PRODUCTIVITY COMMISSION

Private Hospitals in Australia

Commission Research Paper

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The Productivity Commission

The Productivity Commission, an independent Commonwealth agency, is the Government's principal review and advisory body on microeconomic policy and regulation. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

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Foreword

Over the past decade, a number of reports by the Commission and its predecessors have looked at aspects of Australia's health care system. These include: *Exports of Health Services* (IC 1991); *The Pharmaceutical Industry* (IC 1996); *Stocktake of Progress in Microeconomic Reform* (PC 1996); *Private Health Insurance* (IC 1997); and *Productivity Commission Submission to the National Review of Pharmacy* (PC 1999b). The Commission also acts as Secretariat for the Review of Commonwealth/State Service Provision's work on monitoring the performance of health and other government services (SCRCSSP 1999).

This research report on Australia's private hospital industry had its origins in the Commission's private health insurance inquiry. That inquiry raised a range of issues relating to demand for, and the efficiency of, private hospital services; and the nature of contracting between hospitals, health funds and doctors. This report addresses those and other relevant issues.

The primary objectives of the report are informational: to provide a comprehensive overview of the private hospital industry and to detail the key factors affecting its performance. While the report draws attention to a number of related policy issues warranting examination, it does not contain any detailed policy analysis or recommendations.

The report draws extensively on unpublished data contained in the Australian Bureau of Statistic's Private Hospital Expenditure collection and the Department of Health and Aged Care's Casemix Protocol collection. As such, it is likely to be of interest to those in the industry as well as in government. The report has also benefited from information provided in informal discussions between the Commission and government officials and members of the industry. The Commission is grateful to all those organisations and individuals who contributed. Ian Bickerdyke was the primary researcher for the report.

Gary Banks
Chairman

December 1999

Contents

Glossary

Accreditation	Verification by either the Australian Council on Healthcare Standards or the International Standards Organisation that a hospital meets specified quality-related processes and clinical performance requirements.
Acute care hospital	An establishment which provides at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, with round-the-clock qualified nursing and other professional services.
Amendment Act 1995	Abbreviation for the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*. Amongst other things, this Act provides the legislative basis for contracting between hospitals, doctors and health funds through HPPAs, MPPAs and PAs.
Average length of stay (ALOS)	Average number of days spent by individual patients in a particular hospital or group of hospitals.
BOO(T) facility	Facility treating public patients financed, built and run by a private operator in return for patient payments from the State government concerned. Depending on the nature of the particular contract, ownership of the facility may transfer to the State government at the end of the contract period.
Casemix	Describes the mix and types of patients treated by a hospital according to their medical conditions. Casemix is often described with reference to Diagnosis Related Groups (see below).
Clinical revenue profile	Revenue of a hospital segmented according to the hospital's clinical mix of services.
Co-located private hospital	Private hospital sited on the premises of a public hospital to form a joint medical facility or precinct. The two hospitals may sometimes share infrastructure and services.

Compensable patient	Patient whose medical and hospital costs are met by a third party motor vehicle or workers' compensation insurer.
Competitive neutrality	Term used to describe a market outcome in which no individual supplier is advantaged or disadvantaged by government regulations, subsidies, taxation arrangements and the like.
Copayment	Portion of the cost of an insured health service met by the user.
Diagnosis related group (DRG)	Basis for a clinical classification of services provided in hospitals. The criteria for developing groupings are that they are clinically meaningful and involve similar resource use.
DVA patient	War veteran or war widow/widower eligible for free hospital treatment through the Repatriation Private Patient Scheme run and funded by the Department of Veterans Affairs.
Freestanding day hospital (or 'day hospital')	An establishment performing minor operations and other procedures not requiring an overnight stay, which is not part of any private hospital providing overnight care.
For-profit group hospital	A for-profit private hospital whose proprietor owns other private hospitals. Sometimes referred to as 'chain' hospitals.
For-profit independent hospital	A for-profit private hospital whose proprietor does not own any other private hospital. These hospitals are often owned by doctors.
Health insurance fund	Organisation registered under the National Health Act to provide health insurance meeting some or all of the cost of treatment provided to insured private patients in either public or private facilities, as well as contributing to the cost of a range of ancillary medical and dental services provided outside a hospital setting.

HPPA	Hospital Purchaser Provider Agreement. Describes a contractual arrangement between a health fund and a hospital under the provisions of the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*. Where an HPPA is in place, and unless the agreement specifies a pre-determined patient copayment, the hospital must accept the HPPA price as full payment by the fund for the episode of care for eligible contributors.
MPPA	Medical Purchaser Provider Agreement. Describes a contractual arrangement under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* between a health fund and a doctor, covering the provision of medical services to contributors in hospitals. If an MPPA is in place, a health fund is able to pay medical benefits in excess of the Medicare schedule fee, thus allowing for the elimination of out-of-pocket expenses for patients (or limiting them to a pre-determined copayment).
Occupancy rate	Number of patient days provided by a hospital expressed as a percentage of the total number of bed days potentially available in that hospital.
PA	Practitioner Agreement. Describes a contractual arrangement under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* between a hospital and a doctor allowing hospitals to receive payment under HPPAs for medical services provided by the doctor.
Patient revenue	Revenue from patients received by a hospital for accommodation and other fees.
Psychiatric hospital	An establishment devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders.
Other not-for-profit hospital	A not-for-profit private hospital owned by someone other than a religious order or charitable organisation. Bush nursing, community and memorial hospitals account for most of the facilities in this grouping.

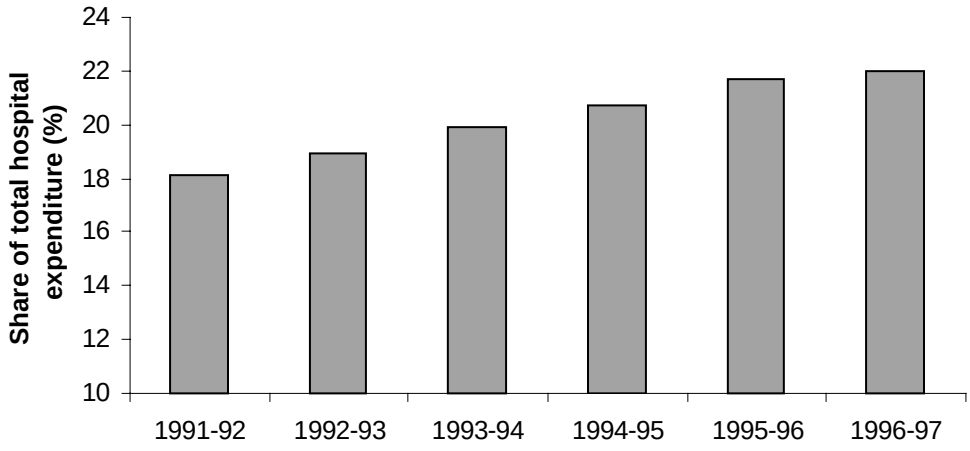
Recoveries	Private hospital income from items such as staff meals and accommodation, facility fees paid by medical practitioners, and patient payments for telephone, TV hire and prostheses. Revenue related to inter-hospital transfers is sometimes included in recoveries.
Religious/ charitable hospital	A not-for-profit private hospital owned and operated by a religious or charitable body. Some of these belong to groups or chains, such as St John of God, Sisters of Mercy or Sisters of Charity. Others operate as independent hospitals.
Self-paying patient	Private hospital patient (or private patient in a public hospital) without private health insurance who meets the full cost of his/her treatment.
Separations	Number of patients treated in a hospital in any particular time period.
Specialised unit	Unit within a hospital providing specialised equipment and back-up staff. Examples include intensive care, coronary care and neo-natal units.

Summary

Private sector involvement in the provision of hospital services takes a number of forms — including the delivery of services to some public patients. However, the treatment of fee-paying patients in 'traditional' private hospitals is by far the most important.

Private hospitals currently provide 30 per cent of acute hospital beds and treat 45 per cent of all surgical patients. Moreover, demand for private hospital services has been growing much faster than demand for public hospital services. Reflecting this, the private hospital share of total expenditure on hospital services increased from 18 per cent in 1991–92 to 22 per cent in 1996–97 (figure 1).

Figure 1 **Growth in private hospital expenditure share, 1991–92 to 1996–97**



Data source: AIHW, Health Expenditure Bulletin No. 15, 1997-98.

Like their public sector counterparts, private hospitals are undergoing some significant structural changes:

- Procedures performed without the need for an overnight hospital stay are accounting for an increasing proportion of activity.
- At the same time, procedures performed on overnight patients are becoming more complex.

- Changes to the relationship between private hospitals and the health funds have increased the pressure on hospitals to deliver their services efficiently.
- Private hospitals are increasingly co-locating with public hospitals to allow for the sharing of facilities and equipment and to provide greater convenience for doctors and patients. These co-locations have had significant ramifications for the viability of smaller, stand-alone, private hospitals.

Yet despite these changes, it is more than a decade since the last major independent study of the 'private hospital industry', undertaken by a Senate Standing Committee.

This report attempts to fill this information gap. Amongst other things, it:

- provides a statistical overview of the industry, drawing on a range of previously unpublished data;
- examines some indicators of the industry's financial performance, efficiency and quality of service (though it does not attempt to benchmark private hospitals against the public hospital system);
- looks at some of the key factors affecting performance; and
- draws attention to some policy issues germane to the industry's future performance. The report does not, however, contain any detailed analysis of these issues or provide policy recommendations.

Structure of the private hospital industry

In 1997–98, there were 317 private acute care and psychiatric hospitals providing treatment to both overnight and day patients and 175 freestanding day facilities. The acute care and psychiatric hospitals are responsible for the large bulk of industry activity, accounting for around 85 per cent of total separations and more than 95 per cent of total industry revenue (table 1).

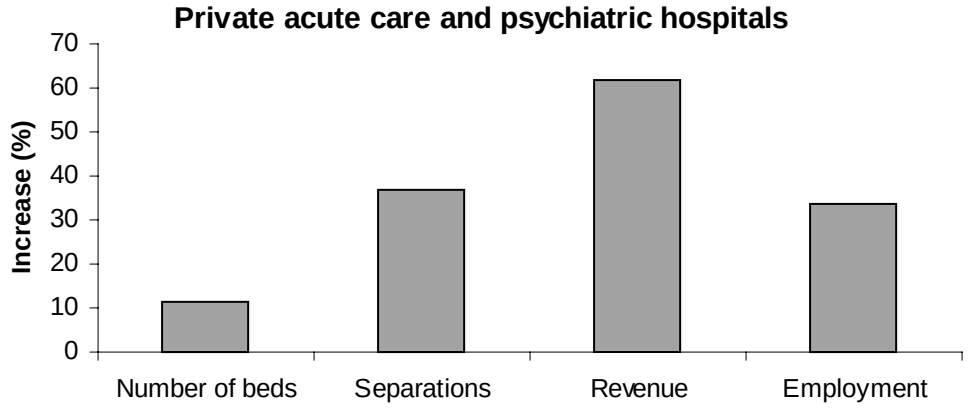
There are four main ownership types in the industry — for-profit group, for-profit independent, religious/charitable, and other not-for-profit hospitals. Together, for-profit group and religious/charitable operators provide around 80 per cent of available beds in private acute care and psychiatric hospitals. Individual hospitals range in size from very small facilities of fewer than 25 beds to major facilities with several hundred beds.

Table 1 **A profile of the private hospital industry, 1997–98**

Acute care and psychiatric hospitals	
Number	317
Number of beds	23 091
Separations ('000)	1585
Revenue ($m)	3517
Employment	41 566
Freestanding day hospitals	
Number	175
Separations ('000)	272
Revenue ($m)	145
Employment	1220

The private hospital industry has grown considerably during the 1990s — available beds in private acute care and psychiatric hospitals have increased by more than 10 per cent, separations have grown by nearly 40 per cent and revenue has risen by more than 60 per cent (figure 2).

Figure 2 **Increase in private hospital activity, 1991–92 to 1997–98**



A feature of this expansion has been an increase in the diversity and complexity of services offered, including the emergence of intensive care, cardiac and oncology units. Such specialised units were once rare outside the public sector.

Another major development has been the strong growth in day procedures, in large part as a result of technological advances that have increased the range of treatments that can be provided without the need for an overnight hospital stay. Between 1991–92 and 1997–98, the number of same day patients treated in private acute care, psychiatric and freestanding day hospitals more than doubled. Indeed, the increase of 400 000 same day patients in acute care and psychiatric hospitals

accounted for virtually all of the growth in total patient numbers in these hospitals over that period.

The market for private hospital services

The markets in which private hospitals compete are not homogeneous. Hospitals offering only general surgery and common specialised services such as obstetrics, tend to compete with other hospitals in the same region. In contrast, the small number of hospitals offering 'super specialties' — such as cardiac procedures — compete for patients from a much broader geographic area.

While such market segmentation is not unusual, the private hospital market is different from many non-hospital markets in two important respects:

- First, in consultation with their patients, doctors make most of the treatment decisions and therefore have a major impact on the demand for a private hospital's services.
- Second, more than three-quarters of private hospital patients have private hospital insurance, with some of the rest receiving treatment as either war veterans or under some form of compensation arrangement. This means that the costs of private hospital treatment are largely determined by negotiations between third parties, rather than by direct interaction between patients and service providers.

Financial performance

Total private hospital revenue in 1997–98 was more than $3.6 billion — a real increase of more than 45 per cent since 1991–92. Most of this growth reflected increased patient numbers in acute care and psychiatric facilities — average patient charges in the acute care sector rose by only about 2 per cent in real terms over the period. In contrast, in the much smaller day hospital sector, a real increase in average patient charges of some 38 per cent magnified the impact on revenue of a large rise in patient numbers (table 2). This significant increase in average charges reflects the increasing sophistication of treatments performed on a same day basis.

Average per patient cost in acute care private hospitals rose by just under 8 per cent in real terms between 1991–92 and 1997–98. Higher non-labour costs — due in part to technological changes — were the major driver of this increase. In day facilities, the real increase in average per patient cost was some 40 per cent over the same period.

