
# Private Cancer Physicians of Australia and Haematology and Oncology Clinics of Australia

Submission to Productivity Commission study Performance of Public and Private Hospital Systems

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# 1 Introduction

The Private Cancer Physicians of Australia (PCPA) Limited and Haematology and Oncology Clinics of Australasia (HOCA) welcome the opportunity to make this submission to the Productivity Commission study Performance of Public and Private Hospital Systems.

The study is being undertaken at a time when Australian Governments are reviewing their collective approach to the delivery of health services to the Australian community. PCPA and HOCA believe that its combined experience yields important insights into issues relevant to this review - not only about the relative efficiency of public and private hospital systems but also the relative ease, comfort and quality of the service delivered to patients.

## 1.1 Private Cancer Physicians of Australia

PCPA is a not-for-profit organisation dedicated to the improvement of the health system for all cancer patients, but particularly for private cancer patients in Australia.

Established in 2007 the PCPA is a membership organisation for medical oncologists & haematologists in private practice in Australia. As of 1 January 2009, membership exceeds 50% of all identified private practitioners in Australia. Membership is open to others significantly committed to private practice or considering private practice.

The PCPA has a pivotal role in the Australian community for the implementation, delivery and planning of improved cancer services in the Private Health Sector.

The mission of the PCPA is to promote and work towards a health system that provides high quality, fair, integrated cancer treatment that benefits patients and supports medical practitioners.

## 1.2 Haematology and Oncology Clinics of Australasia

HOCA is the largest provider of day only ambulatory care service provider for people diagnosed with cancer and diseases of the blood.

The organisation commenced operation in 1988 and since then has provided care for over 55,000 patients. Currently the service is provided at four facilities each of which is a separately registered private hospital. The facilities are located at:

- Auchenflower (Brisbane) on the campus of the Wesley Hospital;

- South Brisbane on the campus of the Mater Hospitals;
- Chermside (North Brisbane); and
- Southport (Gold Coast).

Of the practitioners who provide services at HOCA Clinics:

- all provide inpatient services on a visiting medical officer (VMO) basis to the majority of the major private hospitals in Brisbane;
- over fifty per cent have public hospitals appointments; and
- most provide consulting services and support facilities in regional locations that deliver care for people diagnosed with cancer and diseases of the blood . These centres include Toowoomba, Cairns and a number of other eastern seaboard regional centres.

Greater than fifty per cent of ambulatory oncology services in the greater Brisbane area are provided privately.

## 1.3 Structure of the submission

The submission is set out as follows:

- the increasing incidence and impact of cancer and related conditions in Australia is reviewed (section 2);
- HOCA's services, the characteristics of the services and the characteristics of the service delivery model are described (section 3);
- issues in making cost comparisons are considered and some evidence presented (section 4);
- the discussion is broadened from costs and outputs to health outcome comparisons (section 5); and
- conclusions are drawn (section 6).

# 2 Incidence and impact of cancer in Australia

## 2.1 Growing prevalence of cancer in Australia

Cancers have a significant impact on the mortality and morbidity of the Australian population. Some sobering statistics[1]:

- risk: the risk of being diagnosed with cancer before age 75 was 1 in 3 and before age 85 was 1 in 2. Risks were generally higher for males than females by a factor of 1.4[2];
- incidence: in 2005, for the first time, there were over 100,000 new cases of cancer diagnosed in Australia. This number is projected to grow by over 3,000 extra cases per year in 2006–2010. The growth is due mainly to the ageing of Australia's population but there is also projected to be a small increase in the underlying cancer incidence rate[3];
- deaths: in 2005 there were over 39,000 deaths from cancer in Australia. The death rate from cancer is projected to decrease slightly during 2006–2010. Despite this, the actual number of deaths from cancer is projected to grow by over 800 extra deaths per year. This increase is due to the ageing of the population[4]; and
- burden of disease: the largest contributor to the total burden of disease in 2003 was cancer, accounting for 19% of the total[5]. Hospital utilisation is one aspect of the burden of disease. In the financial year 2006–07 there were over 775,000 cancer-related separations from hospitals around the nation, which accounted for about 10% of all hospital separations in that year. Over 300,000 of these separations were for chemotherapy. The next four largest numbers of separations were due to non-melanoma skin cancer, special screening examinations, secondary cancers and follow-up after surgery for cancer. The number of hospital

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1 AIHW and Australasian Association of Cancer Registries 2008, Cancer in Australia: an Overview, Cancer Series, no.46, Canberra, December.

