to be able to function.

Similarly an under-resourced or underperforming primary care sector can result in a potentially overwhelming increase in workload for hospitals - which adversely impacts on their effectiveness. Inadequate residential or community care will mean that large numbers of people remain in hospital who would be more appropriately cared for elsewhere, occupying beds that are needed by acute care patients.

CHA is concerned that the terms of reference for this study have been drawn up in a way which suggests that the public and private sectors operate independently of each other in a competitive relationship across the entirety of their services. While there are some areas of overlap and competition, CHA suggests it is very simplistic to infer a competitive or independent relationship exists between the two sectors.

The relationship is far more complex - events impacting on one sector are likely to soon impact on the other sector. For example, an influenza pandemic that significantly increased demand in the public sector it is likely to see public health services seeking treatment for public patients in private hospitals. A sudden reduction in private health insurance membership would soon see additional demand placed on public hospitals, which on current projections is already set to struggle with the additional load that is progressively being imposed by the increasing and ageing populations.

In the case of the Catholic hospitals, the delineation between public and private is further confounded by the fact that a number of Catholic health care providers operate significant hospitals in both the public and private sectors including the St Vincent’s Health Australia, Little Company of Mary Health Service and the Mater Health Service in Brisbane.

Role of the private and public hospitals

The Australian system of Medicare provides universal health insurance coverage for Australian residents for medical and public hospital services. All eligible Australian residents are entitled to access public hospital treatment free of charge at the point of service and are required to compulsorily pay for this entitlement through the tax system including the Medicare levy.

By contrast the private hospital system relies for most of its funding on individuals voluntarily agreeing to pay additional funding to purchase private health insurance to enable them to gain access to private hospital treatment (or private patient status in the public hospital). [1]

Given that privately insured patients have already paid for public insurance under Medicare, the private health sector, in order to attract additional funding from individuals, needs to provide a different patient experience to the public sector - particularly in areas where seemingly similar clinical services are offered. [2]

Current perceived benefits of choosing to be treated privately include choice of treating doctor and the ability to receive more timely treatment for elective procedures than is available for a public patient. In addition private hospitals seek to provide a more comfortable patient experience and amenity. In some cases greater amenity can be taken as a slightly longer length of stay (e.g. obstetrics - where a slightly longer length of stay in large, private hospitals can in part be seen as a reflection of the choice of private patients and a reason for paying an addition amount over and above their Medicare contribution).

For some people the values of the hospital provider setting is important in their choice of where they would like to receive their treatment. For example, faith-based providers such as Catholic hospitals provide spiritual support which can be important for many people during a time of sickness and stress. For others, the hospital where their preferred doctor practises will be the determinant of where they seek to receive treatment.

Some aspects of this product differentiation are likely to impact on the cost structures of private hospitals and reinforces the caution that like needs to be compared with like.

Funding mechanisms

The funding mechanisms of the public and private sectors also differ markedly. Public sector funding is essentially capped (even in an episodic payment environment). This means that public hospitals do not have an incentive to provide services beyond the targets that they have been given - particularly for public patients.[3] Additional demand over and above the funding allocations given to public hospitals will result in rationing by extending waiting times.

By contrast, private hospitals operate under fee for service funding models that reward additional activity - until either physical (and workforce) capacity is reached or the marginal costs of treating

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[1] Some patients may also decide to access the hospital system as private patients by self insuring. Private hospital services are also purchased by DVA, work cover agencies, motor vehicle accident schemes as well is by public hospitals.

[2] We do note however that current government policy particularly the Medicare Levy Surcharge makes it financially almost compulsory for very high income earners to hold private health insurance. Additionally the Commonwealth Government also provides a non-means tested rebate of between 30 and 40% of private health insurance premiums. Recent budget changes currently before the Parliament will wind back rebate eligibility to individuals earning more than $75,000 per year (and more than $150,000 per year for families).

