Comments on the Discussion Draft of Public and Private Hospitals

In commenting on the Discussion Draft, may I start by congratulating you on the huge amount of very valuable data presented and the excellent discussion of the difficulties experienced in its interpretation.

I have several concerns, which related to issues of sub acute care, geriatric care, maintenance care and rehabilitation where definitional differences are apparent from state to state and, I believe, between the two sectors. These issues may have important implications for your costing comparisons as well as big policy implications.

Firstly in relation to the data, I have no doubt you have sought to use acute DRG data to get as close comparison as you can between the two sectors. In the public sector, however, the constant complaint about availability of beds to serve pressures from Emergency Departments relates to patients who have not made rapid recovery and, particularly the elderly, are unable to be transferred home or to Nursing Homes, thus occupying expensive acute beds. No doubt these patients get transferred out of the Acute DRG categories and are classified in your data as Maintenance Care in many states (Table 2.6) or in Victoria many reclassified as Geriatric (a huge number in Vic compared with all other states). These numbers are not allowed to interfere with length of stay for acute DRG figures - perhaps reasonably - although their diagnosis on admission would have been so classifiable, but their number must impact on capital cost per patient for the Public System as there are relatively few such patients in the Private Sector (Table 4.3). Most of these in Private Hospitals would be classified in their significantly higher number of Rehabilitation cases (Table 4.3) and probably mostly handled in much cheaper sub-acute facilities of a kind the Public Sector in most States sadly lack on any major scale.

NHHRC has recommended a major investment in Public Sub-Acute facilities to address this problem. My own view is that these might be far batter handled by the Private Sector, and then be used on contract by the public. Nowhere is there any reference which I can find to the development of far cheaper accommodation for Rehabilitation than the Acute Hospitals in the private sector, which are likely to have a cost structure akin to the Private Psychiatric Hospitals which do not need heavy investment in diagnostic facilities and the many other support faculties such as Intensive care etc. Even pharmacy services can be readily outsourced for such facilities and resident medical care may not be essential.

The lack of discussion of provision of services of a kind which should not be blocking high cost beds in the Public Sector is a significant weakness of the Draft as is the possibility that this group of patients may be distorting the assessment of relative capital and service costs.

I do not easily find assessment of the relative costs of Private Psychiatric and rehabilitation facilities on the one hand and Private Acute Care on the other. If you have that data it would be very helpful to get it into the public arena. I believe both for-profit and not-for-profit providers such as Ramsay and Mercy Hospital care respectively have ready access to such data. As Mercy provide good Nursing Home care in facilities which could easily double for Sub-Acute Care with appropriate funding arrangements - some very recently erected in Victoria - their figures of construction costs for this sector could be valuable.

Aged care is a huge area of growth which will impact on both sectors, and any useful data would be welcome in formulating policy.

David Penington