2 Ibid, p.4, based on 2005 data.

3 Ibid, p.vii.

4 Ibid, p.viii.

5 Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD 2007, The burden of disease and injury in Australia 2003, Cat. no. PHE82, Canberra: AIHW.

separations looks set to increase. For each year from 2002–03 to 2006–07 there was an increase of over 23,000 separations per year[6].

The burden of disease imposed by cancers will continue[7]:

> Due mainly to the aging of Australia's population, the number of people being diagnosed with cancer is projected to increase by over 3,000 extra cases per year, the number of hospital separations is projected to increase by over 23,000 extra separations per year and, despite the fact that the cancer death rate is expected to decrease, the actual number of deaths due to cancer is expected to increase by over 800 extra deaths per year. Cancer already has a major impact on individuals, families and the health system. Fuelled by Australia's ageing population, this situation looks set to continue.

The resources consumed in Australia in addressing the burdens imposed by cancer are significant.

## 2.2 Policy implications

The policy implications of these statistics are clear - improvements in the delivery of oncology and related services should be a priority as they will deliver benefits to a large proportion of the Australian population – both in terms of:

- the cost of treatment – even modest gains in the efficiency and efficacy of the delivery of health services for patients suffering from cancer related conditions offer substantial gains for the health sector as a whole; and
- patient outcomes – improvements in patient outcomes, whether in terms of treatment outcomes or broader aspects (such as patient convenience, minimising patient journey length etc) significantly impact on the quality of health outcomes.

6 AIHW 2008, p.viii.

7 Ibid, p.viii.

# 3 Overview of services

## 3.1 Definition of the services provided

HOCA provides day only ambulatory care service for people diagnosed with cancer and diseases of the blood. Most services provided are classified as day chemotherapy (DRG R63Z).

## 3.2 Key characteristics of the services and service delivery model

HOCA uses a "doctor-patient" service delivery model in contrast to the "team based" model that is currently being considered by the Commonwealth. Each of HOCA's registered hospitals is capable of providing a full range of haematology and oncology services. Both outpatient consultations and treatment occurs in one location. Specialist consulting rooms are provided at each clinic.

The service delivery model allows for services to be provided on a stand-alone basis.

Relative to delivery in a public hospital setting, private delivery of haematology and oncology services is characterised by several factors which enable it to deliver better patient outcomes at lower cost ( refer Table 1).

- greater homogeneity of services – day care oncology services represent relatively repetitive standardised treatment modality across clinics and providers. This is in contrast to the heterogeneity of services provided in public hospitals;
- greater specialisation –private care is more highly specialised than is commonly the case in public hospitals enabling specialisation in care delivery that brings substantial gains in relation to the efficiency of service delivery and the speed of diagnosis due to factors such as:
  - purpose built facilities for the range of services provided;
  - responsiveness;
  - flexibility;
  - established and repeated specific relationships with service providers (such as radiation therapy, pathology & radiology) all of which are co-located providing access to all essential treatment modalities in one location
- higher patient volumes –a specialised private facility, offering a smaller range of services than a public hospital can achieve greater service volumes. For example,

HOCA currently provides treatment for 230 – 250 patients per day across its four locations with a further 200 plus outpatient consultations per day. Annualised patient contacts are in excess of 100,000 annum;

- greater consistency and continuity in personal relationships - in a HOCA style facility, clients typically have ongoing contact with the same doctor and other personnel as opposed to the model adopted in public hospitals involving a range of clinicians and nursing staff;
- differences in how service delivery is coordinated; and
- closer proximity to clients – services provided by private facilities will on average be geographically closer to patient's home. The location decisions of major hospitals involve numerous considerations rather than the optimal distribution of day care facilities. This is particularly important for cancer related treatments which involve particularly acute patient impact.