[3] In some jurisdictions, public hospitals have an incentive to attract additional private patients even where they have long waiting lists for public patients (but only a limited budget for the treatment of public patients).

an additional patient begin to exceed marginal revenue. Private hospitals also need to negotiate their costs annually or biannually with health funds, a cost control discipline not present in public hospitals.

Public funding models have grant components not attached to a specific activity target. Private hospitals must fund all of their costs through revenue generated via throughput.

It is natural to expect that hospitals will respond to their respective funding models in differing ways - and again the differing choices hospitals make will impact on their cost structures. It is important to understand that the difference in costs may have more to do with the funding incentive rather than underlying efficiency.

Inter-linkages between public and private systems

Many private hospitals are co-located with a public hospital. Many doctors work in both sectors - as a salaried or sessional medical officer in the public sector and as an independent practitioner in the private sector.

Many doctors view their work time spent across both types of hospitals as complementary and contributing to their overall work and remuneration package. Remuneration rates are lower in the public system compared with the private sector and many doctors who work in the private sector see it as part of their professional duties to work for part of a week in a public hospital - including undertaking teaching responsibilities. Their incomes are supplemented by working in the private sector. If the private sector work was not available, many specialist doctors may well decline to work in Australia in favour of overseas locations where remuneration potential is much higher.[4]

It is not only doctors who move across both sectors. The same applies to nurses, allied health workers and even patients. Medical students also often follow their supervising doctors from the public to the private sector as part of their training programs where they gain access to differing case types and throughput.

The above commentary is to reiterate CHA's view that the health system including the public and private hospitals needs to be seen in a more holistic way as part of a broader system rather than competing, disaggregated parts which have no impact on any of the other parts. We need to be very careful in applying a reductionist methodology in any analysis, or to draw policy conclusions without recognising that the performance of one part simultaneously influences and is influenced by the performance of the whole. Given that the Private sector is responsible for 40% of all hospital separations per year (AIHW) it is vital that the two systems continue to work in a complementary way to support the health of all Australians.

Having said the above, CHA nevertheless is cognisant of the significant community resources that are devoted to the operation of hospitals in both sectors with annual expenditure on public and private hospitals of $27b and $7.1bn respectively in 2006-07[5]. It is important for hospitals from each sector to continue to improve efficiency and to learn lessons from each other.

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[4] Indeed the current moves in the US to extend health care coverage to an additional 40 million people will create additional demand on the global medical (and nursing) labour market. This is a potentially significant risk for Australia given that Australian medical and nursing qualifications recognised and highly regarded in the US.

[5] Health expenditure Australia 2006-07, AIHW 2008 Table 4.1

Cost analysis

We now move to comment more specifically on the proposed comparison of hospital costs. CHA notes that given the short time frame available for the completion of the study, the Commission will be using existing data sets.

Again it is necessary to make some preliminary remarks in relation to the available data.

It should be noted that for the purpose of the terms of reference and timeframe of this study, CHA regards many of the existing data sets as containing a number of weaknesses which will make it difficult, if not impossible, to draw reliable conclusions. These weaknesses include incompleteness in coverage, inconsistency in definitions of inputs and processes and in some cases more deliberate misstatements or manipulation of data as has recently been reported by the Victorian Auditor-General which found in an audit of four public hospitals that "it was not possible to assure that reported performance against the majority of indicators fairly represented actual performance".[6]

One particular example of an inconsistency in data which highlights the problems in making comparisons even between jurisdictions in the public sector is set out in the most recent AIHW report on Australia's hospitals and relates to the amount spent on food services per casemix adjusted separation.[7] This amount ranges from $15 in the ACT through to $47 in Victoria. Whilst the possibility exists that ACT patients are placed on a starvation diet in what is Australia's otherwise most expensive hospital system, the more likely explanation is that this is a good indication of the different ways that costs are recorded against different cost buckets in different jurisdictions.

