SUBMISSION FROM THE

HEALTH SERVICES UNION

to the

PRODUCTIVITY COMMISSION DISCUSSION DRAFT PUBLIC AND PRIVATE HOSPITALS

9 November 2009

OVERVIEW

The Health Services Union (NSW and ACT Branch) is an industrial organisation of employees, with some 38,000 members in the public and private sectors of the health, aged care and disability services industry in NSW. HSU members in the hospital sector include a wide variety of clinical, managerial and supporting roles. In the ACT the HSU coverage extends to nursing roles.

The Health Services Union and its members ('the HSU') welcomes the opportunity of providing feedback to the Productivity Commission on the important area of the hospital sector, and the respective complementary roles undertaken by the public and private health systems. Feedback received is generally supportive of the notion that detailed and intensive analysis needs to be done. Indeed it is noted that much further work needs to be undertaken to develop a comprehensive framework for future analysis as the basis of decision making - including for funding. However, as the Discussion Draft issued by the Productivity Commission concedes, issues still exist with current data and its capacity to underpin definitive conclusions.

Furthermore, concerns exist that any comparison and subsequent conclusions must adequately reflect the still considerable differences between the public and private hospital sectors in the types and complexity of clinical and preventative care to be provided; the need for the public system to ensure equitable access for all; a further requirement for public hospitals to provide free provision of care to all; and the subsequent requirement to provide and maintain a level of hospital care throughout all communities. Members would submit that it is these differences that whilst large only reinforce the complementary nature of the two and any attempt to deal with both as a single homogeneous system would lead to grave error or assumptions being made.

The following comments and feedback concern only those aspects on which HSU received feedback from members. Any enquiries regarding the document should be directed in the first instance to Mr Dennis Ravlich, HSU Director of Operations, (t: 9229 4923; e: dennis.ravlich@hsu.asn.au).

Response or commentary provided by HSU members

[Feedback from HSU members have been conveniently collated under the most relevant draft finding.]

DRAFT FINDINGS 4.1 and 5.1

Complementary rather than competitive?

HSU member feedback not surprisingly reflected the general conclusions of draft finding 4.1, in that there is a significant diversity within and across the public and private hospital sectors, although noting some key similarities. However, the issue that most feedback was received on was the observation (and general theme developed) that the respective hospital sectors do not service a comparable patient population or are required to fulfil the same societal expectations.

Member feedback accordingly reflected the view that there is ample room for public, not-for-profit private and for-profit private hospitals to operate in a complementary fashion, particularly as there is no shortage of demand from health consumers - now and into the future. When taking a global view of the entire hospital system, many HSU members considered that the significance of the continuing increase in demand, along with the distinguishable 'target' audience for each, left notions of assuming or using competitive neutrality as perhaps misplaced. Are the sectors in fact in competition or largely (for practical purposes) complementary and servicing particular patients and/or providing particular services/clinical procedures?

Accordingly, feedback received raised genuine questions regarding whether notions or modelling based on competition and a level playing field are apt arbiters or indicators in such an environment.

Public hospital obliged to provide certain services

The discussion draft, for example, identifies that the private hospital sector does not have the same degree of service obligation as the public sector. Federal, state and territory governments/administrations are expected and required to provide via the public hospital system:

- a system of free health services accessible by all (so that hospitals may be maintained in communities that may not be justifiable if undertaken on a profit motive);

- that whilst such public hospital services may vary in the level and intensity of services provided, they nonetheless undertake and fill 'gaps' within communities not otherwise undertaken, such as for example primary care, aged care, and services to remote and/or indigenous communities;

- the provision of emergency care (which increasingly has been subject to increasing utilisation by the community for a number of identified factors, including filling the care 'gap' previously occupied and provided by general practitioners[1]);

- the consequent demand to provide emergency and acute care services to communities in a timely and accessible fashion and the consequential difficulties in maintaining safe environments for clinical decision making; and

- provide an environment for clinical placements and teaching to ensure the next generation of health professionals.

This must be also viewed against an environment whereby the pressure on the public health system is profound and currently facing immense pressure - with it generally being viewed as being at crisis point[2].

It is generally accepted that there will be a large increase in demand for health care with commensurate increase in funding required. Governments and most commentators believe that some of the obligations upon the public health system, such as equity of access and the provision of services in regional and remote locations need to be achieved to a much higher level[3]. All of these contribute toward the overall structure and performance of public hospitals who do not exist or are structured to provide services solely on a cost driven or motivated basis.