The cost implications of these characteristics are discussed in the following section. They lead to an expectation that costs will be significantly below those in larger, facilities, especially where the spectrum of care delivered is much broader.

# 4 Cost comparisons

## 4.1 Making valid cost comparisons

The Issues Paper highlights a host of issues that arise in making valid cost comparisons. HOCA agrees that each of the following issues can impact on cost and output comparisons:

- constraints imposed by basic data availability;
- ensuring that the services being compared are clinically similar;
- choosing appropriate levels of aggregation for comparisons (national, state, regions, individual hospitals);
- controlling for differences in the mix of services provided, given cost differences by service;
- measuring capital costs (cost of capital and depreciation);
- allocation of common costs to individual measured services (e.g. overheads and some forms of capital);
- ensuring that all costs are taken into account and dis-entangling costs from the financing of costs;
- controlling for rates of hospital-acquired infections, readmissions and returns, adverse events, access to services, and the responsiveness of service providers to clients.

In comparisons between private and public hospitals, there are an additional range of competitive neutrality issues, such as, differences in access to salary sacrifice arrangements and tax obligations. Rules that advantage either public or private providers will impact on the relative cost of providing services, but the difference will be unrelated to differences in the efficiency of service provision.

## 4.2 Asserted superiority of public hospital efficiency is misleading

PCPA and HOCA are concerned that there appears to be an assumption held by many in public health circles that public hospital delivery of health services is more efficient than systems which give a greater role to direct relationships between the patient and

the health service provider. Further, in some quarters there appears to be a belief that in a pure technical or productive efficiency sense, public hospitals can deliver health services more efficiently than can private hospitals. Moreover, it has been suggested that PHI funds should be redirected to the public sector on the basis of the untested assertion that doing so will produce superior outcomes.

These assumptions are neither supported nor strongly rejected by existing Australian empirical evidence. Studies can be found to support both viewpoints. Of course, much of the growth in the private hospital system has been in response to deficiencies in the public system.

What is clear is that Australia's system has a mix of public-private financing and service provision and the system has performed relatively well, although there are continuing and significant opportunities for improvement. We believe that the share of health services delivered by private providers (profit and not-for-profit) will continue to grow over time. This is because private financing and provision -

- increases the overall level of funds available for capital investment: a major contribution of the private hospital sector to the health system is its capacity to raise capital[8]. The private sector, mainly private hospitals, accounts for 60% of the total per annum capital spend in health care for facilities and for specialised equipment (AIHW 2007a: 74). The development of PHI and private hospitals since the 1990s has been an important factor in enabling the Australian health system to meet the demands created by new technologies and for modern facilities;
  - HOCA's own experience is that the private sector delivers health capital investment projects more efficiently (e.g. in terms of cost and timeliness) offering advantages that improve health outcomes and notes that this is consistent with the experience of UnitingCare Health)[9];
- setting aside the debate about overall relative efficiencies, is clearly more efficient for services that can be delivered in a day care ambulatory setting, as HOCA's experience shows;
- strongly contribute to service delivery innovations. According to a report to the Australian Health and Hospitals Reform Commission, private and non-government sectors have much to offer in developing new models of care to overcome the fragmentation of health funding programs. Private providers are

[8] Foley, M. 2008, A Mixed Public-Private System for 2020, A paper commissioned by the Australian Health and Hospitals Reform Commission, July, p.23.

[9] submission no.15

often better placed to innovate than public authorities. Models which provide greater autonomy to public providers to participate in purchasing opportunities in a competitive environment would also stimulate innovation[10];

- increases the availability of health services for people who value and are willing to pay for health services that cannot be provided through public provision, or not provided within a timeframe and to a quality standard desired by patients.

Moreover, in the case of radiation oncology services provides evidence that public hospitals are in fact less efficient than private facilities for these services.

## 4.3 Available evidence – the case of regional radiation oncology

There is limited evidence available on the relative cost performance of private and public providers of haematology and oncology services.

However, a recent study compared a private Commonwealth funded regional radiation oncology facility in Toowoomba (Radiation Oncology Queensland (ROQ)) with a Queensland Health Facility (QHF) in Brisbane. The comparison concentrated on service delivery and costs but was not able to look at changes in access to services[11].