Table 2 **Some financial performance indicators for the private hospital industry[a], 1991–92 and 1997–98**

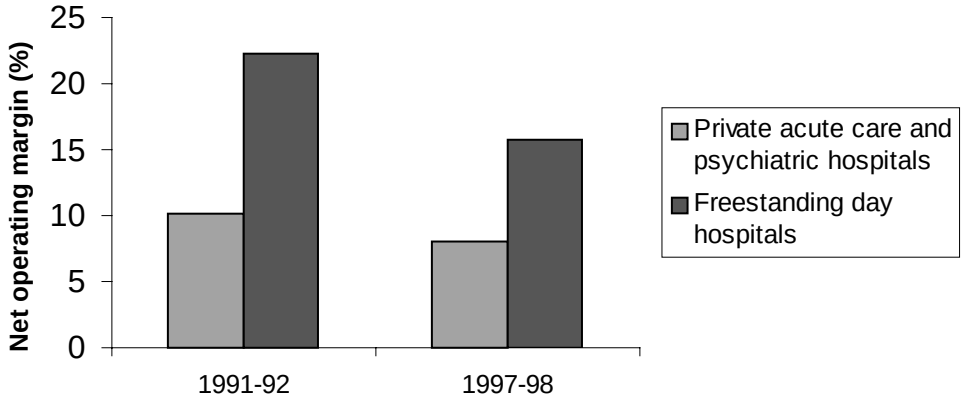
	1991–92	*1997–98*
Acute care and psychiatric hospitals		
Total revenue[b] ($m)	2177	3517
Average revenue per admission (1991–92 dollars)	1881	1979
Average patient charge per admission (1991–92 dollars)	1793	1828
Average recurrent expenditure per admission (1991–92 dollars)	1689	1819
Freestanding day hospitals		
Total revenue[b] ($m)	45	145
Average revenue per admission (1991–92 dollars)	369	477
Average patient charge per admission (1991–92 dollars)	332	457
Average recurrent expenditure per admission (1991–92 dollars)	287	402

a The consumer price index has been used as the deflator in the 1991–92 price equivalent calculations.

b Includes non-patient revenue such as income from investments and donations.

The average net operating margin for acute care and psychiatric hospitals declined from 10.2 per cent in 1991–92 to 8.1 per cent in 1997–98. Profitability in freestanding day facilities declined even more significantly over this period. That said, the average operating margin for day facilities of 15.8 per cent in 1997–98 was still close to double that in the acute care sector (figure 3).

Figure 3 **Private hospital net operating margins[a], 1991–2 and 1997–98**



a Total revenue less total recurrent expenditure as a proportion of total revenue.

Other performance indicators

The efficiency of private hospitals has improved during the 1990s:

- While average costs per separation have increased, when allowance is made for greater patient complexity, unit costs have declined. For example, between 1993–94 and 1996–97, real casemix-adjusted costs per separation in acute care hospitals fell by 3 per cent.
- Average length of patient stay (casemix-adjusted) fell from 4.3 days in 1993–94 to 3.7 days in 1996–97.

There are, however, marked variations in outcomes within the industry. In particular, for-profit group hospitals tend to have the lowest costs and have been mainly responsible for the industry-wide reductions in casemix-adjusted costs.

But considerable caution is required in drawing any conclusions about the relative efficiency of for-profit private hospitals and their not-for-profit counterparts. Observed differences in unit costs could reflect a range of factors other than variations in efficiency. One relevant consideration is service quality, although determining the contribution (if any) of quality differentials to variations in hospital costs is very difficult. Indeed, indicators of the quality and appropriateness of private hospital care are limited, even at the industry-wide level. Nevertheless, one indicator of quality is that nearly 70 per cent of private acute care and psychiatric hospitals are accredited by either the Australian Council on Healthcare Standards or the International Standards Organisation.

Factors influencing private hospital performance

Regulatory requirements

The operation of Medicare, the institutional and funding arrangements for public hospitals and the regulation of the private health insurance sector, all have significant impacts on outcomes in the private hospital industry.

There are also regulations that directly influence the operations of private hospitals. These include:

- State and Territory licensing provisions for private hospitals, which mandate compliance with a range of operational and quality requirements. In most jurisdictions, they also incorporate controls on the number and geographical location of private hospital beds; and
- Commonwealth legislation governing the relationships between private hospitals, doctors and health funds.

These regulations are variously directed at ensuring the provision of safe, high quality private hospital services, promoting equitable access to these services and providing incentives for efficient service delivery.

However, the industry and some commentators have raised concerns about aspects of the regulatory framework.

Contractual relationships

Contractual and other arrangements between private hospitals and doctors and health funds influence outcomes in the industry in a number of ways. For example:

- Arrangements with doctors on such things as terms of access to hospital facilities, and equipment and staffing levels, can have significant ramifications for hospital costs.
- The level of remuneration for treating insured patients which is provided for in contracts with health funds can be crucial to a hospital's financial viability.

In this latter regard, private hospital operators claim that the current contracting framework gives the funds too much negotiating power, which they are using to unfairly reduce rates paid to hospitals.

Determining whether the balance of negotiating power is appropriate is far from easy. While the current contracting framework (introduced in 1995) may well have shifted the balance towards the health funds, the funds still need contracts with sufficient hospitals in each geographic area to offer their members adequate coverage. Thus, the negotiating strength of individual hospitals will depend on the services they provide and the degree of competition they face from other hospitals. More generally, a negotiating framework that allowed hospitals to readily pass on any cost increases to health funds and their members would not be in the interests of the community.

That said, there may be a case for examining some aspects of the current contracting framework. For example, private hospitals (other than those in the same ownership group) are not allowed to share information with other hospitals on the outcomes of rate negotiations with the health funds. While this prohibition may help to preclude collusion between hospitals, it may also impose costs by making it more difficult for hospitals to determine what performance improvements are necessary to secure contracts with the funds.

Demand drivers

While future demand for private hospital services will depend crucially on the regulatory and health policy framework, there will also be some broader influences at work:

- Continued growth in incomes will increase demand for health care, including private hospital services. This is particularly the case given the discretionary component of many private hospital treatments — some may be genuinely optional from a health perspective while, in other cases, treatment at some personal cost in a private hospital is a way of avoiding queues in the public hospital system, or gaining access to a higher standard of accommodation.
- Technological developments will provide new treatment options. Some of these will increase the range of services that private hospitals can offer. Some will improve the safety of treatments and the likelihood of successful outcomes. And some will reduce the time spent in hospital and thereby the cost of treatments. Technological changes are also likely to facilitate an even greater emphasis on day surgery.

A number of commentators have suggested that ageing of the population will be another significant influence on demand for private hospital services into the next century. However, there is evidence that the primary effect of ageing is to delay the onset of high expenditure on health care, rather than to increase its duration. The significant recent growth in per capita health expenditures in the over 65 age group appears to have more to do with the expanded range of treatment options and to income growth, than to ageing as such.

A future policy agenda

As noted, this report does not include detailed policy analysis or contain any policy recommendations.

However, the Commission has briefly explored a number of policy issues that are important to private hospitals and which may warrant closer assessment, including:

- whether it is appropriate for governments to restrict the number of private hospital beds;
- the implications of differences in licensing requirements across jurisdictions and between day hospitals and acute care hospitals;
- a lack of competitive neutrality, both within the private hospital sector — particularly as regards input tax exemptions for not-for-profit hospitals — and between private and public hospitals competing for private patients;

- the efficacy of the legislative framework underpinning agreements between private hospitals and doctors and health funds, including the effects of controls on information sharing by stand-alone hospitals;
- how to improve quality and clinical indicators for hospital services and make more information available to consumers, health funds and other interested parties; and
- the arrangements governing the supply of medical specialists available to work in private (and public) hospitals.

1 Introduction

The private sector's role in the delivery of hospital services takes a number of forms. Apart from the treatment of fee-paying patients in 'traditional' private hospitals, private operators deliver services to some public patients under a variety of contract arrangements with government. And, private contractors provide various clinical and non-clinical services to many public hospitals.

While private sector involvement in the delivery of public patient services is increasing, the treatment of private patients continues to be its most important role. Private hospitals provide 30 per cent of acute hospital beds and account for 45 per cent of all surgical episodes.

Like its public sector counterpart, the 'private hospital industry' is undergoing some significant structural changes. Private hospitals are performing more complex procedures, the importance of day surgery is growing, hospitals' relationships with health funds are changing significantly, and co-located public and private hospitals are becoming increasingly common.

Yet despite these changes, and the importance of private hospitals to Australia's overall health care system, the last major independent study of the industry was more than a decade ago (SSCPHNH 1987). This report presents up-to-date information on the nature and role of the industry.

1.1 Scope of the report

Australia needs a private hospital industry that delivers high quality, cost efficient and appropriate services and that is responsive to its customers needs. The first part of this report looks at how well the industry is performing against these broad criteria.

But it is also important to look forward. Indeed, from a policy perspective, the future development of the industry and the role of government in helping to shape that development are crucial. To this end, the second part of the report looks at some key influences on the private hospital industry's future performance.

However, the report does not contain any detailed analysis of these issues or provide policy recommendations. Rather, it sets out an agenda for further research and analysis and identifies areas where better information is needed to inform policy choices.

In looking at the industry, it is important to recognise that private hospitals are not homogeneous. The size of hospitals, the services they provide and ownership structures vary considerably. And, with increasing contracting out of the financing and operation of public facilities, the distinction between 'public' and 'private' hospitals is becoming blurred. The report draws attention to the implications of differences within the private hospital industry for performance, as well as for future policy arrangements. While the report does not benchmark the performance of private hospitals against that of public hospitals, it draws attention to the inter-relationships between the two hospital systems and the institutional and funding arrangements applying to them.

1.2 Information sources

Each year since the early 1990s, the Australian Bureau of Statistics (ABS) has collected information on the structure and performance of the private hospital industry. The results of this annual survey are published in *Private Hospitals, Australia*.

However, to facilitate a more comprehensive analysis of the industry, the Commission has drawn together a range of previously unpublished data.

- It obtained a large amount of unpublished data from the 1991–92 and 1996–97 ABS surveys. These data cover such things as staffing, costs and revenues, patient characteristics and types of treatment. The data differentiate between hospitals according to ownership, size, casemix and the like.
- The Commission also accessed material from the Hospital Casemix Protocol collection maintained by the Commonwealth Department of Health and Aged Care (DHAC). This collection contains data from all the health insurance funds on hospital charges, benefits paid, types of procedures and patient characteristics, for the different types of private hospital.
- One of the major health funds assisted the Commission by augmenting the data supplied to the DHAC.

The Commission supplemented this information with 'desk top' research and interviews with: private hospital owners, managers and staff; the major health funds; Commonwealth and State government officials; industry bodies and

associations; quality accreditation agencies; and academics. The Commission thanks those organisations and individuals who contributed to the report.

1.3 Report outline

As noted above, the first part of the report examines the nature and performance of the private hospital industry:

- Chapter 2 looks at the different forms of private sector involvement in the provision of hospital services, the structure of the 'private hospital industry' and how the industry is evolving over time.
- Chapter 3 discusses the markets for private hospital services. As well as examining differences in the types of services provided and the geographical distribution of private hospitals, it looks at the characteristics of private hospital patients, the doctors providing services to them and the health insurance funds.
- Chapter 4 provides an overview of the industry's financial performance, including information on its revenues, costs and profitability.
- Chapter 5 looks at broader economic and social performance indicators, including cost-efficiency and service quality.

The second part of the report examines some of the key influences on the industry's performance:

- Chapter 6 describes the industry-specific regulatory arrangements, as well as noting some broader health care policies impinging on demand for private hospital services.
- Chapter 7 discusses the nature and implications of the relationships between private hospitals, doctors and the health funds.
- Chapter 8 looks briefly at some of the non-policy influences on future demand for private hospital services, including income growth and distribution, technological change and the ageing of Australia's population.

Drawing on this analysis, the final chapter canvasses a future policy agenda for the private hospital industry.

2 The private hospital industry

This chapter examines the structural characteristics of the private hospital industry, and how these are changing over time.

However, these changes are occurring against a backdrop of broader developments in the private sector's role in the delivery of hospital services. The chapter therefore commences with a brief discussion of that changing role.

2.1 The private sector's role in the delivery of hospital services

Traditionally, private hospitals were primarily involved in the provision of services to fee-paying private patients. The treatment of public patients free of charge was largely the responsibility of public hospitals, which also provided care for a significant number of fee-paying patients.

In recent years, the role of public hospitals in treating private patients has declined significantly — in 1997–98, around 19 per cent of insured separations were in public institutions, compared with 36 per cent in 1993–94 (AIHW, *Australian Hospital Statistics*).

Conversely, governments are looking increasingly to the private sector to help provide public health care services. In keeping with this trend, the private sector's role in the delivery of public hospital services is becoming more important.

A number of factors have contributed to this change, including:

- (self imposed) funding constraints on governments which have limited their capacity to invest in new or expanded public hospital facilities;
- the perception that private involvement will lead to higher quality care and/or better value for money because of sharper efficiency incentives and the scope for private firms to exploit synergies from bundling construction, financing and hospital operations.

For their part, private hospital operators have seen the development of links with the public sector as a way of augmenting demand for their services and skills.

A variety of arrangements now exist that involve a mix of public and private participation in ownership, management, delivery of services and financing of hospitals. The key types of arrangements can be characterised as follows.

Traditional public hospitals

According to the AIHW (1999a) a public hospital is:

> An establishment controlled by State and Territory health authorities which provides acute care. It provides free shared-ward accommodation and treatment by a hospital-appointed doctor. In addition it provides, to those who choose to be private patients, private ward accommodation and/or doctor of choice.

In the limiting case, a public hospital's services would be provided without any private sector involvement.

However, many public hospitals contract out some non-clinical services such as catering, cleaning and information technology support. And, private health care companies supply clinical services such as pathology to some public facilities. Public hospitals contract out services for a variety of reasons, including opportunities to reduce costs, improve service quality and increase flexibility.

Franchised public hospital services

Franchising is an extended form of contracting out. In essence, it involves a state government contracting out the entire management of an existing public hospital to a private health care company. For instance, in 1995, Health Care of Australia (HCOA) leased the Mersey Hospital in the north of Tasmania.

BOOT-type arrangements

BOO and BOOT arrangements extend the franchising approach by introducing private sector financing to the construction and operation of facilities for treating public patients. Under such arrangements, the private sector builds and finances new hospital facilities to treat public patients in return for the right to operate the facilities and receive patient payments from state governments:

- Under a BOO arrangement, the private sector Builds, Owns and Operates a hospital facility. The state government then purchases public hospital services for a specified period of time. When the agreement expires or is terminated, the private company or consortium retains ownership of the facility.

- A BOOT project is the same except that, at the end of the contract period, ownership transfers to the state government.

Some examples of existing BOO and BOOT projects are given in box 2.1. New projects expected to come into operation in the next few years include the Mildura Base Hospital (Victoria) and the Robina Public Hospital (Queensland).

