Australian Government
Department of Veterans' Affairs

National Competition Policy Inquiry
Productivity Commission

SUBJECT: PRODUCTIVITY COMMISSION - REVIEW OF NATIONAL COMPETITION POLICY ARRANGEMENTS

Purpose

The Repatriation Commission and the Australian Government Department of Veterans' Affairs (DVA) wish to indicate their interest in the current inquiry into National Competition Policy arrangements.

This paper sets out DVA's role as a purchaser of health care and the significance of initiatives related to National Competition Policy and its instruments in its cost-effective purchasing of those services.

The Repatriation Commission, through the Department of Veterans' Affairs, is a major purchaser of health services which are bought at taxpayers' expense in the order of $4bn per annum (growing closer to $4.5bn in 2004-05). This is equivalent to the health expenditure by the State of Queensland. The Repatriation Commission is also the purchaser of health services for a very significant proportion of Australia's elderly population, with 15 % of Australia's population over the age of 75, and 25 % over the age of 80 being veterans or war widows eligible to have the costs of treatment met by DVA.

The Repatriation Commission believes that DVA health purchasing indicates the benefits of using the tools of competition policy, including competitive neutrality, to facilitate the purchasing of health services for a large group of elderly Australians on terms that serve both the interests of this group and the taxpayer interest. It believes that its experience as a health purchaser is relevant to the Inquiry and it has a strong interest in the deliberations of the Inquiry.

Background - DVA as a purchaser of health services

The Repatriation Commission, through the Australian Government Department of Veterans' Affairs, purchases health services for the veteran treatment population of 330,000 beneficiaries. This treatment populations is broken into two groups - Gold Card holders, where the Commission accepts responsibility for the cost of treatment for all conditions (currently some 273,600 people), and White Card holders, where responsibility is only accepted for specific conditions (currently some 56,100 people). The average age for this treatment population is more than 75.

To ensure that eligible beneficiaries are able to access required treatment, the Commission has contractual arrangements in place for a broad range of health services. Under these arrangements, the Commission purchased $3.967 billion of health services in 2003/04. This can be broken into the following categories:

	Expenditure ($billion)	Episodes/ Items
Public hospital treatment	$0.699	140,708
Private hospital treatment	$0.889	236,528
Medical consultations	$0.660	12,176,273
Allied health consultations	$0.164	3,453,781
Community nursing	$0.061	166,562
Pharmaceuticals	$0.472	14,823,724
Residential care	$0.686	
Veterans home care	$0.076	492,485
Other health care expenses	$0.254	
Total	$3.967	

With this expenditure, the Repatriation Commission is a major purchaser of health services. The Private Health Insurance Administration Council reported that private health insurers purchased $3.302 billion of private hospital services in 2002/03. This incorporates expenditure such as pharmaceuticals, which DVA counts separately from its hospital expenditure, and it indicates that DVA is approximately 25 % of the private hospital market (excluding self-insured patients). Similarly, the total DVA health expenditure of $4 billion sits between the health budget for Queensland, which was $4.3 billion in 2002/03 and the WA health budget of $3 billion in the same period.

Legislation and Policy Environment

Legislation

The Repatriation Commission is empowered to arrange the treatment of eligible persons under Part V of the *Veterans' Entitlement Act 1986.*

Section 84(1) (b) states "The Commission may arrange for the provision of treatment for veterans and other persons eligible to be provided with treatment under Part V at a hospital or other institution in accordance with arrangements referred to in paragraph 89(1) (b) or (c)."

Section 89 (1) states that the Commission may ...
"(b) enter into arrangements with appropriate authority of the Commonwealth, a State or territory for the provision at a hospital or other institution operated by the Commonwealth, the State or the Government of a territory, as the case may be, of care and welfare for persons eligible to be provided with treatment under this Part; and

(c) enter into arrangements with the body (other than an authority referred to in paragraph (b)) operating a hospital or other institution for the provision, at that hospital or institution, of care and welfare for persons eligible to be provided with treatment under this Part."