Data were collected from the two facilities from January 2008 to June 2008 inclusive. A number of factors were compared including case mix, staffing levels, delay times for treatment, research, training and treatment costs.

The case mix between the two areas was similar with curative treatments making up just over half the work load in both centres and two thirds the work being made up of cancers of breast and prostate. Staffing levels were leaner in ROQ especially in the areas of nursing, administration and trial coordinators. Research activity was slightly higher in ROQ.

[10] Foley 2008, p.25.

[11] Poulsen, Michael, Middleton, Mark, McQuitty, Simon, Ramsay, Jonathan, Gogna, Kumar, Martin, Jarad, Khoo, Eric, Wong, Winnie, Fairweather, Ray, and Euan Walpol 2009, Comparison of a Commonwealth Funded Regional Radiation Oncology Facility in Toowoomba with a Queensland Health Facility, Submitted for publication to the Journal of Medical Imaging and Radiation Oncology, July. A copy of the study is available upon request.

**Box 1 A private-public service delivery model**

In 2002, the Baume Report highlighted the need for expansion of radiation oncology services, including Toowoomba and in 2003, the Department of Health and Ageing invited tenders for setting up a regional radiation oncology facility in Toowoomba as part of a national plan to improve access to radiation oncology services.

Toowoomba was selected as the first project with a sum of $8.6M allocated towards the project. Radiation Oncology Queensland (ROQ), a private health service provider, and St Andrew's Toowoomba Hospital (SATH) were successful in their application which was a collaborative venture with SATH providing the land and the building with a day care unit and ROQ being the operator of the radiotherapy facility. The $ 8.6M was spent on the construction of the building, the purchase of the first linear accelerator and planning equipment. Attracting staff to rural locations is a problem for many centres especially physics and medical staff. ROQ has been fortunate in achieving full staff levels during its period of operation.

The facility treats both public and private patients and a tripartite agreement between Queensland Health (QH), ROQ and SATH was signed to allow the treatment of public inpatients which make up less than 5% of the workload. ROQ operates as an independent private facility but enjoys an excellent working relationship with QH given the joint appointments of its medical staff and directors. It is also part of the state wide training network for radiation oncology registrars.

The average Medicare cost per treatment course was similar in both centres ($5000 per course). However, the total cost of an average treatment including patient, State and Commonwealth costs, showed that the privately financed ROQ facility at Toowoomba provided treatments at 30 per cent less cost. Other relative performance results were:

- output per full-time equivalent staff member (number of treatment courses divided by the number of FTE in that staff group): the most marked differences were in nursing, administration and clinical trials coordinators where the ratio of output per FTE for the Toowoomba versus QHF facility was 1.53, 1.23 and 1.47, respectively;
- treatment delay times: treatment delay times were calculated from the ready for care date to the date of the first radiation treatment. The average at ROQ was 21 days. A ready for care date was not recorded at the QHF but the average time from the date of booking for planning to first treatment was also 21 days.

The other principal conclusions of the study are:

- the Commonwealth funded model involving ROQ has been highly successful. It has produced a state of the art, integrated radiation oncology service that provides treatment for both private and public patients with minimal cost to the State Government;
- a paperless working environment appears to have contributed to the better relative cost performance;

- there has been a sound working relationship develop between ROQ and Queensland Health with shared multidisciplinary meetings (MDMs), and an agreement that allows the treatment of public inpatients at ROQ;
- patients now have a choice in terms of having their treatment locally or in Brisbane. QH have also gained much needed spare capacity for its departments in Brisbane as well as making significant savings on recurrent costs; and
- this model of care could be considered at other selected regional sites in Australia as a cost effective way of expanding services outside metropolitan areas.

## 4.4 Proposed benchmarking study

HOCA would be willing to participate in a benchmarking case study comparing the relative performance of the provision of oncology services. For targeted DRGs, HOCA believes that it would be able to provide data in a manner that would allow many of the issues in making valid comparisons to be addressed.

# 5 Outcomes

Health outcome measures seek to take into account a broader range of factors in addition to health cost or output measures. Some of the factors include differences in:

- the quality of care and patient safety (e.g. survival rates);
- responsiveness to patients and patient satisfaction;
- clinical research activity; and
- access to services.