Box 2.1 **Examples of BOO/BOOT hospital projects**

Hawkesbury Hospital, Windsor (BOOT): The hospital functions as a not-for-profit private hospital, with a contract to supply acute care hospital and community health services for public patients for 20 years — after which, the New South Wales Government will assume ownership. The hospital, opened in 1996, has 127 beds. It replaced the old 96 bed Hawkesbury Public Hospital. Only the Uniting and Catholic Churches were invited to tender, with the latter winning the contract. The hospital is operated by the Hawkesbury District Health Service — a wholly owned subsidiary of Catholic Health Care.

Port Macquarie Base Hospital (BOO): This 161 bed hospital is owned and operated by HCOA. Opened in 1994, it provides services for public and private patients. It has a 20 year services agreement with the New South Wales Department of Health for the provision of services to public patients.

Latrobe Regional Hospital (BOO): This 257 bed hospital, which is owned and operated by the Australian Hospital Care Group (AHC), opened in 1998. The Victorian Government is purchasing public patient services from AHC for a 20 year period.

Joondalup (BOO): In April 1996, the Western Australian Government signed a 20 year agreement with HCOA to upgrade the 84 bed Wanneroo Hospital. The contract specifies that HCOA will finance, design, build, occupy and operate an upgraded hospital providing 265 public beds and 70 private beds. The new facility opened in March 1998.

Source: SCRCSSP 1998b

Another variant of this approach is Build, Own, Lease-Back (BOLB). Here, the private sector operator constructs the hospital and leases it back to the public sector which runs the facility. The Mount Gambier hospital in South Australia operates under this sort of arrangement.

Joint delivery of public and private hospital services by religious groups

Under arrangements with state and territory governments, more than 20 religious/charitable hospitals, including seven major teaching hospitals, provide about 3000 beds for use by public patients.

As a joint venture between the religious/charitable owners and governments, these arrangements have much in common with BOOT-type facilities:

- the owners finance the construction and operation of these facilities;
- the government pays them for treating public patients;
- there can often be one management structure covering both the public and private components; and
- the two components often share staff.

However, in contrast to a BOOT-type facility, the private hospital component is operated (and licensed) as a separate 'private hospital' within the hospital complex. Thus, costs and accounts are separately maintained.

Traditional private hospitals

The AIHW (1999a) defines private hospitals as:

> Privately owned and operated institutions catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Includes private freestanding day hospital facilities.

Hence, the key characteristics of a private hospital are: private ownership; private management; doctor of choice; and charges for services rendered.

The traditional private hospital grouping includes facilities that the public sector has sold to private owners. Some of these facilities continue to provide some services to governments under contract. Two examples are:

- the Repatriation General Hospital, Hollywood, Western Australia, privatised in 1994; and
- the Repatriation General Hospital, Greenslopes, Queensland, privatised in 1995.

Both were sold as part of a divestment program by the Commonwealth. Access for veterans to these facilities continues through specific Hospital Services Agreements between the Department of Veterans Affairs and the hospitals.

Co-locations

The traditional private hospital group also includes hospitals that are co-located with a public facility to form a joint medical facility or precinct. While there may be some 'sharing' of facilities, the private hospital is not usually involved in the delivery of any public hospital services. Moreover, co-located public and private hospitals operate at arm's length. Indeed, the Commonwealth has guidelines to this effect, which it applies before 'declaring' a co-located private hospital for health insurance purposes (see chapter 6). These are principally designed to reduce the Commonwealth's exposure to cost shifting. This could occur, for example, if services that were formerly provided to public patients in the public hospital — at a state government's expense — are provided, after co-location, by the private hospital (with the Commonwealth incurring some of the expense for the medical services involved).

Co-location was rare in Australia a decade ago, but has gained popularity since the mid 1990s, particularly in New South Wales and Victoria (see table 2.1).

The growth in co-locations reflects complementarities and economies of scope in the provision of public and private hospital services:

- Co-locations may reduce duplication of services and facilities and allow for some sharing of costs.
- Co-locations may help the public sector retain and/or attract medical specialists, by providing them with convenient access to private patients. As well as contributing to the quality of patient care, this may increase the viability of teaching services, allow public hospitals to install better technology and assist in nursing recruitment.
- Apart from greater convenience in accessing their private patients, co-locations offer medical specialists a back-up service in the public hospital in the event of complications in treating those patients. Moreover, specialists may prefer to work in conditions that enable them to interact with their peers and to have access to a wider range of cases.
- Access to a wider range of specialists and the security of a back-up service in the public facility will, in turn, assist the private hospital to attract patients.

That said, co-locations can have downsides. Some free-standing hospitals have claimed that the relationships between co-located private and public hospitals may breach competitive neutrality principles (see chapter 7). Further, while co-locations may be financially advantageous for state governments, the magnitude of the benefit is likely to be reduced by some loss of private patient revenue in the co-

located public facility. And, as noted above, co-locations give rise to potential cost shifting problems.

Table 2.1 **Some examples of recent hospital co-locations**

Name of private hospital	*Opening Date*	*Approved Beds*	*Owner*	*Name of co-located public hospital*
New South Wales				
Armidale Private, Armidale	1998	32	HCOA	New England Regional
North Shore Private, Sydney	1998	164	Ramsay	Royal North Shore
Prince of Wales Private, Sydney	1997	168	HCOA	Prince of Wales
Southern Highlands Private, Bowral	1996	64	Alpha	Bowral and District
St. George Private, Sydney[a]	1995	206	HCOA	St George
Victoria				
Coonara Private, Melbourne	1988	34	Coonara Private	Alfred
Frances Perry House, Melbourne	1998	55	HCOA	Royal Women's Hospital
Geelong Private, Geelong	1998	61	HCOA	Geelong
Melbourne Private, Melbourne	1995	120	HCOA	Royal Melbourne
Queensland				
Caboolture Private, Caboolture	1999	44	HCOA	Caboolture
South Australia				
Flinders Private, Adelaide	1999	100	Ramsay	Flinders Medical Centre
Northern Yorke Private	1995	10	Northern Yorke Private	Wallaroo
Western Australia				
Peel Health Campus, Mandurah	1997	20	Health Solutions International	Mandurah District
ACT				
National Capital Private	1998	110	HCOA	Canberra

a St George Private is located adjacent to the public hospital, but is not a co-location in the strict sense.

Source: DHAC Personal Communication.

2.2 Defining the private hospital industry for this study

As noted above, the key distinguishing features of a 'private hospital' are that: it is privately owned and managed; it charges for services rendered; and it offers patients the choice of doctor. These features are used to define private hospitals for the purposes of this report.

Under this definition, the following types of hospitals collectively comprise the private hospital industry:

- privately owned and operated hospitals (acute care, psychiatric and day) that charge patients fees for accommodation and other services. (This group includes facilities co-located with public hospitals and formerly government-owned facilities sold to the private sector);
- the private hospital component of religious/charitable hospitals; and
- the private hospital component of BOOT-type facilities such as Hawkesbury, Port Macquarie and Joondalup, where the public and private components are owned and managed by the same operator.

This definition is the same as that employed by the ABS and the Commonwealth Department of Health and Aged Care from whom the bulk of data used in this report is sourced. And, with the exception of BOOT-type facilities, the definition also coincides with the types of institutions licensed as private acute care or psychiatric hospitals by state/territory governments, plus freestanding day hospitals approved by the Commonwealth. (BOOT-type facilities providing services to both public and private patients are regarded by state governments as part of their public health care systems.)

2.3 Industry structure and activity

This section describes the structure and activity of the private hospital industry on an Australia-wide basis. (Industry data classified by state are provided in appendix B). All of the data in this section comes from the ABS Private Hospitals collection. Most of the tables are current to 1997–98. However, in those tables relying on unpublished data from the collection, the latest year is 1996–97. This is also true of the ABS data reported in subsequent chapters.

Number of hospitals

In 1997–98, there were 492 private hospitals in Australia. Of these, 294 were acute care hospitals and 23 psychiatric hospitals. These hospitals are the principal focus of this report. The remaining 175 hospitals were freestanding day facilities.

Acute care and psychiatric hospitals

The number of acute care and psychiatric hospitals operating in 1997–98 was virtually the same as in 1991–92.

However, the number of beds, separations, patient days and revenue all grew significantly over this period (table 2.2). The principal measure of industry output — hospital separations — increased by some 37 per cent, while revenue grew by more than 60 per cent. The increase in activity was accompanied by a one-third rise in employment.

Table 2.2 **Private hospital industry data, 1991–92 and 1997–98**

	1991–92	*1997–98*	*percentage change*
Hospitals[a] (no.)	319	317	– 0.6
Available beds[b] (no.)	20 745	23 091	11.3
Separations ('000)	1157	1585	37.0
Patient days ('000)	4891	5859	19.8
Revenue ($m)	2177	3517	61.6
Employment (no.)	31 097	41 566	33.7

a Private acute care and psychiatric hospitals.

b Average for the year.

Source: ABS Private Hospitals 1991–92, 1997–98.

Private hospital services are concentrated in the major population centres. In 1997–98, nearly two-thirds of private hospitals and 73 per cent of private hospital beds were located in the capital cities. In per capita terms, there were 1.44 and 0.91 private acute care and psychiatric beds per 1000 population in capital cities and other areas, respectively.

Freestanding day hospitals

New technologies are increasing the number of treatments that can be provided on a same day basis. As a consequence, there has been significant growth in the number of freestanding day hospitals during the 1990s. Between 1991–92 and 1997–98, the number more than doubled (from 72 to 175), with a further increase to 186 in February 1999 (DHAC, personal communication).

However, despite this growth in numbers, day hospitals still account for a relatively small share of activity in the industry. For example, while representing around 35 per cent of private hospital establishments in 1997–98, they accounted for less than 15 per cent of separations and less than 4 per cent of industry revenue in that year.

Size of private hospitals

The average size of private hospitals has increased in recent years. Thus, while the total number of acute care and psychiatric hospitals remained virtually the same

between 1991–92 and 1997–98, there was an 11 per cent increase in the available number of beds, with the average hospital size increasing from 65 to 73 beds. These increases mainly reflected the addition of a number of new large hospitals (over 100 beds) and the exit of some smaller hospitals (table 2.3).

Table 2.3 **Number of private hospitals[a] and available beds, by hospital size, 1991–92 and 1996–97**

Hospital size	*1991–92*		*1996–97*		
	Hospitals	*Beds*	*Hospitals*	*(1997–98)*	*Beds*
0–25 beds	68	1 056	67	(66)	985
26–50 beds	100	3 787	90	(87)	3 476
51–100 beds	98	7 096	96	(95)	7 027
101–200 beds	40	5 359	49	(52)	6 837
Over 200 beds	13	3 447	17	(17)	4 641
Total	319	20 745	319	(317)	22 966

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals 1991–92, 1997–98, and unpublished ABS data.

The increased number of larger hospitals is reflected in a significant increase in their activity and market share. For example, in 1997–98, private hospitals with over 100 beds accounted for 58 per cent of industry separations, up from 48 per cent in 1991–92 (table 2.4). This increase came at the expense of hospitals with 25–100 beds. The smallest private hospitals — up to 25 beds — increased their separations by nearly 50 per cent, and maintained their market share.

Ownership of private hospitals

There are two broad ownership categories for private hospitals:

- 'for-profit' facilities. This group can be further sub-divided into group/chain hospitals and independents; and
- 'not-for-profit' facilities, operated by religious/charitable organisations or other not-for-profit entities.

In 1997–98, there were 180 for-profit and 137 not-for-profit private acute care and psychiatric hospitals in Australia. These numbers were little different from those in 1991–92.

However, within the for-profit group, the number of group hospitals has increased during the 1990s, and the number of independents declined (table 2.5).

Table 2.4 **Patient days and separations, by private hospital[a] size, 1991–92 and 1997–98**

	1991–92			*1997–98*		
	Patient days	*Separations*	*Share of separations*	*Patient days*	*Separations*	*Share of separations*
	('000)	('000)	%	('000)	('000)	%
0–25 beds	244	29	3	191	43	3
26–50 beds	799	165	14	710	186	12
51–100 beds	1 534	404	35	1 561	436	28
101–200 beds	1 354	337	29	1 986	573	36
Over 200 beds	960	222	19	1 410	347	22
Total	4 891	1 157	100	5 859	1 585	100

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals 1991–92, 1997–98.

Table 2.5 **Number of private hospitals[a] and available beds, by hospital ownership, 1991–92 and 1996–97**

	1991–92			*1996–97*		
	Hospitals	*Beds*	*Average bed size*	*Hospitals*	*Beds*	*Average bed size*
For-profit group	114	7 217	63	120	9 516	79
For-profit independent	62	2 838	46	57	2 248	39
Religious/ charitable	75	8 138	109	75	8 825	118
Other not-for-profit	68	2 552	38	67	2 377	35
Total	319	20 745	65	319	22 966	72

a Private acute care and psychiatric hospitals.

Source: Unpublished ABS data.

Increases in the average size of for-profit group hospitals have been largely responsible for the overall increase in average hospital size during the 1990s. That said, religious/charitable hospitals are, on average, still considerably larger than hospitals in the other ownership categories (table 2.5).

As would be expected, the increase in the numbers and size of for-profit group hospitals has been accompanied by a rise in their share of patient separations.

Indeed, by 1996-97, the market share of the for-profit groups rivalled that of religious/charitable hospitals at a little over 40 per cent (table 2.6).

Table 2.6 **Patient days and separations, by private hospital[a] ownership, 1991–92 and 1996–97**

	1991–92			*1996–97*		
	Patient days	*Separations*	*Share of separations*	*Patient days*	*Separations*	*Share of separations*
	('000)	('000)	%	('000)	('000)	%
For-profit group	1 588	410	35	2 393	639	42
For-profit independent	617	143	12	500	127	8
Religious/ charitable	2 101	470	41	2 379	628	41
Other not-for-profit	585	133	12	582	144	9
Total	4 891	1 157	100	5 854	1 539	100

a Private acute care and psychiatric hospitals.

Source: Unpublished ABS data.

Private hospital services and procedures

A feature of the expansion of the private hospital industry during the 1990s has been an increase in the diversity and complexity of services offered. This has seen more widespread availability of specialised facilities such as intensive care, cardiac, neurological and oncology units (table 2.7).

The principal procedures undertaken in private acute care hospitals in 1997–98 were operations on:

- the digestive system (20 per cent);
- the musculoskeletal system (13 per cent);
- the nose, mouth and pharynx (7 per cent);
- female genital organs (7 per cent); and
- the cardiovascular system (7 per cent).