Maintenance is another common area of inconsistency in reporting against cost buckets and can impact on the reported costs of specific DRGs. Chemotherapy can also be problematic for cost accounting purposes: patients may attend for a number of sessions of chemotherapy, each resulting in a separate admission, yet the drugs may be costed against only one admission in a particular fortnightly period.

Again it needs to be borne in mind that the cost collections have been established on the basis that comparison and benchmarking will mostly occur within each sector rather than across different sectors. As identified in Round 11 National Hospital Cost Data Collection Report[8], there are many technical differences in the methodologies of collecting and reporting data across the differing jurisdictions. For example NSW reports that it has a higher average reported cost as "the majority of NSW episodes are drawn from principal referral and major teaching hospitals, which on average are more expensive due to higher infrastructure costs and more complex nature of the patients being treated"[9]. Victoria does not report depreciation costs; its cost buckets "vary from the NHCDC in the areas of nursing, medical, on-costs and ward supplies buckets"[10].

Most costs are modelled using weights (greater than 10 years old) rather than actual utilisation, and the application of those weights may not be consistent or relevant across sectors.

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[6] Access to Public Hospitals: Measuring Performance, Victorian Auditor General's Report, April 2009, 2008-09:18

[7] Australia's Hospitals 2007-08, AIHW Table 4.1d

[8] National Hospital Cost Data Collection Cost Report, Australian Government Department of Health and Ageing Round 11 (2006-07

[9] Ibid p51

[10] Ibid p61

Peer groups

As the Commission has identified in its issues paper, it is important to only compare hospitals within peer groups, to ensure comparisons are being made between organisations that have broadly similar case-mixes and loads. The Commission's proposal to publish according to the following breakdown of hospital groupings appears to strike a reasonable balance between ensuring appropriate comparator is and not disclosing the identities of individual hospitals.

The Commission has advised of its intention to disaggregate only along one dimension at a time. For example,

Public: NSW, Vic, Qld, SA, WA, Tas, ACT, NT
Private: NSW, Vic, Qld, SA, WA, Tas/ACT/NT

or

Public: In major city, outside major city
Private: In major city, outside major city

or

Public: Large hospital, Medium, Small hospital
Private: Large hospital, Medium, Small hospital

Measurement of episodes, not procedures

In relation to cost measurements, CHA is strongly of the view that any comparative analysis between hospitals and hospital sectors can only be based on case-mix adjusted separations that take account of complexity and expected resource utilisation.

CHA concurs with the Commission's proposal to separately report the costs of hospitals, medical services (including pathology and imaging) and pharmaceuticals. Medical costs will need to be extracted from HCP records that are supplied by the health funds to the Department of Health and Ageing and combined with the hospital data from the NHCDC data set.

In addition the arrangements for the management and purchasing of prostheses in both sectors are quite different and should be excluded from this particular study. In particular, whilst the private sector has detailed prostheses billing data (a requirement for reimbursement), this does not apply in the public sector where prostheses tracking is less detailed and usually modelled using weights rather than actual utilisation. To put this into perspective, prostheses can be over 20% of costs in some hospitals, depending on the casemix.

In saying this, we do not contend that comparisons of the effectiveness of prosthetic purchasing and management between the public and private sectors should not be made. This area should be subject to scrutiny - but only in the context of a specific enquiry that takes full account of the different arrangements between sectors. Indeed we would hope and expect the current Commonwealth Health Department enquiry into health technology assessment would indeed be looking at public and private sector prosthetic purchasing and management arrangements as part of its remit to improve private sector arrangements. The Commission could recommend the implementation of a unique Australian catalogue code for each item with TGA approval (ie. consumables and prostheses) that would facilitate a more robust comparison of these high cost line items.

Capital depreciation is another difficult and complex area, with many different methods of accounting for this input across both the private and between different public sector jurisdictions. Given the short time frame for the Commission's report this factor should be excluded from this study. Should studies of this type be undertaken in the future, CHA recommends that work be undertaken to develop a common and transparent methodology for reporting on capital depreciation.