The interpretation of cost or output comparisons can lead to wrong conclusions where there are performance differences on these types of service attributes.

## 5.1 Outcome indicators

### 5.1.1 Evidence on survival rate performance

A study of survival outcomes was undertaken for all patients diagnosed with colorectal cancer in Western Australia between 1993 and 2003[12]. The aim of the study was to determine whether treatment in private versus public hospitals was an independent predictor of improved survival outcomes in patients with colorectal cancer. Risk was stratified according to the covariates known to influence survival in patients with colorectal cancer. The main outcome measures were overall survival and cancer-specific survival rates.

Between 1993 and 2003, 5809 patients with colorectal cancer were managed in Western Australia. Of these, 1523 patients (26%) were treated in private hospitals. Patients treated in private hospitals were younger, and had a lower 30-day postoperative mortality rate. In addition, they had a higher index of relative socioeconomic advantage/disadvantage, a higher index of economic resources, and a higher index of education and occupation.

Independent predictors of improved overall survival included: treatment in a private hospital, diagnosis at a younger age, female sex, and cancer stage. Independent

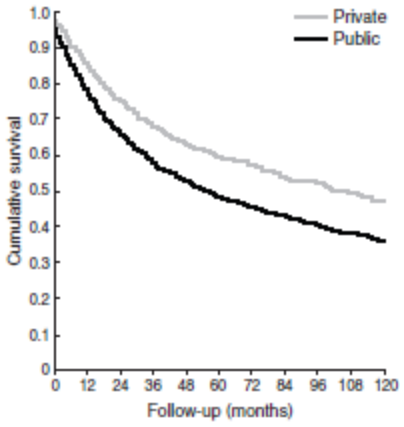
[12] Morris, Melinda, Iacopetta, Barry and Cameron Platell 2007, Comparing survival outcomes for patients with colorectal cancer treated in public and private hospitals, MJA, Vol.186, No.6, March.

predictors of cancer-specific survival included: treatment in a private hospital, diagnosis at a younger age, and cancer stage.

Patients treated in private hospitals had significantly better 5-year overall survival and cancer-specific survival rates when compared with patients treated in public hospitals (figure 1).

**Figure 1**

**4 Comparison of overall survival rates of patients treated for colorectal cancer in public versus private hospitals in Western Australia (1993–2003)**




Source: Reproduced from Morris et al 2007

The results of the study indicate that patients with colorectal cancer treated in a private hospital had improved survival outcomes when compared with patients treated in a public hospital. The relationship held, even when corrected for stage of disease, patient age and sex, use of adjuvant therapies, and disease location. The improvements in survival outcomes were noted for all stages of cancer.

The study was not able to control for all prognostic factors, such as, mode of presentation (i.e. emergency v elective treatment), general health of the patient (e.g. smoking status or preoperative physical fitness), and quality of surgery.

An analysis of the socioeconomic indexes for the study population showed a marked difference between those treated in public versus private hospitals. Patients treated in a public hospital had significantly lower scores for the index of relative socioeconomic advantage/disadvantage, the index of economic resources, and the index of education and occupation. However, the authors found that none of the socioeconomic indexes were significant predictors (in univariate and multivariate analysis) of either overall or cancer-specific survival outcomes. There was also no difference in either stage of disease at presentation or postoperative mortality rate between these groups.

### 5.1.2 Clinical research activity

HOCA, like many private facilities, is involved in practitioner training and clinical research, however we are cognisant of the fact that this commitment falls below the commitment expected and delivered in the public sector and the consequent cost impact.

That said, HOCA is heavily involved in clinical trials due, in part, to its high patient volume. The clinical trials are an important part of the process of research through to commercialisation, and making improved pharmaceuticals available to patients.

### 5.1.3 Access to services

The Issues Paper proposes to use waiting times for elective surgery and emergency department waiting times as an access indicator for public hospitals. Similarly, waiting times for the results of test procedures can provide an indication of performance quality differences, as well as potentially impacting on quality of health outcomes (e.g. adverse events).