With the divestment of the Repatriation General Hospitals (RGH), the "Repatriation Private Patient Scheme" was established. The legislative basis for this lies in section 90A of the Act, under which the Commission may determine "Repatriation Private Patient Principles" setting out the circumstances in which treatment is to be provided to beneficiaries as private patients.

(In addition, Section 90 provides for "Treatment Principles", which set out the arrangements for the Repatriation Commission to issue guidelines for the provision of treatment including provision of hospital services.)

Policy **Environment**
In addition to the Veterans' Entitlements Act, DVA exercises its responsibility to purchase hospital services within broader public policy settings. In particular:

• Australian governments for many years have accorded a high status to veterans, strongly supported by public opinion, which underpins a particular set of health eligibilities including the provision of hospital treatment to entitled beneficiaries;

• DVA conducts its approach towards health care for beneficiaries within the broader setting of the Commonwealth and State policies under which health care is delivered; and

• over the past two decades or so a stringent approach has developed towards the financing of all public sector activities. Public agencies are expected to actively pursue value for money and observe efficient resource allocation principles as set out in an array of requirements generally interpreted by central agencies.

The Repatriation Commission has a number of statutory obligations under the Veterans' Entitlements Act including a mandate to purchase cost effective, quality, timely hospital services for veterans. In general, there are three principal objectives to which the purchasing of hospital services has regard:

*the appropriate professional clinical quality and safety of the health service provided;

*the accessibility, timeliness and other non-clinical qualities of the service which are valued by beneficiaries; and

• cost reduction or containment.

The Purchasing of Hospital Services

As indicated above, the purchase of hospital services accounts for more than 40 % of DVA's health expenditure. As the veteran population ages, flexible arrangements are increasingly necessary for the Commission to take account of the changing treatment needs of veterans. This has been a major factor in the changes in the provision of hospital services to veterans over the last fifteen years.

Originally, medical treatment (including hospital care) was provided directly by the Commission through a network of Repatriation Hospitals (RHs). In 1989 the Australian Government decided that the Commission should divest itself of the remaining RHs and integrate them with the State health systems. To facilitate this integration, the Commission and the Australian Government entered ten year Arrangements with four States to incorporate the RHs into their State health systems. The Commission sold a further three RHs and entered into ten year contractual arrangements with those facilities for the provision of treatment for eligible veterans.

With the transfer and sale of former RHs there was a progressive introduction, between 1992 and 1996, of the Repatriation Private Patient Scheme (RPPS). The RPPS provides acute

hospital care for eligible veterans, war widow(er)s and their dependants in local facilities. Under the Scheme, an eligible veteran, war widow(er) or dependant may be admitted directly to a local public hospital, former RH or a contracted Tier 1 Veteran Partnering (VP) private hospital, as a private patient, in a shared ward, with the doctor of his or her choice.

In short, the RPPS has an order of preference for hospital admissions according to three Tiers:

- Tier 1 - all public hospitals, all former RHs and selected VP private hospitals in each State;
- Tier 2 - other contracted private hospitals; and
- Tier 3 - non-contracted private hospitals.

Financial responsibility for hospital and medical treatment in a public hospital, a former RH, a VP private hospital, other contracted hospital or Day Procedure Centre (DPC) is accepted by the Commission with no cost to the entitled veteran. Should a veteran require hospital care, the treating doctor is able to arrange treatment at the nearest suitable facility. Whilst the aim of the RPPS is to use public hospitals, former RHs or VP private hospitals wherever possible, the Scheme provides a safety net of contracted private hospitals and DPCs.

DVA officers, on behalf of the Commission, utilising both National Office and State *Office* personnel, negotiate arrangements for the purchase of hospital services with all State and Territory governments for public hospital services within their jurisdictions, with private hospitals and with DPCs.