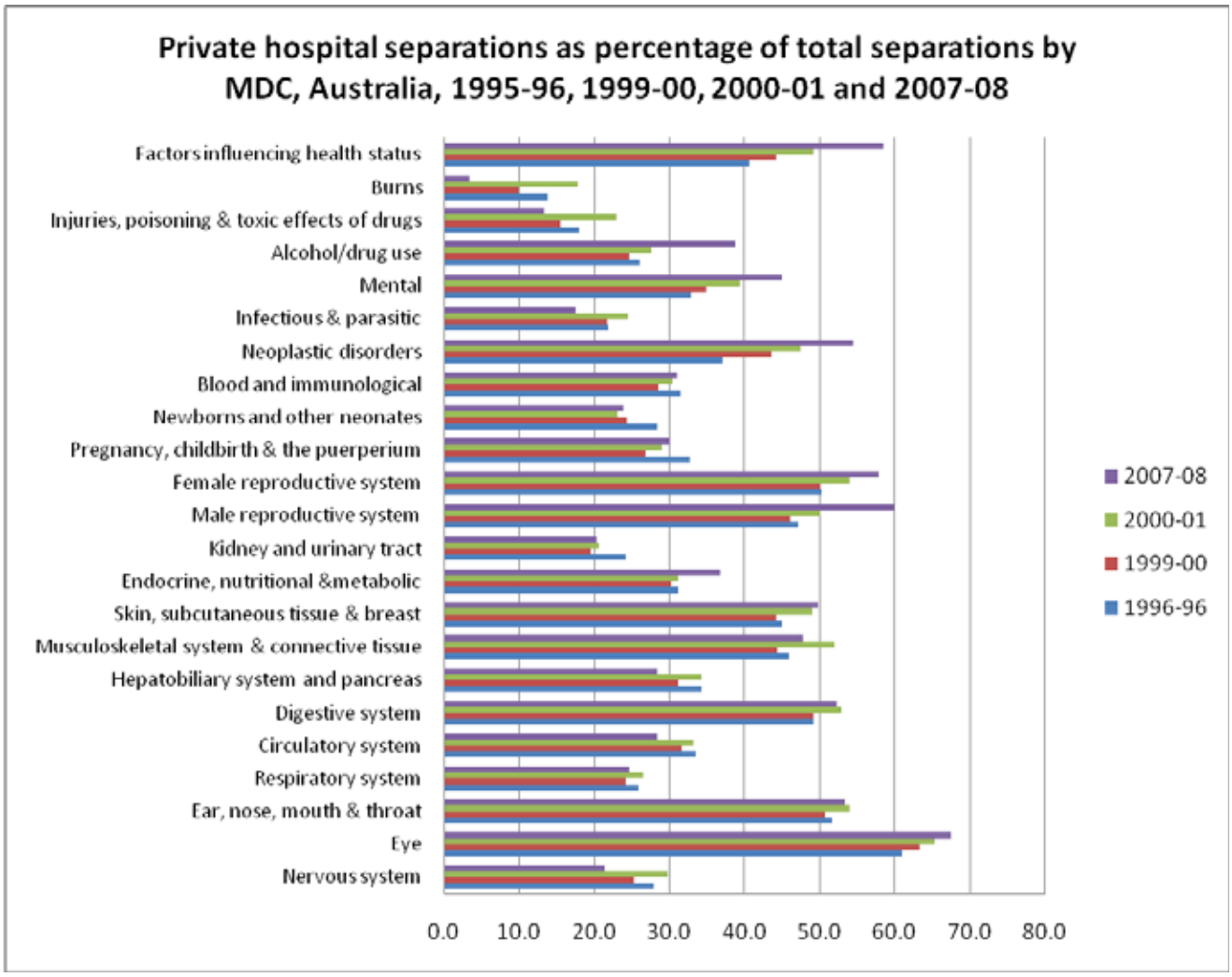
In relation to the use of particular cost collections, CHA considers that the NHCDC collection is the most appropriate source of hospital cost data - with Round 11 the most recent source, however, noting that it comprises a sample size of 82 private hospitals and 59% of private sector acute separations - so there may be questions about its representativeness. Public sector representativeness in Round 11 is more robust with 238 public hospitals and 89% of acute separations.