Private hospitals are able to determine or limit their services and activities around major metropolitan centres for example (as noted in the Discussion Draft). The public health system simply cannot. Public hospitals are unable to ration or determine demand upon its services. So over the last decade when demands upon emergency department care have increased significantly, the public health system has not been able to ignore or 'ration' its services in this area[4].

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1 *Review of the Financial Aspects of the Ambulance Service of NSW*, Independent Pricing and Regulatory Tribunal of NSW, November 2005, pp 8 *("... lack of access to alternative services and changes in medical practice that have reduced after-hours General practitioner services")*.

2 See for example the *Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals*, Peter Garling SC, November 2008, Overview pp *2 "NSW Health: On the Brink"*.

3 *A Healthier Future for all Australians, Final Report June 2009*, National Health and Hospitals Reform Commission, Executive Summary, pp 3.

4 For a useful overview on the increase - and reasons - driving the increased demand for emergency department care (and that accordingly of ambulance services) see *Review of the Financial Aspects of the Ambulance Service of NSW*, Independent Pricing and Regulatory Tribunal of NSW, November 2005, pp 8.

Rather it has had to accommodate it directly (with the attendant shift of resources to the task) or alternatively identify and fund alternative methods of addressing community needs in this area.

Members are clear in their views that an increase in any one area upon the public health system must inevitably have a knock on effect on other aspects and service delivery models it provides.

Accordingly this goes some way to raising the question as to whether the public-private hospital sectors are truly comparable.

Comparable but to what extent?

Accordingly members recognised some value in such comparisons and identifying areas of similarity. This did not however mask the concerns expressed as to the considerable differences and inherent variation of obligations across the sectors that inevitably impact on costs, staffing, capital decisions/expenditure etc which would make it exceptionally difficult to truly disaggregate into its component parts - no matter how careful one is in approach.

The Terms of Reference of the Commission for this study specifically refer to a requirement to *"take into account the costs of capital, FBT exemption,* ***and other relevant factors.****"* [our emphasis]

Feedback received certainly believes that reference to *"other relevant factors"* would encapsulate the variety of services and obligations, for example, imposed and expected of the public health sector. Accordingly, quite serious attribution of these should be made and how they consequently impact upon activities, costs and staffing decisions elsewhere within the hospital or sector.

It also suggests a broader scope to the inquiry is required to be undertaken that may take a longer period of consideration or examination. Certainly an exhaustive analysis of the cost and revenue components of the public and private hospital sectors needs to be undertaken, which may require data to go beyond being *"experimental"* and being more robust and reliable. Members noted positively the quite proper caveat applied in the Discussion Draft that data and certain assumptions were derived in a manner that required a degree of circumspection.

Clearly difficulties and risks exist if decision making or policy settings were based on incomplete or inadequate data such as that currently available. The need to develop continuous improvement through a superior system of data capture and reporting is also noted in the Final Report of the National Health and Hospitals Reform Commission[5], which whilst primarily targeted toward clinical data and the better achievement of health outcomes, it must however inevitably impact upon funding issues and costs.

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5 For example, see the summary contained in *A Healthier Future for all Australians, Final Report June 2009*, National Health and Hospitals Reform Commission, Executive Summary, pp 8.

DRAFT FINDING 5.4

FBT liability

Members working in the public hospital and the not-for-profit private hospital sectors expressed some considerable concern as to what conclusions, if any, the Productivity Commission may make in any final considerations. A number of members (employees) in these two sectors have access to benefits that arise from salary packaging and FBT exemptions ('*benefits*'). Some have been reflected in the industrial instrument (award or agreement) governing conditions of employment[6].

Variation in 'uptake'

Anecdotal evidence suggests that there is wide variation in the uptake of *benefits* between different facilities and between professions/award classifications. This variability casts some doubt on any assumption that the use of any capped exemption is the same across the public and not-for-profit private hospitals. Equally it could not be assumed there would be a 'standard' uptake if applied to for-profit hospitals.

Accordingly, there is marked variance in the utilisation of the *benefits* by employees. Therefore any conclusion or assumption or modelling that, for example, all employees do actually access these *benefits* would be incorrect.

NSW public health retains 50% of the benefit

Members believed that the analysis and attribution of the value of the *benefits* fails to take into account a number of pertinent factors. One of these is that in NSW, the public health system 'retains' (some members would suggest confiscate) 50% of the tax saved from salary packaging. Further, as it would appear that the employee also pays the administration fee for salary packaging, it can be argued that the majority benefit from salary packaging by employees is actually returned to the employer ie the NSW public health system.