HOCA's day clinic environment provides better access to services than most public hospitals (some public hospitals provide a similar range of services). This is particularly true in terms of 'on-site' access due to the co-location of services. In the public hospital environment, a patient may need to make a number of appointments over different days for what HOCA would typically do in a single visit. One of the benefits is faster turn-around times in terms of test results. Services are better coordinated and delivered faster.

## 5.2 Drivers of superior private sector performance

### 5.2.1 Benefits of HOCA's service delivery model

HOCA is confident that the way in which it delivers services produces more efficient health outcomes than provision of the same services in public hospitals. The service delivery model:

- uses fewer resources to produce a given health output resulting in lower cost provision;
- reduces economic costs typically not accounted for (e.g. the opportunity costs of client's time);
- reduces risks;

- results in better resource allocation; and
- delivers intangible benefits, such as, higher customer satisfaction levels.

While the model is not suitable for the provision of all health services, it offers significant benefits for the delivery of the types of services that can be provided by day care facilities. By increasing contestability for the provision of such services, greater specialisation is achieved consistent with the relative comparative advantages of the private and public sectors.

The highly specialist nature of HOCA's services, and co-location with essential services, provides close working relationships with allied health professionals and ensures that private sector delivery is more responsive to the needs of private patients.

**Table 1 Benefits of Private delivery service delivery model in provision of day care services**

| Driver | Supporting conditions and factors | Impact on health outcomes |
|---|---|---|
| Specialisation to comparative advantage | HOCA services are homogeneous, and there is a far greater degree of specialisation (concentration in relatively few DRGs). These factors support and develop high levels of expertise in the range of services provided | Lower cost per output (e.g. separation) |
| Economies of scale | High service volumes are achieved through specialisation | Lower cost per output |
| Market test | Purchasing of health services gives greater power to clients relative to the public hospital context (the market test). Stronger incentives for private provider to be accountable and responsive to client demands | More efficient resource allocation in terms of both productive and allocative efficiency. Benefits of innovation more internalised, therefore, incentives stronger |
| Consistency in relationships | Day clinic environment supported by co-location of essential services | Reduced risks, reduced economic costs, intangible benefits |
| Stand alone service provision | Tight integration of supporting services, co-location | Significantly reduces coordination costs, including costs related to delay times and associated risks |
| Spatial distribution of services | There is scope for oncology services to be provided in regional centres (e.g. the ROQ model) to be geographically closer to patients | Health system cost savings, and patient savings (e.g. reduced travel and wait times) |
| Motivated health workforce | The institutional environment in which people work and the incentives they face matter to their motivation and performance. The private delivery model, including consistency in relationships and clearer accountability, is more likely to result in an "engaged" workforce | Impacts on cost of service provision, responsiveness to clients, lower risks (e.g. adverse events), and improved intangibles (e.g. client satisfaction) |

### 5.2.2 Health workforce engagement

While focusing on a labour input, the engagement of the health workforce is also an indicator of the quality of services provided to clients. One linkage is that a poorly

motivated workforce (one aspect of 'engagement') would be expected to provide lower quality care.

The Best Practice Australia (BPA) database on Employee Engagement contains in-depth profiles of the working experiences and working lives of over 160,000 health care respondents throughout Australia, New Zealand and some overseas healthcare providers. The issues canvassed in the profiles include:

- Engagement Culture
- Job Satisfaction
- Work-Life Integration
- Employee Satisfaction
- Trust in Management
- Values-in-Action
- Change Management
- Perceived Client Satisfaction
- Management Skills
- Leadership Style
- Team Norms
- Internal Service
- Bullying, Abuse and Violence from Co-workers
- Bullying, Abuse and Violence from Patients/Clients
- Workplace Safety
- Corporate Governance
- Patient Safety Practices

Private sector healthcare employees are much more engaged with their organisation than are public sector healthcare employees. Early evidence from BPA's Culture Impact Study suggests a significant linkage between employee engagement and how patients judge their healthcare experiences. It is understood that BPA will report this information at a later date.

Table 2 suggests that private provision is generally a better institutional environment for the delivery of patient services. We believe this relates to the fact that there is generally greater clarity in incentives in the private sector, clearer roles and responsibilities for service providers, and a greater need to be responsive to client demands.