Table 2.7 **Private hospitals[a] with specialised units[b], 1991–92 and 1997–98**

	1991–92	*1997–98*	*Growth (per cent)*
Special care			
Neonatal ICU	20	60	200
Separate ICU	11	30	173
Separate CCU	3	21	600
Combined ICU/CCU	17	33	94
High dependency unit	64	83	30
Other			
Cardiac surgery unit	4	15	275
Neurosurgical unit	1	7	600
Oncology unit	8	36	350

a Private acute care and psychiatric hospitals.

b Only a selection of specialised unit types reported in the ABS data are shown in the table.

Source: ABS Private Hospitals 1991–92, 1997–98.

By far the fastest growth in procedures performed in private acute care hospitals has been in cardiovascular operations which have more than trebled during the 1990s. Other procedures which have grown significantly faster than total separations include digestive, respiratory and nervous system procedures and obstetrics. Further information on procedures in private hospitals is contained in chapters 3 and 7 and appendices A and B.

Another significant development has been the growth of same day stays. This has partly reflected the increase in separations in freestanding day facilities from a little over 120 000 in 1991–92 to more than 270 000 in 1997–98. More than 55 per cent of separations in day hospitals involve either digestive system or eye procedures.

But even more significant has been the growth in same day separations in private acute care (and psychiatric) hospitals. Between 1991–92 and 1997–98, the proportion of same day patient separations in these hospitals increased from 27 to 45 per cent (table 2.8). Indeed, the increase in same day separations accounted for most of the overall growth in demand for private hospital services — overnight stays in private hospitals increased by only 3 per cent over this period. The large difference in growth rates primarily reflects the previously noted technological improvements that allow many procedures that used to require overnight stays to be undertaken as day procedures.

Table 2.8 **Patient classification by procedure or treatment, private hospitals [a], 1991–92 and 1997–98**

Patient category	*1991–92*			*1997–98*		
	Hospitals	*Separations*	*Share of separations*	*Hospitals*	*Separations*	*Share of separations*
	no.	('000)	%	no.	('000)	%
Overnight patients	*319*	*846*	*73*	*317*	*872*	*55*
Advanced surgery	197	85	7	212	131	8
Surgery	222	357	31	228	314	20
Medical and minor surgery	291	321	28	285	329	21
Obstetrics	111	57	5	119	63	4
Psychiatric	36	18	2	40	20	1
Rehabilitation	27	6	1	37	14	1
Same day patients	*159*	*311*	*27*	*285*	*713*	*45*
All patients	*319*	*1 157*	*100*	*317*	*1 585*	*100*

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals 1991–92, 1997–98.

2.4 Mergers and hospital diversification

Mergers and the diversification of hospital activities, particularly by group hospitals, are also contributing to the changing nature of the private hospital industry. These developments are outlined briefly below.

Mergers and partnerships

Mergers and partnerships offer a number of potential advantages to participating hospitals. For example, such arrangements may:

- create a wider base of activity over which to spread overheads;
- improve bargaining power when dealing with health funds. (As discussed in chapter 3, payments by the funds are the dominant source of revenue for most private hospitals);
- be more attractive for doctors, in turn potentially increasing the range of services available; and

- provide an opportunity to increase the average casemix complexity of the hospital's procedures. As discussed later in the report, hospitals indicated that complex procedures are more profitable than less complex ones.

Reflecting these advantages, there have been several recent merger and partnership type arrangements. For example, in 1998, the Sisters of Mercy combined with the Sisters of Charity in Melbourne to merge Mercy Private and St Vincent's Private.

Diversification

Some of the for-profit groups have broadened their operations to include other health related activities. HCOA and Alpha have been the most active players in this regard, acquiring a range of health care services, including GP services and diagnostic services, such as pathology and radiology. Amongst other things, such diversification may make hospital groups less dependent on the outcomes of contract negotiations with the health insurance funds.

Other hospital groups have sought to strengthen their market position by diversifying their patient base. One example is Ramsay's contract with the Department of Veterans Affairs to treat war veterans.

At the individual hospital level, one facility told the Commission that, in response to increased competition from other hospitals, it had introduced an emergency department. While this emergency department is unlikely to be profitable in its own right, the hospital said that it provides a significant flow of patients to other parts of the facility — approximately one in four emergency admissions at the hospital are subsequently admitted as patients and 27 per cent of all bed days now originate from the emergency department.

3 The market for private hospital services

This chapter describes the market in which private hospitals operate (section 3.1) and profiles the other key market participants — patients, health funds and doctors (section 3.2).

3.1 Market definition

In looking at the market for private hospital services, two important features are the nature of the activities (or the 'products' sold) and the geographic distribution of those activities. These aspects are considered below.

It is also important to recognise that private hospitals face competition from the public hospital system. For example, around 19 per cent of insured private patients receive their treatment in public hospitals, (although whether many of these patients are potential private hospitals customers has been the subject of debate — see chapter 7). More generally, demand for private hospital services is influenced by the availability of free treatment in public hospitals, including for those with private health insurance who elect to be treated as public patients.

Product markets

Hospitals provide the infrastructure that allows doctors to treat patients. This includes human resources — particularly nursing staff — as well as beds, theatres, equipment and other facilities.

However, hospitals are not homogeneous institutions — the 'infrastructure packages' available to doctors and their patients are typically tailored to meet specific doctor/patient requirements.

Thus, while many private hospitals have the capacity to provide sophisticated surgical procedures as well as basic medical treatments, in practice, the facilities and services offered vary significantly. Indeed, many private hospitals target niche markets using specialised equipment and back-up staff to differentiate their

services. Table 3.1 provides an indication of the various sub-markets in which private acute care hospitals compete.

Table 3.1 **Private acute care hospitals with specialised units[a], by State, 1997–98**

Specialised units	*NSW/ ACT*	*Vic*	*Qld*	*SA/NT*	*WA*	*Tas*	*Aust.*
Intensive care (ICU)	12	6	6	5	1	0	30
Coronary care (CCU)	8	7	2	3	1	0	21
Combined ICU/CCU	11	6	9	0	4	3	33
High dependency	19	32	9	12	6	5	83
Neonatal ICU	16	16	16	4	6	2	60
Cardiac surgery	6	4	4	1	0	0	15
Neurosurgical	3	3	1	0	0	0	7
Specialist paediatric	4	6	11	0	2	1	24
IVF	3	0	2	0	1	1	7
Renal dialysis maintenance	2	4	1	2	1	0	10
Oncology	6	16	8	2	3	1	36

a Only a selection of specialised unit types reported in the ABS data is shown in the table.

Source: ABS Private Hospitals, 1997–98.

Geographic markets

In most jurisdictions, a considerable number of private hospitals offer advanced surgery, surgery, medical, obstetrics and same day services (table 3.2). Less complex surgical procedures and certain same day treatments are also available in freestanding day hospitals. In contrast, the number of private hospitals that cater for psychiatric, rehabilitation and nursing home type patients is far smaller.

However, such data are not, by themselves, a good indicator of competitive pressures in the private hospital market. A patient's choice of hospital is often constrained by geographic considerations. Thus, the ACCC recently observed that private hospitals compete 'in a number of separate geographic markets, the boundaries of which are dependent on the nature of the particular service being considered.' The ACCC went on to argue that:

- For basic private hospital services such as general surgery and common specialised services provided at most hospitals, the geographic market is limited to the local region surrounding a particular hospital. In these cases, convenience for patients — in terms of proximity to family and friends — and for doctors is an important constraint on the geographic limits of the market.

Table 3.2 **Number of private hospitals[a] offering services according to patient classification, by State, 1996–97**

Patient classification	*NSW/ ACT*	*Vic*	*Qld*	*SA/NT*	*WA*	*Tas*	*Aust.*
Overnight patients							
Advanced surgery	66	61	33	26	17	7	210
Surgery	67	70	35	29	23	7	231
Medical[b]	81	91	48	39	24	8	291
Obstetrics	25	36	20	17	12	3	113
Psychiatric	12	8	6	3	5	1	35
Rehabilitation	12	12	3	3	0	2	32
Nursing home type	7	23	16	8	2	1	57
Same day patients	83	88	46	38	25	9	289
Total	89	101	50	42	27	10	319

a Private acute care and psychiatric hospitals.

b Includes minor surgery.

Source: ABS unpublished data.

- Conversely, for 'super-specialised' services — such as complex cardiac procedures — the geographic market appears to be state-wide 'as there are fewer suppliers and patients must travel from regional areas to receive treatment.' (ACCC, 1999b, p. 36)

Further, as noted above, demand for a private hospital's services will also depend on whether potential patients can readily access treatment in nearby public hospitals.

3.2 Market participants

Apart from the hospitals, several other parties are involved in the buying and selling of private hospital services. They include the 'ultimate consumer' — the patient. However, between the hospital and the patient there is always one other participant (the doctor) and usually another (the health fund). Importantly, the hospital deals with doctors and health funds on a regular basis, while it may see individual patients only once or twice in their lifetime.

From a policy perspective, two aspects of this arrangement are particularly significant. First, doctors and health funds both often act as agents for the patient. Second, responsibility for choosing the product — primarily assumed by the doctor — is separate from responsibility for paying for it — primarily the role of the health fund on behalf of its contributors. As discussed in chapter 7, these characteristics have significant implications for the nature and level of competition in the private hospital market and pose a number of challenges for hospitals.

Patients

Various ABS and AIHW data indicate that patients with private health insurance account for around 76 per cent of separations in private acute care and psychiatric hospitals. Self-paying patients (9 per cent), Department of Veterans Affairs (DVA) patients (9 per cent), compensable patients (5 per cent) and eligible public patients (2 per cent) account for the remainder.

Insured patients

Nearly 6 million Australians are covered by private health insurance — or some 30 per cent of the population. Population coverage in individual jurisdictions ranges from 24 per cent in the Northern Territory (which has only one private hospital) to 35 per cent in Western Australia (table 3.3). In 1997–98, there were around 1.2 million insured separations in private acute care and psychiatric hospitals and a further 150 000 insured separations in day facilities (ABS, *Private Hospitals 1997–98*).

Table 3.3 **Membership of health insurance funds, by State and Territory, September 1999**

	NSW[a]	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*NT*	*Aust.*
Number of persons covered ('000)	2113	1416	1023	472	661	158	46	5890
Share of population covered (%)	31.3	29.9	29.0	31.6	35.3	33.6	23.9	30.9

a Includes the ACT.

Source: PHIAC 1999.

Department of Veterans' Affairs patients

The DVA provides free hospital treatment to eligible veterans and war widow/widowers through the Repatriation Private Patient Scheme (RPPS). The scheme provides treatment for eligible beneficiaries as private patients in public hospitals, with a safety net system employing contracted and non-contracted private hospitals.

Unpublished ABS data indicate that, in 1996–97, 275 private hospitals provided services to DVA patients, compared with 193 in 1991–92. There were around 135 000 DVA patient separations in private hospitals in 1997–98 (see appendix A) — a figure expected to increase in the future due, amongst other things, to the ageing of war veterans.

Compensable patients

Compensable patients are those whose hospital treatment is payed for by some form of compensation scheme. Most suffer from workplace or motor vehicle injuries and are covered by workers' compensation and third party motor insurance, respectively. The number of compensable patients treated in private hospitals increased by nearly 30 per cent between 1991–92 and 1997–98 to around 73 000 (see appendix A).

Self–paying patients

As noted above, self-paying patients account for about 9 per cent of private hospital separations in Australia.

However, it is important to recognise that self-paying patients provide less than half of the revenue private hospitals receive directly from patients. As set out in appendix A, copayments made by insured patients account for the bulk of payments by individuals to private hospitals.

Eligible public patients

A small number of public patients currently receive treatment in private hospitals under contract arrangements with state governments. Unpublished ABS data indicate that, in 1996–97, there were around 40 000 such separations in more than 60 private hospitals, compared to around 16 000 separations in 1991–92.

Doctors

In 1997, across Australia, there were nearly 16 000 specialists, or around 86 per 100 000 people. Across jurisdictions, this ratio ranged from 100 in South Australia to 56 in the Northern Territory (table 3.4).

Table 3.4 **Specialists per 100 000 population, by State, 1997**

Specialty category	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*ACT*	*NT*	*Aust.*
Internal medicine	25	24	18	28	20	17	26	16	23
Surgery	15	16	15	19	14	12	15	9	15
Pathology	4	3	4	5	5	4	4	2	4
Other specialties	44	49	39	49	38	37	45	29	44
Total	88	93	75	100	77	69	91	56	86

Source: AIHW 1999b

Categorisation of specialists and levels of availability are sensitive to the taxonomy used. However, in broad terms, most specialists work in 'internal medicine' and in the 'other specialties' category which includes specialties such as anaesthesia, dermatology, ophthalmology, obstetrics, diagnostic radiology and psychiatry. In 1997, less than one-fifth worked in the surgery field.

The supply of specialists is controlled by medical colleges having regard to such things as 'optimal' specialist to population ratios and the availability of teaching positions in hospitals. Specialist to population ratios vary widely across individual specialties — for example, in 1997, there were 5.5 general surgeons, 3.7 orthopaedic surgeons, 0.5 cardiothoracic surgeons and 10.0 anaesthetists per 100 000 population respectively (Commission estimates based on AIHW 1999b). As noted in chapter 9, there has been ongoing debate about the adequacy of the supply of some specialities.

The AIHW data further indicate that in 1997, across Australia, around 3260 specialists worked in private hospitals. They were supported by around 1350 primary care and hospital non-specialist clinicians and some 350 specialists-in-training. Around three-quarters of these specialists and other clinicians worked in capital city hospitals, with less than 7 per cent working in hospitals in small country centres (table 3.5).

Table 3.5 **Clinicians working in private hospitals, by region, 1997**

	Capital city	*Other metropolitan*	*Large rural centre*	*Small rural centre*	*Other rural and remote areas*	*Aust.*
Specialist	2469	276	343	141	33	3262
Specialist-in-training	305	34	7	3	2	351
Primary care	652	113	90	69	74	998
Hospital non-specialist	267	46	23	8	2	346
Total	3693	469	463	221	111	4957

Source: AIHW 1999b.

At the jurisdictional level, Commission estimates based on AIHW data for 1996 suggest that the per capita number of specialists and other clinicians working in private hospitals is much higher in New South Wales than in the other jurisdictions (table 3.6). This is despite the fact that the proportion of the population covered by private health insurance is lower in New South Wales than in a number of the other states and territories.