CHA supports the view that it is preferable to examine hospital costs rather than charges given that there is no consistent relationship between costs, which capture a hospital's resource utilisation, and charges, which represent the outcome of a commercial negotiation process.

CHA also supports the notion that the Commission should report hospital costs as a discrete output along with discrete reports of medical (including pathology and imaging) and prostheses. Pharmacy should also be disaggregated due to the wide variation in reporting between and even within facilities. The proposed disaggregation better reflects the way that services are provided in the private sector and will enable similar information can be extracted from the public sector records to allow comparative data to be published.

It will need to be noted that however, it is likely that, on current datasets, the Commission will be reporting cost versus charges (particularly for the medical items). The Commission could recommend methods to facilitate true cost comparison in the future.

In relation to specific DRGs where comparisons could be made between public and private sector costs, CHA contends that the analysis should extend well beyond the 20 DRGs identified in the Commission's issues paper. The identified DRGs do not include the specialties of ophthalmology or ENT where the private sector is undertaking a significant part of the total caseload. If the number is limited to 20 DRGs, the hospitals that do not do a lot of these DRGs as core business would be unfairly represented, if represented at all. Analysis should be at an aggregated casemix adjusted level to ensure a better picture.



CHA contends that, to avoid accusations of bias in sample selection, and to gain a better overall understanding of trends, it is better to have a much wider range of DRGs in the sample and that they should comprise a range of acute separations comprising surgical, medical and other cases. It is also important to ensure there is a reasonable volume of cases in each DRG that is analysed in both sectors. CHA suggests a minimum of 100 cases in both sectors and that each peer group has a reasonable volume (say at least 20). We also suggest that psychiatric, drug, alcohol and rehabilitation DRGs be excluded given the lack of robust classification systems and high variability in inputs and costs. DRG grouping has predominantly evolved around representing resource homogenous groups in the acute care settings. DRGs do not reflect mental health or non-acute activity well. The exclusion of the above DRGs would still leave 445 DRGs available for analysis.

In relation to the fringe benefits tax concessions available to employees in the public and not-for-profit sectors, CHA notes that these concessions accrue to employees. They do not directly impact on the cost of wages that are payable by employers. CHA is not able to comment on whether for-profit operators have additional costs to pay in order to attract labour.

Recommendations for future work

CHA recommends the creation of an Office of Hospital Cost Data to be established within the current Commonwealth Department of Health and Ageing with responsibility to oversee the creation of a national robust and consistent hospital cost data set to collect information across all jurisdictions as well as the private sector – with governance arrangements comprising representation from both sectors.

As the Commonwealth moves to activity-based funding for public hospitals, CHA would propose that Commonwealth funding to the states be made contingent upon the States and Territories contributing future data that is high quality and consistent in format and definition, ie. in a form that would enable the Commission to undertake studies such as this one.

Given the demonstrated propensity for gaming and manipulation of data within the health sector, CHA also proposes the establishment of an independent data audit agency with the power and ability to audit data submitted to hospital cost data collections in all jurisdictions and the private sector.

Safety and quality indicators

In relation to safety and quality data, as distinct from funding issues, there are datasets that are currently collected by bodies such as ACHS (useful - although limited in scope by its voluntary nature) as well as a number of the jurisdictions (especially in Queensland and Western Australia) that would allow comparisons to be made across the public and private sectors.

The mandatory nature of the collections in the above jurisdictions provide a strong basis for appropriate cross sectoral comparisons. The Australian Commission on Safety and Quality in Health Care is well placed to provide guidance in this regard.

CHA urges caution in drawing conclusions in relation to unplanned three-admissions within 28 days. Some unplanned re-admissions may be associated with the normal course of a chronic condition that does not have any relation to any preceding hospital treatment.

