NSW HEALTH

Mr David Kalisch
Commissioner
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601

Dear Mr Kalisch

Study to examine the Relative Performance of the Private and Public Hospital Systems

I am writing to you further to discussions of the Commission's preliminary costing results at the teleconference on 17 September 2009.

NSW Health has sought advice from Dr John Deeble on a range of matters associated with the Commission's Study. As you may be aware, over the last decade Dr Deeble has provided significant advice to the Queensland, Victorian and South Australian Governments in relation to hospital capital and its financial treatment. Accordingly Dr Deeble is well-placed to offer an informed assessment of the Commission's current approach to capital. He has also made important observations about the Commission's methodology in terms of taking account of the cost of pharmaceuticals and allied health. Attached is a document that highlights issues with the current methodology and proposes alternative approaches.

In summary the Commission's current approach to the treatment of capital is not acceptable to NSW Health. I understand that it was agreed at the Roundtable discussion that if a suitable methodology could not be found then capital would be excluded from the analysis. The attached provides advice on the only appropriate methodology for the treatment of capital. I also intend to circulate this advice to all other States and Territories with the suggestion that we hold a teleconference if required.

I would appreciate your urgent response to the issues raised in the attached prior to the release of the Draft Report, including advice on how you intend to treat capital. Should your officers require further advice please ask them to contact Ms Liz Hay, Policy Manager, IGFSB on 0427 459 516.

Yours sincerely

J. M. Anderson

for Dr Richard Matthews
Deputy Director-General, Strategic Development

2. 10. 09

NSW Department of Health
ABN 92 697 899 630
73 Miller St North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Tel (02) 9391 9000 Fax (02) 9391 9101
Website www.health.nsw.gov.au

Productivity Commission Inquiry into the Performance of the Public and Private Hospital Systems

Introduction

This submission focuses on the key issues for NSW Health arising from the preliminary results and methodology of this Inquiry as provided to the NHCDC Reference Group teleconference on 17 September, 2009. In summary, NSW Health's understanding of the preliminary results is as follows:

1. The Commission has presented its preliminary results according to a methodology which recognises that the costs of treating patients are recorded in different ways and in different places in the public and private hospital systems. It therefore groups those costs according to whether the coverage of the reported data is comparable in the public and private hospitals; those where the costs reported by the private hospitals need to be supplemented from other sources and into two other groups, namely medical services where the charges to private hospital patients are not recorded at all; and the cost of using capital, where public hospital costs have been increased by a notional 'opportunity cost of capital' to reflect the total cost to the community of providing hospital treatment in that way. It also attempts to estimate the cost of capital use in the private hospitals, but as will be shown, there are major practical and conceptual problems in that approach.

2. The results are shown in terms of average cost per casemix weighted separation, excluding private free-standing day surgery hospitals, using the standard methods of allocating 'cost buckets' by DRG. That is the correct procedure and it is assumed that it has been correctly followed across all the cost groupings. There are some questions in relation to allocating capital charges in this way – relative 'capital use' does not follow operating service use exactly - but they are comparatively minor.

Issues

The results are very much as would be expected, with overall costs per casemix weighted separation being very similar between the two systems. However there are three areas where problems arise. The first two are:

(a) In the 'comparable' group, the **costs of allied health services are not in fact comparable across the sectors**. They are all included in the public hospitals, but in the private hospitals they are provided by private professionals who bill the patients directly, in the same way that doctors do. Some of those costs (usually about half) are reimbursed by the private health insurance funds under their 'general' or ancillary benefits, but there is no way to identify the in-hospital component of those benefits with current data.

(b) Pharmacy costs, which are correctly shown in the non-comparable group. The private hospitals provide some drugs directly: very expensive drugs for which the Commonwealth provides subsidies to both public and private hospitals under a special program, and; non-specific items for which there is an agreement with the private health funds for them to be included in reimbursable hospital fees. The cost of these two components is reported by the AIHW (Health Expenditure Australia, 2006-07, Table 4.15). **However patient-specific medications are dispensed by private chemists and are eligible for PBS**

benefits. Their cost is unknown but some information could be obtained from the PBS, because there are PBS arrangements for 'branch' pharmacies to be embedded in the larger private hospitals and their dispensing could be identified.

The major issue is the question of **capital charges** and here there are both practical and conceptual problems. The rationale is as follows:

(a) Box 2 in the NHCDC handout quoted the Commonwealth Department of Finance and Administration requirement that "*the cost of the implicit taxpayer guarantee to support government borrowing should be included when considering cost of capital for public hospitals" and that "the rate of return in the public and private sectors should be equal at the margin….*" Because the public hospitals do not operate commercially, that means that an additional amount (the UCC rate) should be added to their reported costs. The standard UCC rate is 8% on their (depreciated) capital.

(b) For neutrality, the same 8% UCC rate should therefore be applied to the reported costs of private hospitals as well. That requires that the capital currently used in both the public and the private hospital sectors is known.