Table 3.6 **Clinicians working in private hospitals per 100 000 population, by State, 1996**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*ACT*	*NT*	*Aust.*
Specialist	24.3	15.3	11.4	11.7	10.8	16.4	11.7	7.7	16.8
Specialist-in-training	3.1	1.8	1.2	1.2	1.4	1.7	1.0	1.1	2.0
Primary care	10.7	2.4	3.1	3.3	1.8	4.6	3.2	1.1	5.4
Hospital non-specialist	2.6	0.9	2.3	1.2	1.0	3.8	1.3	2.2	1.9
Total	40.6	20.4	18.1	17.4	14.8	26.5	17.2	12.1	26.1

Source: Commission estimates based on AIHW 1998; ABS, Yearbook Australia, 1998.

Health funds

In June 1998, there were 44 registered health funds, of which 28 were open to the public generally and 16 were restricted membership organisations operating as 'closed funds'. All but three operated on a not-for-profit basis.

In June 1998, the five largest health funds accounted for almost three-quarters of hospital insurance membership, with the three largest funds — Medibank Private, MBF and National Mutual Health Insurance (now AXA Health Insurance) — covering over half of all fund members (table 3.7).

Table 3.7 **Membership and market shares of major health funds, hospital insurance, June 1998**

Health Fund	*Membership*	*National market share*	*Cumulative market share*
	('000)	%	%
Medibank Private	756	28	28
MBF	517	19	47
National Mutual	314	12	58
HCF	215	8	66
HBF (WA)	205	8	74
NIB	136	5	79
Other open health funds	386	14	93
Restricted membership health funds	190	7	100
Total	2 719	100	

Source: PHIAC Annual Report 1997–98.

At the state/territory level, concentration is even higher. At June 1997 — the latest data available to the Commission — two health funds covered 70 per cent or more of private health insurance membership in each state, other than in New South Wales where 70 per cent of membership was divided between three funds (table

3.8). This concentration may have implications for rate negotiations between health funds and private hospitals (see chapter 7).

Table 3.8 **Degree of health fund[a] concentration, by State, June 1997**

State	*Largest insurer – percentage of total membership in state*	*Largest two insurers – percentage of total membership in state*	*Largest three insurers — percentage of total membership in state*
NSW[b]	26	49	70
Vic	45	71	86
Qld	55	91	94
SA	53	74	87
WA	73	92	95
Tas	50	80	99
NT	60	100	na

na not applicable

a Open membership health funds only.

b Includes the ACT.

Source: PHIAC Annual Report 1996–97.

Other market participants

State and Commonwealth governments

State and territory governments are responsible for the licensing and regulation of private hospitals. They also influence the industry through their policies in relation to the management of the public hospital system, privatisation of public hospital facilities, contracting of public patients and co-locations.

Commonwealth government legislation similarly has a major influence on the private hospital industry. Notable examples include the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* — which regulates agreements between private hospitals, health funds and doctors — and recent legislation enacted to encourage health fund membership. Commonwealth policies in relation to Medicare and public hospital funding also have important flow-on effects for demand for private hospital services.

Chapter 6 describes the current regulatory requirements of the Commonwealth and state and territory governments, with chapters 7 and 9 pursuing some particular ramifications for the industry.

Quality accreditation agencies

Private hospitals seek accreditation as a quality assurance measure for patients and clinicians. There are currently two competing accreditation schemes in Australia run by:

- the Australian Council on Healthcare Standards; and
- the International Standards Organisation.

The role of accreditation agencies and their impact on the private hospital industry are discussed in chapter 5.

Consumer advocates

While doctors and health funds often act as agents for private hospital patients, there are several consumer groups that represent patients in a general advocacy sense and in helping to resolve particular problems. These include the Australian Consumers' Association, the Consumer Health Forum and the Council on the Ageing — 'an independent consumer organisation representing the interests of all older people'.

4 Financial performance

The financial performance of the private hospital industry has implications for all of the parties involved in the delivery and consumption of private hospital services:

- Satisfactory financial performance is obviously a pre-requisite for private hospitals to survive and prosper.
- The fortunes of hospitals will, in turn, have implications for the quality and range of services available to patients (see chapter 5) and for the access of doctors to private hospital facilities.
- There will also be implications for the capacity of health insurance funds to offer attractive private hospital cover to their members (see chapter 7).

This chapter looks at the two broad drivers of profitability in the sector, namely revenues (section 4.1) and costs (section 4.2), before concluding with an analysis of profitability (section 4.3).

Much of the data in this and subsequent chapters is presented in both 'current' and 1991–92 prices. The Consumer Price Index was used as the deflator in all 1991–92 price equivalent calculations.

4.1 Private hospital revenues

Overall picture

Private hospital revenue consists principally of patient revenue (around 92 per cent of total revenue Australia-wide in 1997–98), with recoveries (5 per cent) and other items (for example, investment income and bequests) making up the balance. Around 70 per cent of total revenue comes from health funds. Other sources of revenue include payments by patients (self-funded treatment and copayments), funding by the Commonwealth for Department of Veterans Affairs (DVA) patients, and payments made by governments and private insurers for compensable patients (see appendix A).

During the 1990s, private hospital revenues have grown strongly:

- In 1997–98, private acute care and psychiatric hospital revenue across Australia was more than $3.5 billion (table 4.1). In real terms, this represented an increase of more than 40 per cent since 1991–92. On a 'per hospital' basis, revenue increased from $6.8 million to $11.1 million over the period.
- The day hospital sector's revenue grew from around $45 million in 1991–92 to $145 million in 1997–98 — an increase of some 190 per cent in real terms.

Table 4.1 **Private hospital revenue[a], 1991–92 and 1997–98**

	1991–92	*1997–98*	*Real change*
	$m	$m	%
Patient revenue	2075	3249	40
Recoveries	45	175	246
Other	58	93	43
Total revenue	2177	3517	44

a Private acute care and psychiatric hospitals. The total revenue figures include non-patient revenue which is excluded from most of the subsequent revenue tables.

Source: ABS Private Hospitals 1997–98.

Strong growth in private hospital revenues occurred in all jurisdictions, with the largest increases reported in Queensland, Tasmania and Western Australia. During the 1990s, New South Wales/ACT has overtaken Victoria as the leading private hospital revenue earner (see appendix tables B.6 and B.7).

Average revenue

There are two common ways of presenting information on hospital revenues: revenue per admission and revenue per patient day. The latter, also known as 'the bed day charge', has to date provided the main basis for rate negotiations between private hospitals and health funds. However, the concern of the funds to limit premium increases has seen them put greater emphasis on episodic, or case, payments as a way of encouraging greater efficiency in the delivery of private hospital services. Hence, revenue per admission (the 'admission' charge) is becoming an increasingly used indicator.

In 1997–98, the average admission charge for private acute care and psychiatric hospitals was around $2 050. This was some 14 per cent higher than the average charge in 1991–92. However, in real terms, the increase was just 2 per cent (table 4.2). Moreover, this increase was entirely due to the rise in average charges by for-profit group hospitals. Average charges by not-for-profit and stand alone for-profit hospitals declined in real terms over the period (appendix table A.14).

In contrast to the very small increase in average admission charges, the average charge per patient day increased in real terms by nearly 17 per cent between 1991–92 and 1997–98 (table 4.3). This difference mainly reflects the significant fall in the average length of patient stay (ALOS) in private hospitals during the 1990s (see chapter 5). This means that non-accommodation charges, such as theatre charges, are spread over fewer days, leading to higher total daily charges.

Table 4.2 **Average admission charges[a], private hospitals[b], 1991–92 to 1997–98**

	Average charge (current prices)	*Average charge (1991–92 prices)*	*Real change on previous year*
	$	$	%
1991–92	1793	1793	
1992–93	1851	1832	2.2
1993–94	1895	1843	0.6
1994–95	1943	1830	-0.7
1995–96	2002	1810	-1.1
1996–97	2054	1832	1.2
1997–98	2049	1828	-0.2
Change: 1991–92 to 1997–98	256	35	2.0

a Patient revenue per separation.

b Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals, various years.

Table 4.3 **Average charges per patient day[a], private hospitals[b], 1991–92 to 1997–98**

	Average charge (current prices)	*Average charge (1991–92 prices)*	*Real change on previous year*
	$	$	%
1991–92	424	424	
1992–93	445	440	3.8
1993–94	458	446	1.4
1994–95	483	455	2.0
1995–96	498	450	-1.1
1996–97	540	482	7.1
1997–98	554	495	2.7
Change: 1991–92 to 1997–98	130	71	16.7

a Patient revenue per bed day.

b Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals, various years.

Average charges in private acute care and psychiatric hospitals are significantly higher than those in freestanding day hospitals. This primarily reflects the more complex procedures performed in acute care hospitals. In 1997–98, the average admission charge in freestanding day hospitals was a little over $500 (table 4.4) — or around a quarter of the average admission charge for acute care and psychiatric hospitals. That said, between 1991–92 and 1997–98, real average admission charges in day hospitals increased by significantly more (38 per cent) than in other private hospitals.

Table 4.4 **Average charges[a], day hospitals, 1991–92 to 1997–98**

	Average charge	*Average charge (1991–92 prices)*	*Real change on previous year*
	$	$	%
1991–92	332	332	
1992–93	391	387	16.7
1993–94	396	385	-0.6
1994–95	436	410	6.7
1995–96	451	408	-0.7
1996–97	499	445	9.2
1997–98	512	457	2.7
Change: 1991–92 to 1997–98	180	125	37.7

a Patient revenue per separation.

Source: ABS Private Hospitals, various years.

Effects of increased hospital usage on revenues

The large difference in the growth in private hospital revenues and admission charges during the 1990s points to the influence of increased hospital usage on the industry's financial performance. Indeed, the Commission estimates that more than 90 per cent of private hospital revenue growth over this period can be attributed to increased admissions (appendix table A.7). (Between 1991–92 and 1997–98, admissions to private acute care and psychiatric hospitals increased by some 37 per cent).

Growth in admissions has also been the major factor underlying revenue growth in most of the individual private hospital ownership and bed size groupings. Only in the 51–100 bed size category have increases in average charges accounted for the majority of total revenue growth (appendix table A.8).

Revenues and the clinical profile of patients

Over 90 per cent of private hospital revenue comes from accommodation and theatre charges, with the remainder coming from charges for intensive care, prostheses and pharmaceuticals (see appendix figure A.1).

The clinical revenue profile of acute care and psychiatric private hospitals has changed in the 1990s (table 4.5). In particular, the revenue share of advanced surgery and same day patients has risen, while that of other forms of surgery has fallen. In the case of advanced surgery, the increase in revenue share has been associated with only a small rise in the share of separations. In contrast, the similar increase in the revenue share for same day patients has been accompanied by a significant increase in the share of separations.

Table 4.5 **Private hospital[a] clinical revenue profile, 1991–92 and 1996–97 (percentage shares)**

	1991–92		*1996–97*	
Patient type[b]	*Revenue share*	*Separations share*	*Revenue share*	*Separations share*
Advanced Surgery	19	7	25	8
Surgery	29	31	25	21
Obstetrics	7	5	6	4
Medical and minor surgery	31	28	24	21
Psychiatric	7	2	5	1
Rehabilitation	2	0.5	3	1
Nursing home type patient	0.1	0.1	0.3	0.1
Same day	6	27	11	44

a Private acute care and psychiatric hospitals.

b Patient classification applying for Medicare and health fund benefit purposes. Patients undergoing the most complex treatment (advanced surgery) generally attract the highest daily accommodation and theatre charges.

Source: Commission estimates based on unpublished ABS data and HCF Charges Survey 1996.

A similar change in revenue profile is evident across the different hospital size and ownership groups. The increase in the revenue share of advanced surgery and day surgery has been strongest in for-profit group hospitals and the smallest hospitals (0 to 25 beds), respectively (appendix tables A.4 and A.5).

A further indication of the contribution of different treatments to private hospital revenues is provided by reference to the leading Diagnosis Related Groups (DRG) revenue episodes. The highest DRG revenue earners are confinement, hip replacements, knee procedures, lens procedures and major affective disorders (appendix table A.3).

Within the day hospital sector, although general surgery and specialist endoscopy have made a significant contribution to the growth in total revenues, their revenue shares have fallen (table 4.6). This has mainly reflected the very strong growth in revenue of facilities included in the 'other' category — such as those specialising in plastic and cosmetic surgery, sleep disorders, fertility and IVF, oncology and dental/oral surgery.

Table 4.6 **Day hospital patient revenue, by type of specialty, 1991–92 and 1997–98**

Specialty	*1991–92*		*1997–98*	
	$000	%	$000	%
General surgery	16 355	40	45 087	32
Specialist endoscopy	12 461	30	28 250	20
Ophthalmic	5 823	14	25 622	18
Other[a]	6 278	15	40 104	29
Total	40 917	100	139 062	100

a 'Other' includes fertility, plastic surgery and sleep disorder clinics.

Source: ABS Private Hospitals, 1991–92, 1997–98.

4.2 Private hospital costs

Overall picture

Over the period 1991–92 to 1997–98, private acute care and psychiatric hospital recurrent expenditure across Australia rose from just under $2 billion to around $3.2 billion, or nearly 50 per cent in real terms (table 4.7). On a 'per hospital' basis, recurrent expenditure increased from $6.1 million to $10.2 million.

Labour costs account for nearly 60 per cent of recurrent costs in the industry. Wages and salaries account for nearly 90 per cent of labour costs, with superannuation (5 per cent); payroll tax (2 per cent); and other on-costs (5 per cent) making up the remainder.

Non-labour costs in 1997–98 comprised: drugs, medical and surgical supplies (33 per cent); depreciation, interest and contract services (31 per cent); administrative expenses (20 per cent); food (5 per cent); repairs and maintenance (5 per cent); and other domestic services (5 per cent).

As is apparent from table 4.7, non-labour costs have grown slightly faster than labour costs during the 1990s, with growth in capital expenditure being slightly

higher again. While the majority of capital expenditure has been for the purchase of land and buildings, the strongest growth in spending has been on medical and computer equipment (table 4.7).

Table 4.7 **Private hospital[a] expenditure, 1991–92 to 1997–98**

	1991–92	*1996–97*	*1997–98*	*Real change 1991-92 to 1997–98*
	$m	$m	$m	%
Recurrent expenditure	1 955	3 088	3 232	47
Labour costs	1 189	1 829	1 900	43
Non-labour costs	766	1 258	1 332	55
Gross capital expenditure	212	307	376	58
Land & buildings	120	166	np	
Computer equipment	6	11	np	
Major medical equipment	31	63	np	
Plant & other equipment	37	53	np	
Other	18	14	np	

np Not published. Components of gross capital expenditure for 1991–92 and 1996–97 come from unpublished ABS data.