Additionally it may not always be possible to track a patient who is listed to two or more different hospitals within a 28 day period.

Comments on other potential indicators

Relative Stay Index is a useful indicator. However, caution must be applied where differences arise as a result of product differentiation between public and private sectors, ie. obstetrics –many private hospitals don't provide an extended midwifery service in the home following discharge – which will partially account for the reported difference in length of stay.

Length of stay needs to be used in conjunction with other effectiveness and outcome indicators: a hospital may well have a reduced length of stay if its patients are discharged sooner than clinically indicated.

Costs per separation will depend on many factors related to organisation, patient and doctor. For example, in rural areas, proximity to the treating facility also influences LOS as patients may not be in a position to leave hospital as easily as in metropolitan facilities.

High rates may reflect both good reporting and systems - not the opposite. There could well be a perverse incentive to "game" reporting of adverse events in order to demonstrate good performance.

It is well documented that strong leadership and culture underpins excellent risk management. While a valid measure may prove elusive, these aspects are critical to an organisation's overall safety culture.

As a final comment, hospitals currently are required to report to multiple bodies on quality and safety data. This is inefficient and ineffectual. It would be helpful to identify appropriate data for reporting and require each hospital to report such data to a single body.

Workforce characterisation

The age distribution of the hospital professional workforce may provide useful demographic data as to the sustainability of its workforce - although CHA is not sure that this data can be used as an indicator of hospital performance.

We would be very concerned about any measures of performance that measured doctor or nurse productivity merely on the basis of ratios such as number of separations per doctor or nurse. The use of such indicators could send signals that use of fewer than clinically appropriate numbers of clinical staff is to be encouraged.

In relation to multivariate analysis, CHA considers that this analysis may provide useful additional knowledge about factors affecting hospital performance. CHA draws the Commission's attention to the significant clinical teaching and research that is undertaken by Catholic private hospitals (as well as a Catholic public hospitals) and these activities should be taken into account. The same applies to research that is also being undertaken within Catholic hospitals.

In relation to informed financial consent, CHA considers it is an important right for patients to be given, where possible, an estimate of the amount of likely out-of-pocket costs that will be incurred in undertaking a therapeutic procedure. Ideally this information should be provided in circumstances that allow patients to make a genuine choice about whether or not to proceed and with which provider. It should be mandatory for a registered health benefit organisation to have the facilities for eligibility checking 24/7.

The current data collected by IPSOS would appear to be well based to enable continuing work with the various medical specialty groups to increase rates of informed financial consent. CHA supports the potential role that IT and E-health solutions such as Eclipse may be able to provide in coordinating complex data from differing health providers and private health insurers and presenting that information to patients in a timely and readily understandable format.

In relation to the indexation of the Medicare Levy Surcharge Thresholds, CHA does not propose the adoption of a particular index other than noting that it is important that whatever index is chosen, it provides a reasonable representation of movements in income levels.