Without dwelling on the history of the introduction of salary packaging being made available to employees within NSW public hospitals, it would be sufficient to say that the approach of the then NSW Health Administration Corporation was that it would only permit access by employees to salary packaging if it 'shared' the resultant savings. In essence, it was offering '50% of something or 100% of nothing'.

Whilst the majority of members subsequently accepted this proposition and facilitated its inclusion in relevant awards from 1 January 2002, it certainly has impacted upon the total savings accrued by employees and probably on the number of employees who have taken up access to the *benefits*.

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[6] See for example clause 45 in the *Health Employees' Conditions of Employment (State) Award*, one of the applicable industrial instruments in the NSW public health system.

As a result, as participating employees in the NSW public health sector have their savings reduced it should impact upon any calculation as to the reduction of private hospital labour costs by 0.7% (ie it is incorrect).

Does it offer or actually lead to a competitive advantage?

Members pointed to various submissions or reports that tended to contradict the view that these *benefits* create a competitive disadvantage for the for-profit private hospital sector and impacts upon their ability to attract and retain health professionals. Some clearly identified that *"[t]he attraction of better financial rewards and conditions in the private sector has resulted in surgeons and other proceduralists moving increasingly or exclusively to the private sector.*[7]*"*

"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."

This was a point made by a number of members. The capacity to receive higher salary or rewards in the for-profit sector for health professionals was much higher than the earning capacity achievable in public health at various comparable clinical and experience levels. In fact some feedback suggested that the *benefits* were one way to assist public hospitals to retain highly qualified and competent practitioners.

Certainly, such *benefits* may be one important component in assisting public hospitals to attract and retain qualified health professionals at regional and rural health facilities. Vacancies in such areas and increasing demands for a variety of clinical skills have been traditionally difficult to fill. Any changes to these *benefits* may have an unintended consequence of diminishing the obligations on public hospitals to ensure that key services are provided - regardless of geographical location.

As one member indicated:

".... The ability to offer a salary packaging and entertainment cards to benefit recruitment, particularly to rural and remote areas are minimal in the overall scheme of what is available as tempters (salaries and untaxed benefits) in many other competing industries."

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7 *A Healthier Future for all Australians, Final Report June 2009*, National Health and Hospitals Reform Commission, Executive Summary, pp 51.

Investing in the training of future professionals

Further, investment by the public hospital system in providing the clinical training and mentoring environment for future health professionals and practitioners was continually raised by members as an important element (and cost). It provides the proper workplace framework that permits clinical progression and subsequent utilisation of superior skills via initial development years or via the continuing training framework lasting many years for medical officers. This is a cost 'built into' the public hospital system, which however is absolutely essential.

Members also noted that any suggestion that the public hospital system should pay payroll tax (ie the government tax itself) completely overlooks the obligations and societal expectations placed upon the public hospital system that prevents it from making decisions about employment (for example) in the same way that the private sector can.

Finances planned

Many members who currently have opted to access these *benefits*, which from time to time may include contractual commitments such as decisions regarding the salary packaging of a car lease, were anxious that no change would be undertaken that would impact on these contractual arrangements or impact in a negative way on the wages received on a net basis. Such changes for many members - whether working in public hospitals or not-for-profit private hospitals - would have a significant impact that may disturb the labour market in unintended ways.

DRAFT FINDING 6.1

Reiterate previous comments that the current lack of data, or the degree of manipulation that is required to reach some comparable statistics, is an inadequate basis of making any far reaching conclusion or basis of significant change. Existing reporting arrangements may be currently inadequate but clearly these should remain in place and be improved until more appropriate measures are adopted and implemented.

Any changes to systems currently in place, whether these relate to the Medicare surcharge, or to the application of specific taxes or levies, must be evidence-based.

DRAFT FINDING 7.1

Members noted the observation that the private hospital sector had leaner staffing levels (although anecdotal evidence received from some members questioned the accuracy in all situations of this conclusion). Nonetheless, for the reasons outlined previously (and not repeated) staffing levels in the public hospital system is inextricably linked to a whole variety of obligations and outcomes. It is also rejected at this time, for the reasons previously advanced, that this may also be solely due to taxation and salary benefits available to the public and not-for-profit hospital sectors.

DRAFT FINDING 7.2

Members also noted that whilst the Discussion Draft observed that shorter hospital stays were evidenced in the private hospital sector. However, such preliminary conclusions, along with infection rates, must be treated with a considerable degree of circumspection, as properly noted by the Productivity Commission, due to the obligations imposed upon the public hospital sector, and the particular patient profile confronting that sector.