Early evidence from BPA's Culture Impact Study suggests a significant linkage between employee engagement and how patients judge their healthcare experiences. It is understood that BPA will report this information at a later date.

**Table 2 Health workforce engagement**

| Sector | Healthcare workers who have responded (number) | Engaged (%) | Swinging Voters (%) | Disengaged (%) |
|---|---|---|---|---|
| Health Sector | 166,508 | 36% | 43% | 21% |
| Govt Public Healthcare organisations | 72,209 | 29% | 46% | 25% |
| For-Profit Healthcare organisations | 31,318 | 43% | 41% | 16% |
| Not-for-Profit Public Healthcare organisations | 15,305 | 37% | 43% | 20% |
| Not-for-Profit Private Healthcare organisations | 25,955 | 40% | 41% | 19% |
| Residential Care organisations | 12,170 | 43% | 37% | 20% |
| Community Services organisations | 9,551 | 53% | 35% | 12% |

Source: Best Practices Australia 2009

# 6 Conclusions

PCPA and HOCA recognise that both public and private hospitals have a role in the delivery of health services in Australia. However, in PCPA and HOCA's view, the key is the comparative advantage of each sector in the services that are performed and, in light of that comparative advantage, the procurement strategies which are utilised for service delivery.

PCPA and HOCA believe that the provision of day care and related services for the treatment of cancer related conditions has characteristics that lend itself to greater contestability in the treatment of public patients, including:

- clearly defined services;
- accurate identification and assignment of costs between sectors;
- robust measures of outcomes, including patient satisfaction;
- ability to manage screening behaviours by providers seeking to avoid treating high cost patients.

Clearly issues of market design will need to be addressed in the development of a contestability model so as to ensure that the contestability of public patients does not lead to perverse outcomes. However, given the relative ease with which contestability can be pursued for the provision of day care related oncology services, PCPA and HOCA believe that provides an important opportunity to begin to explore this method of service delivery. The lessons that are learned through this process will inform future expansions of this form of procurement of health service delivery.

# A Specific comments on the Issues Paper

## A.1 Relative Performance of Public and Private hospital systems - comparative hospital and medical costs

### A.1.1 Scope of benchmarking

The delivery of cancer care services does not fall into the 'elective category' and it is focus in areas such as those provided by HOCA that may well see improved economies of scale and reduced care delivery costs in areas with high levels service utilization. Treatment in such specialist environments can reduce the costs associated with overnight admissions, which if unwarranted have significant cost and access implications.

Therefore, HOCA does not support the the "exclusion of free standing day hospitals" for comparative analysis as proposed in the Issues Paper.

### A.1.2 Private practice clinics within the public sector

The expansion of 'private practice clinics' within the public sector should be reviewed with care as funding is essentially 'federal'. Some of the component costs associated with care, especially in modalities such as chemotherapy (where medication costs can be extremely high), become difficult to identify and handle properly when making service delivery cost comparisons.

## A.2 Partial Indicators of performance

Cost per separation and cost per DRG are good partial indicators, but the challenge will be the definition of cost. HOCA is willing to submit data to the inquiry on an 'in confidence' basis.

### A.2.1 Data sources

NHCDC data would probably be most relevant from 2006-07. Where 'No Gap' billing occurs the medical costs would be easy to calculate and from a 'real' cost perspective should be available from the major health funds. Most health fund contracts include episode of care medication costs as a hospital payable item so again such costs would be available either from hospitals or pharmacy service providers.

### A.2.2 Regions

HOCA practitioners provide services in many regional locations. HOCA believes that the duplication of medical practitioner and resources and facilities delivering care in non-metropolitan areas should be an area of focus for the review. Experience to date indicates that more flexibility in the approach to the delivery of services in regional areas could yield significant savings and improve efficiencies for a range of modalities.

### A.2.3 Hospital peer groups

With respect to the proposed peer group classification system, when costing services, some consideration should be taken of the 'business structure' of providers. In the case of HOCA, the individuals clinics, while geographically dispersed, function as separate operational units, but significant business administration costs are managed at a corporate office level. Depending on the view taken, organisations such as HOCA could be classified as 'Very Large' or 'Small'.