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals, various years; unpublished ABS data.

Average costs

In 1997–98, recurrent expenditure per admission (or 'average cost') in private acute care and psychiatric hospitals was about $2 040, a real increase of a little less than 8 per cent from 1991–92 (table 4.8). As noted, over the same period, real average charges increased by 2 per cent (table 4.2).

Reflecting the decline in ALOS during the 1990s, increases in average recurrent expenditure per admission have been significantly lower than the increases in average recurrent expenditure per patient day. The real increase in average daily expenditures of 23 per cent between 1991–92 and 1997–98 (table 4.9), was three times the increase in average expenditure per admission over this period.

In freestanding day hospitals, average recurrent expenditure per admission of $450 in 1997–98 was some 40 per cent higher in real terms than in 1991–92. The general surgery and endoscopy specialties — which account for the bulk of separations — were responsible for most of this increase. Average costs for the 'other specialties' group of procedures declined in real terms over the period.

Table 4.8 **Recurrent expenditure per admission, private hospitals[a], 1991–92 to 1997–98**

	Average cost (current prices)	*Average cost (1991–92 prices)*	*Real change on previous year*
	$	$	%
1991–92	1689	1689	
1992–93	1705	1687	-0.1
1993–94	1780	1731	2.6
1994–95	1859	1751	1.1
1995–96	1944	1758	0.4
1996–97	2006	1789	1.8
1997–98	2039	1819	1.7
Change: 1991–92 to 1997–98	350	130	7.7

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals, various years.

Table 4.9 **Recurrent expenditure per patient day, private hospitals[a], 1991–92 to 1997–98**

	Average cost (current prices)	*Average cost (1991–92 prices)*	*Real change on previous year*
	$	$	%
1991–92	400	400	
1992–93	409	405	1.2
1993–94	430	418	3.3
1994–95	462	435	4.1
1995–96	483	437	0.3
1996–97	527	470	7.7
1997–98	552	492	4.7
Change: 1991–92 to 1997–98	152	92	23.0

a Private acute care and psychiatric hospitals.

Source: ABS Private Hospitals, various years.

Sources of increases in total costs

A decomposition of the annual changes in recurrent expenditure between 1991–92 and 1997–98 into usage and unit cost components shows that greater use of private hospitals has driven the growth in total costs in the 1990s (appendix table A.18). The Commission's estimates indicate that, over this period, nearly 80 per cent of the increase in real recurrent expenditure was attributable to growth in admissions. This proportion, which is only slightly less than the contribution of increased admissions

to growth in private hospital revenues (93 per cent), underscores the impact of demand growth on recent financial outcomes in the industry.

A similar decomposition according to hospital ownership and size shows that, in all bar the 51–100 bed size category, increased usage has been a more important contributor to total cost growth than increases in average costs per admission (appendix table A.19). Indeed, average costs in the for-profit independent and other not-for-profit ownership groups, and the 26–50 and over 200 bed size groups fell between 1991–92 and 1996–97.

Sources of increase in unit costs

Across all private acute care and psychiatric hospitals, increases in non-labour costs have accounted for some two-thirds of the increase in average real costs per admission during the 1990s (appendix table A.20).

However, the experience varies considerably across individual hospital size and ownership groups. For example, real labour costs per separation in religious/charitable hospitals declined between 1991–92 and 1996–97, meaning that higher non-labour costs (or outsourced labour costs) accounted for all of the increase in real unit costs over this period. In contrast, in for-profit group hospitals, higher unit labour costs accounted for nearly two-thirds of the increase in real average costs per admission.

Across the industry as a whole, the fastest growing component of labour costs has been superannuation (up 81 per cent per separation in real terms over the period 1991–92 to 1996–97). In contrast, real wage and salary costs per separation increased in real terms by only about 1 per cent over this period. The fastest growing components of non-labour costs have been contract services and medical and surgical supplies (up 60 and 43 per cent per separation in real terms, respectively, between 1991–92 and 1996–97). (See appendix tables B. 16–19, 34–37).

Changes in complexity

The Industry Commission (1997) noted that part of the increase in private hospital costs reflects the increasing complexity of procedures undertaken. This has necessitated greater use of high technology equipment and more highly qualified (and better paid) nursing staff, as well as higher spending on drugs, medical and surgical supplies.

The impacts of greater casemix complexity on unit treatment costs are likely to be most significant for that group of patients requiring overnight or more extended hospital stays. Based on DHFS casemix data, the Commission estimates that, in 1996–97, the average overnight patient in a private acute care hospital was 17 per cent more costly to treat in real terms than in 1993–94. This was nearly three times the increase of 6 per cent in the average real unit cost of treating all patients (including same day patients) over the same period.

4.3 Profitability

A firm's or sector's profits can be expressed in a number of ways, including as a percentage of turnover, or as a percentage of the asset base. For comparisons of profitability across sectors, the choice of methodology can be critical, with rate of return on asset measures usually being preferred. However, for comparisons of profitability within a sector over time, more flexibility is possible, with the nature of the available data being an important consideration in the choice of methodology.

In this report, the Commission's has reported four measures of profitability in the private hospital industry — dollar margins on a per day and per separation basis, revenue minus operating costs as a percentage of revenue, and revenue minus total costs as a percentage of revenue. The first three should be regarded as only very general indicators of changes in profitability, as they include no capital cost component. Thus, they do not distinguish the impacts of changes in operating efficiency on profitability from, say, the impacts of investment in new revenue generating equipment. In contrast, the last measure incorporates interest costs and depreciation in the cost base and is therefore likely to provide a better indicator of movements in the industry's profitability over time.

Private acute care and psychiatric hospitals

Reflecting the larger increases in patient costs than in patient revenues, the profitability of private acute care and psychiatric hospitals has declined during the 1990s. Specifically, for the industry as a whole, the 'net operating margin' (total revenue minus total recurrent expenditure, divided by total revenue) declined from 10.2 per cent in 1991–92 to 8.1 per cent in 1997–98 (table 4.10). Indeed, in 1997–98, patient revenues only marginally exceeded expenditures (see tables 4.1 and 4.7). Hence, the positive operating margin was largely attributable to recoveries and non-patient revenues such as investment income and bequests.

Table 4.10 **Private hospital[a] profitability, 1991–92 to 1997–98**

Profit indicator	*1991–92*	*1996–97*	*1997–98*	*Real change 1991–92 to 1997–98*
	$	$	$	%
Gross profit[b]				
Per separation	361	365	na	na
Per day	85	96	na	na
Net profit[c]				
Per separation	192	186	180	-16.4
Per day	45	49	49	-2.9
	%	%	%	
Gross operating margin[d]	19.2	16.7	na	
Net operating margin[e]	10.2	8.5	8.1	

na not available.

a Private acute care and psychiatric hospitals.

b Profit on operations before depreciation, interest expenses and payroll tax are deducted.

c Total revenue less total recurrent expenditure.

d Gross profit as a proportion of total revenue.

e Net profit as a proportion of total revenue.

Source: Commission estimates based on ABS Private Hospitals various years and unpublished ABS data.

Profitability and hospital ownership

The decline in profitability at the industry-wide level in the period to 1996–97 reflected the substantial fall in the margins of the religious/charitable and the for-profit independent hospital groups (tables 4.11 and 4.12). In contrast, the average 'net operating margins' of for-profit group and 'other' not-for-profit hospitals increased slightly over this period. In terms of overall financial performance, for-profit group hospitals were the strongest performers. Indeed, even allowing for liability for company tax — which is not reflected in the data — the for-profit group hospitals would still have had a higher average net operating margin in 1996–97 than the other ownership groups. However, it is important to note that a number of individual for-profit group operators have recently reported significant reductions in their profitability.

Profitability and hospital size

Gross dollar operating profits typically increase with hospital size (table 4.13).

Table 4.11 **Private hospital[a] profits, by ownership group, 1996–97**

Profit indicator	*Profit, 1996–97 ($)*				*Real change, 1991–92 to 1996–97 (%)*			
	For-profit group	*For-profit ind.*	*Religious/ charitable*	*Other not-for-profit*	*For-profit group*	*For-profit ind.*	*Religious/ charitable*	*Other not-for-profit*
Gross profit[b]								
Per separation	453	345	303	260	2.0	-23.7	-23.0	-1.8
Per day	121	88	80	64	5.4	-15.8	-9.1	7.0
Net profit[c]								
Per separation	299	141	94	124	15.0	-49.1	-49.5	7.4
Per day	80	36	25	31	18.9	-43.7	-39.7	20.2

a Private acute care and psychiatric hospitals.

b Profit on operations before depreciation, interest expenses and payroll tax are deducted.

c Total revenue less total recurrent expenditure.

Source: Commission estimates based on unpublished ABS data.

Table 4.12 **Private hospital[a] operating margins, by ownership group, 1991–92 and 1996–97 (per cent)**

Profit indicator	*For-profit group*	*For-profit independent*	*Religious/ charitable*	*Other not-for-profit*
1991–92				
Gross operating margin[b]	23.6	23.2	16.5	13.7
Net operating margin[c]	13.8	14.2	7.8	5.9
1996–97				
Gross operating margin[b]	21.2	17.9	12.8	13.9
Net operating margin[c]	14.0	7.3	4.0	6.6

a Private acute care and psychiatric hospitals.

b Gross profit as a proportion of total revenue.

c Net profit as a proportion of total revenue.

Source: Commission estimates based on unpublished ABS data.

However, this may simply reflect greater casemix complexity in larger hospitals. As noted above, greater casemix complexity usually entails higher operating and capital costs per separation. Hence, higher dollar margins will be required to provide comparable rates of return to those achieved by hospitals with a less complex casemix. Significantly, net operating margins have been similar across the various hospital size groupings (other than the 0 to 25 bed group) (table 4.14).

Table 4.14 also indicates that, in keeping with the overall decline in industry profitability, the gross and net operating margins of all bed size groups other than the 0 to 25 category fell between 1991–92 and 1996–97.

Table 4.13 **Private hospital[a] profits, by hospital bed size, 1996–97**

Profit indicator	*Profit, 1996–97 ($)*					*Real change, 1991–92 to 1996–97 (%)*				
	0 to 25	26 to 50	51 to 100	101 to 200	Over 200	0 to 25	26 to 50	51 to 100	101 to 200	Over 200
Gross profit[b]										
Per separation	123	305	371	358	432	7.9	-20.0	-2.8	-14.1	-11.5
Per day	26	78	97	101	108	91.9	-1.9	-3.0	-2.4	-4.2
Net profit[c]										
Per separation	27	147	210	176	214	124.1	-28.0	-7.7	-17.8	-11.6
Per day	6	37	55	50	54	156.1	-13.2	-7.4	-7.1	-3.7

a Private acute care and psychiatric hospitals.

b Profit on operations before depreciation, interest expenses and payroll tax are deducted.

c Total revenue less total recurrent expenditure.

Source: Commission estimates based on unpublished ABS data.

Table 4.14 **Private hospital[a] operating margins, by hospital bed size, 1991–92 and 1996–97 (per cent)**

Profit indicator	0 to 25	26 to 50	51 to 100	101 to 200	Over 200
1991–92					
Gross operating margin[b]	4.3	19.3	20.8	20.6	17.6
Net operating margin[c]	-3.0	10.3	12.4	10.6	8.7
1996–97					
Gross operating margin[b]	7.6	16.7	18.4	16.6	15.8
Net operating margin[c]	1.7	8.1	10.4	8.1	7.9

a Private acute care and psychiatric hospitals.

b Gross profit as a proportion of total revenue.

c Net profit as a proportion of total revenue.

Source: Commission estimates based on unpublished ABS data.

Other factors influencing profitability

The discussion above suggests that ownership (but not hospital size), has an influence on the financial performance of private hospitals. This finding is consistent with some other studies, including a US study by Renn et al (1985)**,** and a study by Jarden Morgan and Archon (JM&A, 1990) for the Australian Health Ministers' Advisory Council.

The Commission also examined a number of other factors that might influence financial outcomes, including average lengths of patient stay and hospital occupancy rates.

The unpublished ABS data reveal that, in 1996–97, private hospitals with an average patient stay of less than three days were more profitable than those with average patient stays of 3 to 6 days. However, the one-quarter of hospitals with an ALOS of over 6 days recorded the highest average net operating margin (12.6 per cent). This latter result is, in turn, consistent with the finding that hospitals treating longer stay non-surgical patients have been more profitable than those treating mainly surgical patients (see below).

The unpublished ABS data further demonstrate an expected link between occupancy rates and profitability. In 1996–97, private hospitals with an occupancy rate of over 75 per cent achieved the highest average net operating margin (10.2 per cent), followed by hospitals with 65–74 per cent occupancy (8.2 per cent) and 50–64 per cent occupancy (5.8 per cent). Hospitals with occupancy rates of less than 50 per cent had an average net operating margin of only 2.9 per cent.

A number of hospital owners consulted during this study also stressed the importance for good financial outcomes of attracting advanced surgery patients.

However, analysis undertaken by the Commission using unpublished ABS data indicates that in 1996–97:

- While surgical hospitals with the largest proportion of advanced surgery patients recorded the highest dollar profit margins for hospitals in that group, their net operating margins were slightly below the industry average.
- The 109 private hospitals with no advanced surgery patients achieved an average net operating margin more than 50 per cent above the industry average.

Moreover, as noted above, net operating margins do not appear to increase with hospital size, despite the fact that larger hospitals tend to have greater average casemix complexity than smaller hospitals. Together, these data suggest that, across the industry as a whole, charges and health fund benefits relative to treatment costs are not skewed in favour of advanced surgery patients.

Profitability of day hospitals

Reflecting the short stay nature of day hospital procedures, profits per separation are generally lower than in private acute care and psychiatric hospitals (table 4.15). The notable exception is day facilities specialising in ophthalmic procedures, where profits per separation are similar to the average for the acute care sector.

As in the acute care sector, average operating margins achieved by day hospitals declined between 1991–92 and 1997–98 (table 4.16). That said, these margins

remained considerably higher than in acute care hospitals. Moreover, there was some variability in profitability outcomes, with day hospitals specialising in ophthalmic procedures increasing their operating margins slightly over this period.

Table 4.15 **Day hospital profits, 1996–97 and 1997–98**

	Profit per separation ($)					*Real change from 1991–92 (%)*				
	Gen. surg.	Endos -copy	Ophth -almic	Other	All day hosp.	Gen. surg.	Endos -copy	Ophth -almic	Other	All day hosp.
Gross profit[a] per separation 1996–97	110	111	323	168	139	11.5	0.0	139.0	-40.5	7.8
Net profit[b] per separation 1996–97	71	89	271	132	105	26.7	0.5	29.3	-37.0	14.2
Net profit[b] per separation 1997–98	48	82	267	81	85	-14.4	-7.4	27.4	-61.4	-7.5

a Profit on operations before depreciation, interest expenses and payroll tax are deducted.

b Total revenue less total recurrent expenditure.