A key reform in the Commission's purchasing of hospital services has been the implementation of the Veteran Partnering private hospital initiative that commenced in 1999 through a competitive tendering process. The process of contracting with private hospitals and developing ongoing relationships with the contracted facilities has been through a carefully considered strategy aimed at achieving appropriate local access at cost effective prices. The VP hospitals were selected through a tender process and the rollout of Tier 1 contracts proceeded on a State by State basis and hospital by hospital negotiations, even when these hospital by hospital negotiations were with a group owner/manager, for example the Mayne (now Affinity Health) and Ramsay groups. The Tier 1 contracts are of four years' duration with an option to extend for a further two years. Arrangements with these hospitals have been supplemented by contracting with other selected hospitals on a Tier 2 basis, i.e. financial authorisation (prior approval) being required by the Commission. These contracts are of twelve to eighteen months' duration.

As a part of the evaluation of a hospital's tender to provide hospital services to veterans at a particular price, a detailed analysis of the tender was conducted, including an analysis of the services provided and consequent categorisation of the facility. The most complex facilities that provide intensive care, emergency department services and that offer a wide range of surgical and medical specialties are distinguished from less complex surgical and medical facilities which in turn are distinguished from facilities offering medical, rehabilitation and other sub-acute and non-acute services.

A comparison with like facilities was undertaken to benchmark the facility according to quality, utilisation, range of services, access and cost criteria. This ensured that the Commission was comparing like with like and paying appropriate prices for comparable services. It also enabled the Commission to identify cost drivers and quality issues that vary from region to region and State to State. This enabled the Commission to contract effectively with a particular hospital in a particular locality in a fair and equitable manner.

Comparative Prices and Competitive Neutrality

This comparison of like facilities across the public, private not-for-profit and private for-profit sectors required the development of a methodology that enabled meaningful comparison across these three sectors on a like-for-like basis. To prepare this comparison, DVA assembled a comprehensive set of information on the price and usage of individual hospital services and other related data, for each State and by different types of hospital.

A methodology including the application of Competitive Neutrality (CN) principles was then developed to analyse this information for comparative purposes. CN adjustments seek to take account of the absences of State and Federal taxes on public agencies and provide for maintenance of capital and a rate of return on capital. In addition, in the approach adopted by DVA for these calculations:

- took into account as an offset the costs of the teaching responsibilities and some other additional costs imposed on the public hospital systems; and

- ere applied differentially between the for-profit and the not-for-profit sectors.

On a State-by-State basis, the CN adjustments applied by **DVA** allowed a 10-15 % margin in for-profit institution prices and around a 5 % margin for not-for profit institutions over and above costs in comparable public hospitals in each State. Where States require competitive neutrality adjustments in the "sale" of public hospital services these are similarly taken into account.

A recent review of **DVA** hospital services purchasing by TFG International (report available if required) has questioned this approach and drawn attention to the fact that competitive neutrality requirements of Government agencies only formally applies to their actions on pricing as suppliers. At present the principles assume that pricing as purchasers will seek the lowest available price without regard to institutional arrangements of providers.

In consultation with other relevant Commonwealth agencies, DVA has decided to maintain its current purchasing practice which has the effect of:

- claiming for **DVA** as a purchaser, as far as possible, any taxation or institutional price advantage that not-for-profit or public hospitals have compared with private sector prices; and

- having a neutral impact on broad market structure and practice.

Without these adjustments a focus on cash price alone would, in so far as the market operates, see the balance of **DVA** purchases shift towards not-for-profit and public hospital provision of veteran services.

That said, there are inhibitions to market adjustments. Location and ease of access for veterans are also important considerations in contracting for hospital services. As well, while price is an important consideration for DVA as a purchaser, this price is transparent to treating doctors and veterans as the full cost of the hospital service is met by DVA.

In addition, in practice not-for-profit hospitals have tended to have a history of high cost structures and relatively high prices and are slow to adjust to a market view of "reasonable price" for the services they provide.

Competitive Neutrality Principles

The *Australian Government Competitive Neutrality Guidelines* have identified a number of benefits that can be achieved through the application of Competitive Neutrality.