### A.2.4 Other relevant Indicators

*Unplanned readmissions and returns*

Seriously ill patients are not treated in HOCA clinics and are admitted as overnight stay inpatients in other facilities. Side effects of chemotherapy medications are dealt with by a comprehensive after hours services, but resulting urgent admissions are not to HOCA clinics. Such protocols would be in place for many facilities offering day only care. This point is made only to ensure that there are no incorrect assumptions regarding 'readmission rates' in relation to day only service providers.

*Workforce characteristics*

It should be noted that labour costs in an organisation such as HOCA are between 50 and 55 per cent of revenue, including full corporate overheads and practice management fees that are at best 'breakeven'. Care should be taken when considering 'what is labour?'.

### A.2.5 Multivariate Analysis

PCPA/HOCA are conscious of the issues with multivariate analysis and the short comings of partial indicators. This is particularly the case when comparing facilities in the delivery of healthcare since, as stated in the Issues Paper, "...failure to account for these factors can lead to erroneous conclusions about relative efficiency of hospitals".

Differences between hospitals should account for specialist focus and range of services provided and patient numbers treated. This has implications for risk management and clinical outcomes.

### A.2.6 Informed financial consent

PCPA/HOCA emphasises the need to consider any confusion / patient perceptions between:

- episode of care billing and outpatient / review billing by practitioners;
- charges for episode of care / non-episode of care medications; and
- confusion regarding the application of fees / premiums for some health fund products.

These are matters of patient education but some latitude should be applied prior to labelling them as failures of a financial consent process as some of the confusion relates to health fund policy complexity and policy application where multiple healthcare providers / hospitals are involved.

With regard to measurement by Statistical Local Area (SLA) (patient address or hospital address) this may indicate some differential based upon socio-economic status, but we are unsure of the benefit. The issue of charging out-of-pocket expenses is one for individual practitioners and should be considered as a matter between the patient and the practitioner.

Within the private sector the utilization of the 'No Gap' charging systems for medical services provided during an admission should be assessed as this clearly will influence the presence of Gap Payments.

HOCA seeks to ensure that the fees charged for outpatient consultations are clearly defined to ensure that confusion does not exist in the mind of the payer regarding why a 'gap' fee is charged on some occasions and not others.

Any private hospital which has been approved for '2nd tier funding' will have been subject to stringent criteria regarding financial consent. Compliance with such a process should, from a private sector perspective, resolve any issues regarding informed financial consent. The informed financial consent processes used by HOCA endeavour to differentiate both the costs associated with outpatient and inpatient care as we are cognisant of the confusion that can arise.

### A.2.7 Indexation Medicare Levy Surcharge (MLS)

The use of the MLS as a lever to influence levels of private health fund membership is economically sound from a Government perspective. The issue with changes in the MLS will relate to the impact on membership of private health funds and the degree to which the changes impact. To the extent that changes result in increasing numbers of people leaving private health insurance (particularly in the 'high use' categories), the burden on the public health system may well increase. This could put increased pressure on the health system to perform better, including more serious consideration of alternative sources of supply. Benchmarking and other work, such as to be undertaken in this inquiry, could prove valuable in informing supplier selection.

In determining thresholds, Average Weekly Total Earnings (AWTE) would seem fair but some additional measure to ensure that self employed / those employed in areas where personal income can quite legitimately be reduced should be included.

### A.2.8 Improving the feasibility of future comparisons

If the profitability (of in the case of NFPs positive contribution) of domestic private hospital service provision can be isolated and the levels of increase paid by funders of the care provided by such facilities, then provided that the profit (level of positive contribution) are sustainable then the rate of increase paid by funders will be a useful guide to the cost of health fund delivery for a broad range of modalities. However on the other side of the ledger MLS manipulation will have an effect on levels of premium increase requested / applied by health funds.

Length of stay measurement (with a range of parameters), may well lead to a better understanding and more robust assessment of where and how people are treated.

The real test is outcome measurement. PCPA/HOCA recommend that a process of selecting and researching the feasibility of a range of modalities may well lead to immediate opportunities for performance improvement in both sectors.