Source: Commission estimates based on ABS Private Hospitals 1996–97, 1997–98 and unpublished ABS data.

Table 4.16 **Day hospital operating margins, 1991–92 to 1997–98 (per cent)**

	General surgery	Endoscopy	Ophthalmic	Other	All day hospitals
1991–92					
Gross operating margin[a]	24.8	37.5	28.9	34.1	31.2
Net operating margin[b]	14.0	30.0	21.4	25.3	22.3
1996–97					
Gross operating margin[a]	21.8	32.2	31.8	23.9	26.3
Net operating margin[b]	14.1	25.9	26.7	18.8	20.0
1997–98					
Gross operating margin[a]	na	na	na	na	na
Net operating margin[b]	10.0	24.3	21.9	12.3	15.8

na Not available.

a Gross profit as a proportion of total revenue.

b Net profit as a proportion of total revenue.

Source: Commission estimates based on ABS Private Hospitals, various years and unpublished ABS data.

5 Broader performance indicators

This chapter looks at some non-financial indicators of private hospital performance, namely:

- hospital efficiency;
- service quality; and
- appropriateness of services provided.

5.1 Hospital efficiency

Typically, hospital outputs are expressed in terms of episodes of care, as measured by separations or patient days. The following sections examine three indicators of how efficiently these outputs are delivered: cost efficiency, labour productivity and average length of stay.

In interpreting the results, it is important to bear in mind a number of broader factors impinging on the delivery of services by private hospitals:

- The input of doctors and health funds to the delivery of services means that hospital operators do not have full, or even significant, control over many outcomes. Thus, for example, hospital efficiency is affected by how long doctors take in theatre.
- While hospital management can vary some costs in the short term, costs related to such things as infrastructure and equipment can only be changed over the longer term.
- The objectives pursued by hospitals differ. For example, not-for-profit hospitals may put less emphasis on reducing costs and increasing surpluses than for-profit hospitals, particularly if there is any suggestion of compromising the quality of care provided.

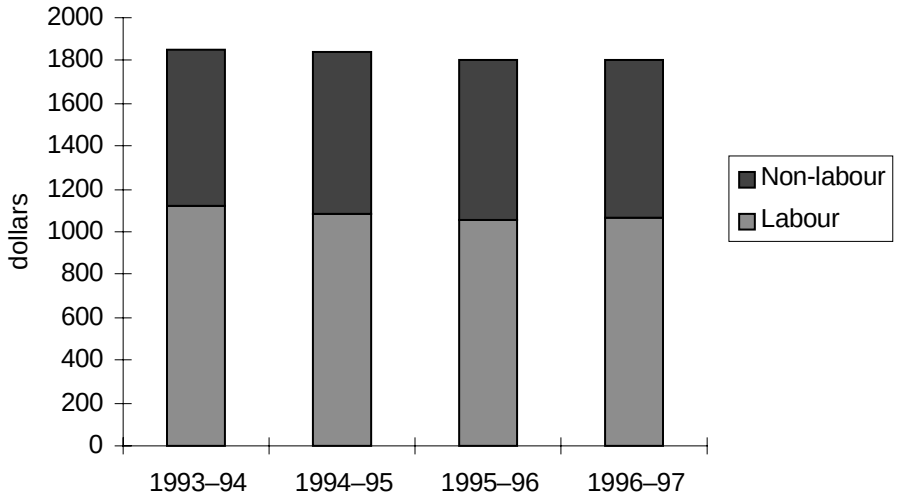
Cost efficiency

Widely varying complexity and severity of patient conditions have a significant impact on the cost of hospital treatments.

Accordingly, to compare the outputs of different hospitals, it is common to use case-weighted data. Average casemix-adjusted (recurrent) cost per separation is often regarded as a good indicator of a hospital's overall cost efficiency.

Figure 5.1 shows the trend in casemix-adjusted costs per separation for all private acute care hospitals between 1993–94 and 1996–97. Over that period, the real average cost per casemix-adjusted separation fell by 3 per cent from around $1850 to about $1800, due mainly to a reduction in unit labour costs of 4.5 per cent.

Figure 5.1 **Real cost per casemix-adjusted separation, private acute care hospitals, 1993–94 to 1996–97**



Source: Commission estimates based on data provided in ABS Private Hospitals 1996–97 and DHFS Australian Casemix Report on Hospital Activity, 1996–97.

Looking at costs per casemix-adjusted separation according to hospital ownership and size (tables 5.1 and 5.2) reveals some differences across the industry:

- Total unit costs in religious/charitable hospitals are considerably higher than for the other ownership groups — 23 per cent above the next most costly group in 1996–97. (However, as discussed below, care is required in interpreting this outcome to mean that religious/charitable hospitals are less efficient.)
- While total costs for the other ownership groups differ little, there is more variation across those groups in individual cost categories. This is particularly the case for non-labour costs.

Table 5.1 **Cost per casemix-adjusted separation, private hospitals[a], by ownership group, 1996–97 ($)**

	For-profit group	*For-profit independent*	*Religious/ charitable*	*Other not-for-profit*	*All hospitals*
Total labour costs	**1021**	**1011**	**1278**	**1113**	**1137**
Nursing staff wages & salaries	578	519	658	617	611
Medical/diagnostic staff salaries	48	71	74	53	61
Admin/clerical staff wages	102	119	140	112	120
Domestic/other staff wages	140	149	215	162	174
Other	43	63	67	47	56
Staff on-costs[b]	110	90	123	123	115
Total non-labour costs	**733**	**763**	**905**	**658**	**801**
Medical & surgical supplies	204	141	202	128	191
Drug supplies	55	54	73	51	62
Administration	150	202	191	123	169
Contract services	107	83	98	91	100
Depreciation and interest	93	162	200	137	148
Other	124	121	141	128	131
Total recurrent hospital costs	**1754**	**1774**	**2183**	**1771**	**1938**

a Private acute care and psychiatric hospitals.

b Excludes payroll tax.

Source: Commission estimates based on unpublished ABS data.

Table 5.2 **Cost per casemix-adjusted separation, private hospitals[a], by hospital size, 1996–97 ($)**

	0–25 beds	*26–50 beds*	*51–100 beds*	*101–200 beds*	*Over 200 beds*	*All hospitals*
Total labour costs	**1087**	**984**	**1043**	**1115**	**1360**	**1137**
Nursing staff wages & salaries	555	506	568	623	704	611
Medical/diagnostic staff salaries	60	41	50	52	91	61
Admin/clerical staff wages	120	112	108	113	148	120
Domestic/other staff wages	159	152	159	166	215	174
Other	88	65	50	50	66	56
Staff on-costs[b]	107	108	108	111	136	115
Total non-labour costs	**598**	**702**	**729**	**818**	**936**	**801**
Medical & surgical supplies	62	137	173	198	245	191
Drug supplies	32	49	51	70	73	62
Administration	172	174	160	175	170	169
Contract services	98	95	93	98	114	100
Depreciation and interest	88	124	122	154	186	148
Other	146	123	130	123	148	131
Total recurrent hospital costs	**1686**	**1686**	**1772**	**1933**	**2296**	**1938**

a Private acute care and psychiatric hospitals.

b Excludes payroll tax.

Source: Commission estimates based on unpublished ABS data.

- Costs per casemix-adjusted separation increase with hospital size. Taken at face value, this might suggest there are diseconomies of scale in service delivery. However, given the nature of the cross tabulations, it is more likely to simply reflect the greater prominence of religious/charitable hospitals in the larger bed size categories. (The Commission did not have access to data on costs for different hospital sizes within particular ownership groups.)
- The very smallest hospitals have relatively high labour costs. However, these are offset by lower non-labour costs.

Labour productivity

As labour accounts for around 60 per cent of recurrent costs, improvements in labour productivity can provide significant savings to hospitals.

One very simple indicator of changes in labour productivity is the change in revenue per employee (RPE). Across the industry as whole, this increased by about 5 per cent in real terms between 1991–92 and 1996–97 (table 5.3). While no correlation between RPE and hospital size was evident, growth in RPE was higher in the not-for-profit sector than in the for-profit sector over this period.

Table 5.3 **Revenue per employee, private hospitals[a], by ownership group and hospital size, 1991–92 and 1996–97**

	1991–92	*1996–97*	*Real change between 1991–92 and 1996–97*
	$000	$000	%
Ownership categories			
For-profit group	80.7	91.9	1.5
For-profit independent	74.4	81.3	-2.7
Religious/charitable	65.0	77.0	5.7
Other not-for-profit	62.4	73.9	5.6
Size categories			
0–25 beds	51.0	65.3	14.2
26–50 beds	69.2	77.6	0.1
51–100 beds	73.9	84.7	2.2
101–200 beds	68.7	83.3	8.1
Over 200 beds	70.7	83.1	4.9
All hospitals	70.0	82.4	5.1

a Private acute care and psychiatric hospitals.

Source: Commission estimates based on unpublished ABS data.

However, care is required in drawing conclusions about movements in labour productivity from changes in RPE. For example:

- Greater casemix complexity may involve proportionately greater non-labour input per separation, leading to higher RPE.
- Similarly, any change in treatment modes that involves replacing labour input with equipment or drugs will lead to higher RPE.

The absence of case-weight data prior to 1993–94, meant that the Commission could not adjust the data in table 5.3 to make an allowance for changes in casemix complexity. Suffice it to say, that the increase in average casemix complexity between 1993–94 and 1996–97, of around 6 per cent for the industry as a whole, exceeded the growth in real RPE over the longer period covered in table 5.3.

Average Length of Stay (ALOS)

The change in the ALOS (adjusted for casemix) is another possible indicator of the efficiency of hospital resource management and treatment protocols. In most countries, ALOS has been falling in both the public and private hospital systems. Amongst other things, this has reflected improved treatment protocols for overnight patients, the substitution of drug treatments for some surgical treatments and increased day admissions. (Chapter 8 discusses some of the technological developments underlying these changes.)

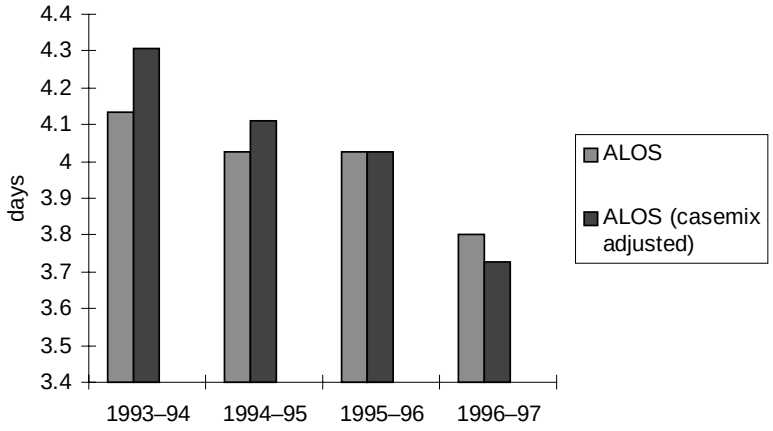
In line with this general trend, both unadjusted and casemix-adjusted ALOS in Australian private hospitals have fallen considerably during the 1990s (figure 5.2). Within the industry, the ALOS for the top 15 DRGs in for-profit group hospitals is on average 5 to 6 per cent lower than for the other ownership groups (table 5.4). Similarly, ALOS in the smallest hospitals is around 10 per cent lower than in the largest hospitals (table 5.5).

Some general caveats on the efficiency indicators

Prima facie, the indicators above suggest that for-profit hospitals, and particularly for-profit group hospitals, are more efficient than their not-for-profit counterparts. Some would argue that this reflects the commercial disciplines on for-profit hospitals to operate efficiently.

However, not-for-profit hospitals also have incentives to provide their services efficiently. For instance, improvements in efficiency could allow a not-for-profit hospital to treat more disadvantaged patients without compromising overall viability, or to provide additional funds for the organisation's other activities. Hence, it is important to look for explanations other than differences in efficiency for the variations across ownership groups in the indicators reported above.

Figure 5.2 **ALOS, private acute care hospitals, 1993–94 to 1996–97**



Source: Commission estimates based on ABS Private Hospitals, 1996–97 and DHFS Australian Casemix Report on Hospital Activity, 1996–97.

Table 5.4 **Average length of stay for top 15 DRGs[a] , private hospitals[b], by ownership group, 1996–97 (days)**

DRG	*For-profit group*	*For-profit independent*	*Religious/ charitable*	*Other not-for-profit*	*All hospitals*
674 Vaginal delivery	5.68	5.90	5.71	5.71	5.73
405 Hip replacement	12.95	14.20	12.71	13.14	12.97
421 Knee procedures	1.51	1.50	1.56	1.59	1.53
099 Lens procedures	1.25	1.29	1.35	1.25	1.30
843 Major affective disorders	8.04	10.31	9.09	9.60	8.69
407 Joint & limb reattachment	11.82	12.13	12.22	12.69	12.22
297 Cardiac intervention	3.49	3.37	4.37	5.40	4.13
656 Uterine, adnexa procedures	4.57	4.48	5.12	4.77	4.80
291 Coronary artery bypass	10.19	9.48	10.05	10.18	10.14
367 Cholecystectomy	3.31	3.31	3.76	3.26	3.51
670 Caesarean delivery	7.34	7.82	7.55	7.70	7.56
274 Circulation disorders	1.57	1.82	1.96	1.58	1.81
320 Hernia procedures	2.54	2.53	2.80	2.57	2.66
335 Colonoscopy	1.23	1.20	1.25	1.21	1.23
332 Gastroscopy	1.22	1.17	1.28	1.24	1.24
Average for top 15 separations	5.11	5.37	5.39	5.46	5.30

a Top 15 DRGs by revenue in private acute care and psychiatric hospitals.

b Private acute care and psychiatric hospitals.

Source: Commission estimates based on DHFS Hospital Casemix Protocol (unpublished data) and unpublished ABS data.