Appendix 1: List of Catholic Hospitals

Canossa Private Hospital	OXLEY	QLD	Private
St Vincent's Hospital Lismore	LISMORE	NSW	Private and Public
Calvary Health Care Sydney	KOGARAH	NSW	Public
Calvary John James Hospital	DEAKIN WEST	ACT	Private
Calvary Health Care ACT Ltd	JAMISON CENTRE	ACT	Private and Public
Calvary Health Care Riverina	WAGGA WAGGA	NSW	Private
Calvary Health Care Bethlehem	SOUTH CAULFIELD	VIC	Public
Calvary Wakefield Hospital	ADELAIDE	SA	Private
Calvary North Adelaide Hospital	NORTH ADELAIDE	SA	Private
Calvary College Grove Rehabilitation Hospital	WALKERVILLE	SA	Private
Calvary Central Districts Hospital	ELIZABETH VALE	SA	Private
Calvary Health Care - Tasmania	HOBART	TAS	Private
Calvary Health Care Tasmania	LAUNCESTON	TAS	Private
Calvary Health Care Tasmania-St Vincent's Campus	LAUNCESTON	TAS	Private
Mercy Hospital Mount Lawley	MT LAWLEY	WA	Private and Public
Cabrini Health	MALVERN	VIC	Private
Brighton Private Hospital	MALVERN	VIC	Private
Cabrini Prahran	MALVERN	VIC	Private
Sacred Heart Palliative Care & Rehab Service	DARLINGHURST	NSW	Public
St Vincent's Hospital	DARLINGHURST	NSW	Public
Mater Hospital North Sydney	NORTH SYDNEY	NSW	Private
St Joseph's Hospital Ltd	REGENTS PARK	NSW	Public
St Vincent's Health (VIC)	FITZROY	VIC	Private and Public
Caritas Christi Hospice	KEW	VIC	Public
Mt Olivet Community Services-Mt Olivet Hospital	KANGAROO POINT	QLD	Private
St Vincent's Hospital Toowoomba	TOOWOOMBA	QLD	Private

Holy Spirit Northside Private Hospital Ltd	CHERMSIDE	QLD	Private
Mater Adult Public Hospital	SOUTH BRISBANE	f	Public
Mater Children's Hospital	SOUTH BRISBANE	QLD	Private and Public
Mater Woman's Public & Private Hospital	SOUTH BRISBANE	QLD	Private and Public
Mater Misericordiae Private Hospital	SOUTH BRISBANE	QLD	Private
Mater Misericordiae Private Hospital Redland	CLEVELAND	QLD	Private
Mercy Care Centre Young	YOUNG	NSW	Public
	ALBURY	NSW	Public
St Vincents & Mercy Private Hospital-MC	EAST MELBOURNE	VIC	Private
Werribee Mercy Hospital	WERRIBEE	VIC	Public
St Vincents & Mercy Private Hospital	FITZROY	VIC	Private
Mercy Hospital For Women	HIEDELBERG	VIC	Public
O'Connell Family Centre Inc	CANTERBURY	VIC	Public
Mater Misericordiae Hospital Bundaberg	BUNDABERG	QLD	Private
Mater Misericordiae Hospital Yeppoon	ROCKHAMPTON	QLD	Private
Mater Misericordiae Hospital Gladstone	ROCKHAMPTON	QLD	Private
Mater Misericordiae Hospital Rockhampton	ROCKHAMPTON	QLD	Private
Mater Misericordiae Hospital Mackay	MACKAY	QLD	Private
Mater Misericordiae Hospital Newcastle	NEWCASTLE	NSW	Public
Mater Misericordiae Hospital Townsville Ltd	TOWNSVILLE DC	QLD	Private
St John of God Health Services-Burwood	BURWOOD	NSW	Private
St John of God Health Service - Richmond	NORTH RICHMOND	NSW	Private
St John of God Pinelodge Clinic	DANDENONG	VIC	Private
St John of God Nepean Rehabilitation	FRANKSTON	VIC	Private
St John of God Hospital Geelong	GEELONG	VIC	Private
St John of God Hospital Warrnambool	WARRNAMBOOL	VIC	Private
St John of God Hospital Ballarat	BALLARAT	VIC	Private

St John of God Hospital Bendigo	BENDIGO	VIC	Private
St John of God Hospital Berwick	BERWICK	VIC	Private
St John of God Murdoch Community Hospice	MURDOCH	WA	Private
St John of God Hospital Murdoch	MURDOCH	WA	Private
St John of God Hospital Bunbury	BUNBURY	WA	Private
St John of God Hospital Geraldton	GERALDTON	WA	Private
St John of God Hospital Subiaco	SUBIACO	WA	Private
Hawkesbury District Health Service Ltd	WINDSOR	NSW	Public
St Vincent's Health Services	BATHURST	NSW	Private
Lourdes Hospital, Health & Aged Care Services	DUBBO	NSW	Public