These benefits include:

- *The adoption of improved business practices by public sector businesses;*
- *Establishing a better basis for resource allocation decisions by business managers;*
- *Improved accountability and transparency;*
- *Improved competitiveness ofAustralia's private sector service provision; and*
- *The unwinding of cross-subsidies in service provision.* (CN Guidelines, p.14)

The Repatriation Commission believes that these are also benefits that it has sought to encourage through an application of the principles of Competitive Neutrality to hospital services negotiations. It encourages an equitable and transparent basis for price determination that recognises the relative differences in cost structures and promotes general industry competitiveness and viability.

It is believed that this broader application of the Guidelines is consistent with, or at least complementary to, the allocative efficiency objectives of CN policy. The principles of CN remain valuable tools in the comparative assessment of relative pricing, albeit tools that should not be used in isolation as the basis for decision making.

The Repatriation Commission notes that the Inquiry is reviewing the implementation of CN principles, particularly their application to a wider range of entities, such as hospitals. As set out above, this is of direct relevance to the Repatriation Commission in its contracting for hospital services.

It should be noted that DVA takes a less structured approach in contracting for other health services. In general, purchase of other health services is at a single "offer" price for each type of service, regardless of whether they are provided by corporate or non-corporate, and private or public entities. This is the case for GP and medical specialist services and is also the case for community nursing services. In many cases the nature of the service is dominated by the labour content and the provider's professional expertise, so elements such as capital costs and institutional overheads can be less material to cost structures. That said it is possible that more fully informed product pricing would allow for these differences.

Examples of single price purchasing can also be seen in other areas of government such as the approach to Commonwealth contracting for employment placement and training services.

It is suggested that any review of competitive neutrality in provision of public sector services and any recognition of the impact of these principles on public sector purchasing of services will need to take account of the circumstances of the "industry" or "service sector" concerned.

Competitive Tension and Hospital Purchasing

The importance of an effective comparative methodology for the evaluation of pricing proposals for hospital services lies in its contribution to DVA's efforts to maintain competitive tension in its purchasing of hospital services. The cost-effective purchasing of these services is dependent in large measure upon the Department's capacity to maintain real competitive tension in the hospital market. In this endeavour, DVA faces a variety of constraints including:

*the limited responsiveness of the market to price signals ; *the

need to preserve veteran access to private hospitals; and

*the limited capacity to respond, at least in the short run, by hospitals already at the margin at profitability or losing money.

Although the DVA treatment population is only about 4 % of the population covered by private hospital insurance, DVA ranks second only to Medibank Private in terms of payments to hospitals for private treatment. This reflects the much higher incidence of hospital care incurred by the aged especially the frail aged.

As a major purchaser of private hospital services, DVA endeavours to ensure that there is equity for all parties through a consideration of the relative costs applying to the various types of hospitals. A failure to do so may give a particular part of the sector an advantage which will reduce competition, impact upon the prices paid and threaten industry viability. This will inhibit DVA's capacity to maintain competitive tension and negotiate cost-effective prices.

The Repatriation Commission and the Review of National Competition Policy Arrangements

In the section of the Issues Paper on unfinished business, questions are asked including:

- Do current processes take appropriate account of adjustment issues?; and
- Is the current public interest test facilitating socially beneficial reform?

The Productivity Commission has indicated in the Issues Paper that it believes that National Competition Policy provides a basis on which reform can be undertaken which benefits the wider community. It also wishes to understand the distributional consequences of competition reform. The Repatriation Commission believes that DVA health purchasing indicates the benefits of using competitive tendering for the purchase of health services including taking explicit account of competitive neutrality principles in the purchase of hospital services. This submission argues that depending on the circumstances of the service sector concerned, such principles can be relevant to the basis of purchase as well as the supply of these services.

For these reasons, the Repatriation Commission has an ongoing interest in the deliberations of the Inquiry and would welcome the opportunity to expand its views during the inquiry process.