Despite reservations over whether the UCC rate should only apply to other <u>public</u> investment, it is government policy and the amounts which the Productivity Commission has proposed are supported while noting that nobody knows exactly how much capital is currently used by the public hospitals. However, the Productivity Commission estimate of $21 billion capital being used for in-patients accords with the results of the full surveys which have been conducted by Dr Deeble for the governments of Queensland, Victoria and South Australia over the last ten years. The PC methodology of using capital expenditures and reported depreciation over a number of years to estimate the probable capital stock is different but it produces very similar results.

However that approach <u>will not work</u> for the private hospitals. The Productivity Commission draft suggests a figure of $3.5 billion for total private hospital capital, only 16% of the public hospital endowment. But private hospitals provide 32% of all hospital beds and as the figures below show, their implied investment per bed would be only about one third of the capital per bed in public hospitals.

	Public hospitals	**Private hospitals**
Capital ($ billion)	21.0	3.5
Beds (2007-08)	54,137	25,617
Capital per bed ($)	387,904	136,528

While the different characteristics of the two sectors would be expected to produce some differences in investment, that is a very implausible result.

The most probable explanation is that, In common with most private sector enterprises, the private hospitals do not legally own all of the assets that they use. Equipment is commonly theirs but buildings are often leased or held on various conditions from separate entities which own and maintain them. In the non-profit sector, buildings are frequently owned by a parent religious or charitable body, rather than the group that operates the hospital. The Productivity Commission cited the accounts of Ramsay Health Care Limited which appears to own its capital assets. Its 2008 accounts are complicated by the acquisition of a number of UK hospitals (all on lease) but in the preceding year it showed depreciated assets valued at $1,162

million, equivalent to $160,000 per bed for 7,200 beds. However that included a number of day hospitals and its depreciation provisions show that its plant and equipment was being depreciated at about 25% a year, nearly three times the rate in public hospitals.

It is very difficult to derive anything from those data. The published information gives little help. The AIHW data on capital expenditures on health show that, over the ten years to 2007-08, private sector expenditures were nearly 50% higher than State and Territory spending. The AIHW comments that most of the spending was on hospitals but warns that the ABS (the source of its data) points to 'quality problems' in the capital series. The public hospital figures can be checked from other sources and they show that about 80% of the reported State and Territory spending was on hospitals However on the private side, the ABS Private Hospital Establishment collection (the most likely source of the Productivity Commission data) shows that, in 2006-07, only $440 million was spent on capital works.- only 13% of the total of $3,253 million in reported private sector development. Where did the remainder come from?

The Productivity Commission's approach is thus very unlikely to produced comparable figures and it is unlikely that States and Territories will be able to accept it. However there is no need to estimate the private hospitals' capital at all, because there is another, related, but more important conceptual issue.

The reasoning is as follows:

(a) the DRG model underpinning the comparisons is based on the costs and payments incurred by the hospitals themselves

(b) in the public hospitals costs and revenue are the same, but for this purpose their costs have been augmented by an UCC charge of 8% on capital used, to reflect the overall cost to the community and to parallel conditions in the private sector

(c) however in the private hospitals cost to the hospital and cost to the community are not the same. The private hospitals make surpluses, or profits to use the commercial term. These have not been included

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(d) in economics, profits are a legitimate cost of production, necessary to retain the capital of a firm. They are a return on capital when all of the costs of operation and management have been deducted. Profits are part of GDP in the national accounts and in the health field, they are included in the AIHW Health Expenditure reports, where expenditures on private hospital services are correctly based on revenues, not outlays.

It follows then, that the cost of capital in private hospitals is already known. It is represented by the surpluses they earn, analogous to the UCC charge on the public hospitals. In 2007-08 the private hospitals, excluding free-standing day hospitals, achieved surpluses of $500 million or 7.1% over their operating costs. Equating those to the UCC charge gives a much more plausible estimate of private hospital capital - $6.25 billion or $244,000 per bed compared with $388,000 in the public hospitals.

But that figure is actually irrelevant. The main point is that if the public hospitals are expected to generate returns of 8% on capital used, the actual returns to private hospital capital must be included on the other side. No other adjustment is needed.

Summary

1 For most of the proposed comparison, the methodology appears to be sound and the results are as expected. However there are three areas where comparability has not been achieved

2 Allied health costs are fully covered in the public hospital system but not in the private hospitals. However there is no obvious source of the data for private hospitals. They could presumably be removed from public sector costs but the amounts are relatively small and noting the discrepancy would probably suffice.

3 Pharmacy costs are not comparable at present and although some PBS-based information might be obtained, it might not be possible in the time frame. In that event, all pharmacy costs (drug costs plus dispensing) should be removed from both the public and private sector DRG calculations.

4 The issues surrounding capital charges have been outlined above. There is a basic conceptual problem with the suggested approach and this needs to be addressed.