Table 5.5 **Average length of stay for top 15 DRGs[a] , private hospitals[b], by hospital size, 1996–97 (days)**

DRG	*0–50[c] beds*	*51–100 beds*	*101–200 beds*	*Over 200 beds*	*All hospitals*
674 Vaginal delivery	5.27	5.81	5.59	5.90	5.73
405 Hip replacement	12.52	13.43	12.35	13.76	12.97
421 Knee procedures	1.54	1.51	1.51	1.61	1.53
099 Lens procedures	1.21	1.40	1.22	1.31	1.30
843 Major affective disorders	8.81	7.81	9.66	na	8.69
407 Joint & limb reattachment	10.45	12.97	11.62	13.48	12.22
297 Cardiac intervention	na	3.15	4.02	4.33	4.13
656 Uterine, adnexa procedures	4.42	4.66	4.98	4.92	4.80
291 Coronary artery bypass	na	9.97	9.82	10.35	10.14
367 Cholecystectomy	3.18	3.27	3.60	3.88	3.51
670 Caesarean delivery	7.51	7.55	7.28	7.96	7.56
274 Circulation disorders	2.00	1.42	1.87	1.89	1.81
320 Hernia procedures	2.61	2.60	2.61	2.85	2.66
335 Colonoscopy	1.17	1.21	1.23	1.31	1.23
332 Gastroscopy	1.15	1.19	1.26	1.36	1.24
Average for top 15 separations[d]	5.07	5.20	5.24	5.58	5.30

na not applicable.

a Top 15 DRGs by revenue in private acute care and psychiatric hospitals.

b Private acute care and psychiatric hospitals.

c Data for hospitals with 25 beds or less cover very small numbers of separations. Hence, the ALOS for this group essentially reflects outcomes in hospitals with between 26 and 50 beds.

d DRG 297 and DRG 291 were not applicable to hospitals with 0 to 50 beds and so the average for other hospital sizes was used in calculating the top 15 average. ALOS for DRG 843 for hospitals with over 200 beds was unusually high due to a small data sample problem, and so again the average ALOS for other hospital sizes was used in calculating the top 15 average.

Source: Commission estimates based on DHFS Hospital Casemix Protocol (unpublished data) and unpublished ABS data.

In this regard, the cost per separation and ALOS indicators do not pick up differences in the complexity of cases within DRGs. In particular, larger hospitals are likely to treat proportionately more 'complex' cases within individual DRGs than smaller hospitals. As noted, religious/charitable hospitals are considerably larger, on average, than hospitals in the other ownership groups (table 2.5). Larger hospitals may also devote proportionately more resources to non-clinical functions such as teaching and research, leading to higher measured costs per separation.

Further, the cost per separation and ALOS indicators make no allowance for any variations in the quality of service delivered to patients. In this context, not-for-profit hospitals often claim they provide a higher quality service than do for-profit hospitals, which adds to their costs.

Broader influences on efficiency outcomes

Efficiency outcomes in the private hospital industry as a whole reflect a wide range of factors including the regulatory and policy environment (see chapter 6), and the market relationships between the hospitals, doctors and health funds (see chapter 7).

However, at this juncture, it is worth emphasising that changes implemented in the mid 1990s to the framework within which private hospitals and the health funds negotiate, have strengthened the incentives for private hospitals to deliver their services efficiently. These changes have reduced the scope for hospitals to pass on cost increases to health funds and their members. This, in turn, has increased the pressure on hospitals to avoid unnecessary patient stays or the delivery of excess services.

5.2 Quality of care

Quality problems in the delivery of hospital services can arise for a number of reasons (see box 5.1). Clinical quality problems — as distinct from poor quality accommodation and meals — can range from minor errors to serious and life threatening events.

The development of indicators of the quality of hospital services has proven difficult for at least two reasons:

- Determining the impact of hospital treatments on the health status of patients can be problematic, particularly if the assessment attempts to go beyond determining the number of patient misadventures.
- Separating the contribution of doctors and hospitals to misadventures and other unsuccessful treatments can also be difficult. This may have contributed to the reluctance of some hospitals and doctors to embrace transparency in relation to quality outcomes.

Quality in the hospital sector is currently monitored using a suite of methods including:

- process indicators that monitor the internal procedures hospitals follow in providing treatment to their patients. This is the basis for the quality accreditation regime applying in the sector (see below);
- clinical performance indicators that record hospital misadventures; and
- indicators of client satisfaction measured via patient surveys. Some hospitals have extended this approach to include follow up checks on patient's health outcomes after their hospital stay.

Box 5.1 **Sources of clinical quality problems in hospitals**

Most of the serious clinical quality problems in hospitals are the result of human error. This is sometimes due to acts of commission by doctors or other health care workers (doing the wrong thing, or the right thing at the wrong time) but, just as often, due to acts of omission (failing to act when action would have helped). According to Wilson et al 1999, the most common errors of omission are failing to review all the available information when making a diagnosis and not organising tests or operations when they would help.

Wilson et al contend that there are four broad factors contributing to mistakes in diagnosis:

- Some doctors are more likely to make mistakes, due to inexperience, poor judgment, failure to keep up with new medical developments and the like.
- Some patients — for example, the very young or old — are unable to effectively communicate with doctors and hospital staff.
- The work environment may be poor, so that the results of completed tests or patient records are unavailable when required.
- The hospital culture may contribute to faulty diagnosis — for example, poor communication between doctors can be a barrier to second opinions.

Some of these contributing factors are beyond the control of hospital management. And, their relative significance may vary between the public and private systems.

Another possible quality indicator is the volume of staff resources devoted to patient care. In this regard, not-for-profit hospitals often point out that they employ considerably more staff per patient than for-profit hospitals. For example, in 1996–97, religious/charitable hospitals had in the order of 15 per cent more nursing and 30 per cent more total staff per patient than for-profit group hospitals (see appendix table B.23).

But while greater staff to patient ratios may facilitate a better service to patients, they may equally reflect inefficiency in service delivery. Thus, this particular indicator is not pursued further below.

Quality accreditation

The level of quality accreditation of private hospitals by external agencies provides one broad indicator of quality in the industry.

Two organisations offer quality accreditation to Australian hospitals:

- The Australian Council on Healthcare Standards (ACHS) operates the Evaluation and Quality Improvement Program (EQuIP). This involves an audit of a hospital's processes in a broad range of areas (such as staffing levels and sterilisation procedures), and measurements of clinical performance, such as the rate of hospital acquired infection.
- The International Standards Organisation (ISO) has a health-care specific accreditation process, linked to ISO 9002. As with EQuIP, the process involves an audit of a range of internal procedures. However, the audit team comes from an accredited quality assessment organisation, rather than ACHS trained volunteers from other hospitals.

ACHS accreditation currently sets industry standards, with only a few private hospitals having sought and achieved ISO accreditation. In 1998, around two-thirds of private acute care and psychiatric hospitals had ACHS accreditation.

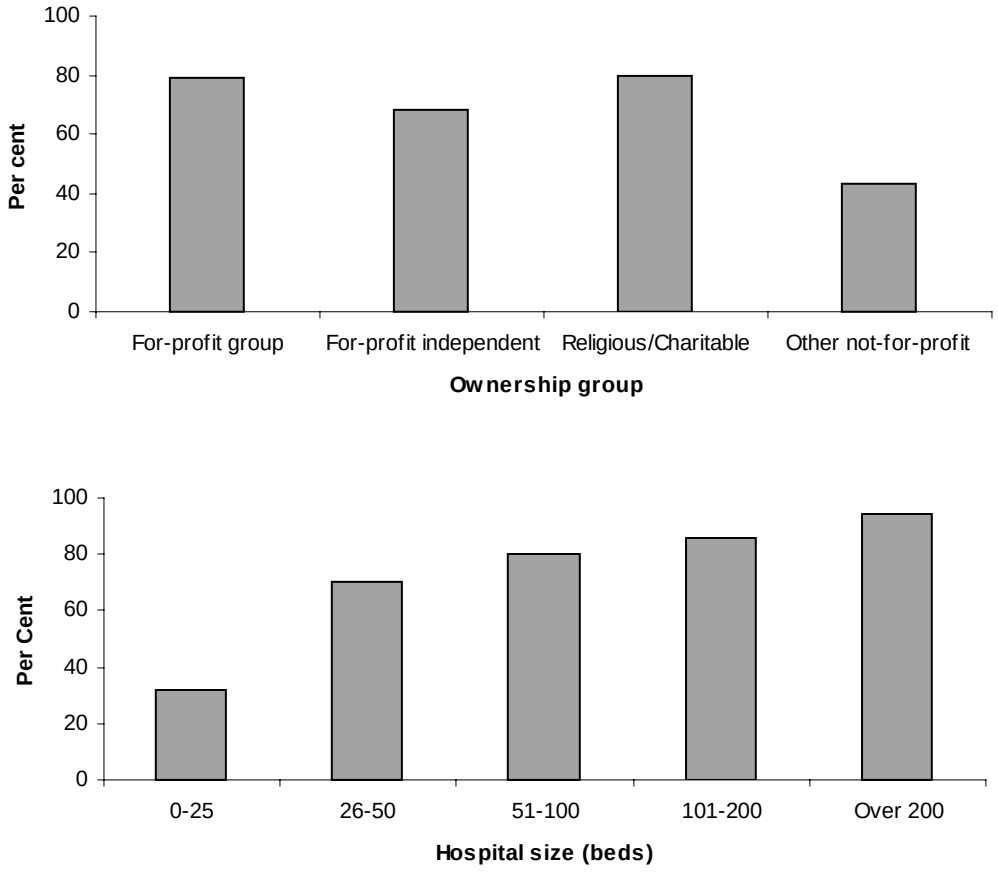
The level of accreditation is strongly correlated with hospital size (see figure 5.3), with the smallest hospitals seemingly much less likely to be prepared to bear the costs of achieving accreditation. Levels of accreditation according to hospital ownership mirror this result — the for-profit groups and religious/charitable organisations, which own most of the largest hospitals, have the highest levels of accreditation.

While quality accreditation has been available for more than a decade, the incentive for hospitals to seek accreditation has increased in recent years:

- There has been greater pressure from health funds for hospitals to be accredited — or at least be working towards it. In the past, health funds sometimes provided extra funding to a private hospital as a 'reward' for accreditation. But, with the introduction of the current contracting framework in 1995 (see chapter 6), it has become common practice for the funds to include accreditation as a condition of a contract with hospitals; and
- Commonwealth legislation specifies that, to be eligible for second tier insurance benefits (see chapter 6), hospitals without a contract with a health fund must be accredited.

However, the lack of good data on hospital outcomes means that it is hard to establish a strong link between levels of accreditation and the quality of private hospital care.

Figure 5.3 **Proportion of private hospitals[a] with ACHS accreditation, by ownership group and hospital size, 1998**



a Private acute care and psychiatric hospitals.

Source: Commission estimates based on information supplied by the ACHS and DHAC.

Hospital misadventures

Another indicator of the quality of hospitals is the incidence of 'service failure' in relation to clinical performance. This involves identifying 'misadventures' and developing ways to compare them across hospitals.

As part of its EQuIP program, the ACHS uses a range of clinical indicators to measure the quality of patient care in acute health care facilities. These indicators cover such things as unplanned hospital readmissions, unplanned returns to the operating room during the same admission, and hospital acquired infections. On the basis of performance against these indicators, the ACHS (1998) has suggested that the clinical quality of care in Australian hospitals — both public and private — is in line with international best practice.

Patient satisfaction surveys

Patient satisfaction surveys cover such issues as the patient's perception of admission and discharge procedures, hospital catering, the standard of accommodation and the helpfulness of hospital staff. Most hospitals consulted during this study said that, in general, over 90 per cent of those filling in patient survey forms are satisfied with their hospital stay. This percentage is broadly in line with the results obtained in surveys of public hospital patients (see SCRCSSP 1999, p. 264).

However, such surveys may offer relatively few insights into clinical concerns or specific areas requiring improvement. Also, the nature of these surveys means that the results are difficult to compare across hospitals and are prone to problems such as selection bias.

Conclusions

While limited in scope, the quality indicators discussed above paint a reasonably positive picture of quality in the private hospital industry.

However, a number of commentators have questioned whether strong conclusions on quality can be drawn from these sorts of measures. For example:

- Ibrahim et al (1998) argued that there is a 'clinically weak and statistically insignificant relationship between [such] indicators and the overall assessment of quality of care'.
- The Report on Government Services (SCRCSSP 1998a) commented that 'the lack of generally accepted indicators of the quality of care provided in Australia's public acute care hospitals continues to be a major concern'. The same observation could be applied to the private hospital industry.
- The ACHS (1998) report contains criticisms by participating hospitals that the indicators are too broad to be meaningful, and that the definitional conventions have excluded many of the procedures undertaken in hospitals.

Moreover, it can be very hard for patients (and sometimes even their doctors) to access the available information on hospital quality. This is because much of the information is collected for internal management purposes, or to inform negotiations between hospitals and health funds, rather than to inform consumers.

These concerns reinforce the importance of the range of initiatives underway to improve the measurement and monitoring of quality in Australia's hospitals and to

provide better information to consumers on the quality of services on offer (see chapter 9).

5.3 Appropriateness of care

A related dimension of service quality is whether the treatment provided is appropriate to the particular condition of the patient. Where inappropriate treatment leads to significant health problems for the patient, it may be picked up in indicators of hospital misadventures. However, there may also be instances where a patient receives:

- high quality, but unnecessary, treatment; or
- an expensive treatment when a cheaper treatment would have provided a comparable health outcome.

Judging what is an 'appropriate' treatment, or what is the 'right' number of medical services for a particular patient is not straightforward. And, although hospitals have some input to decisions on treatments and service levels, doctors make many of these decisions in consultation with their patients. Thus, the limited data on the appropriateness of care relate primarily to the treatments provided by doctors in private hospitals, rather than on the components of care for which the hospitals are solely or largely responsible — for example, nursing services.

Variations in treatment between public and private hospitals

The Industry Commission (1997) found that patients in private hospitals are more likely to receive a greater number of in-hospital medical services than they would as private patients in public hospitals. Similarly, unpublished data from the then DHFS's Hospital Casemix Protocol show that, in 1996–97, there was an average of 6.83 medical services per episode in private acute hospitals, compared with 5.32 services per episode for private patients in public hospitals. More specifically, as part of an international study coordinated by Harvard and Stanford universities, Richardson and Robertson (1998) looked at variations in the treatment of heart attack admissions to public and private hospitals in Victoria and Western Australia over the ten years to 1996. Amongst other things, the Australian study found that private hospital patients were much more likely to receive 'expensive high-tech' medical interventions following a heart attack than patients in public hospitals.

However, as noted by Richardson and Robertson (1998), it is not clear whether this sort of data is evidence of overservicing in private hospitals or underservicing in public facilities, or both. Significantly, a new study — the Measures of Appropriate

Clinical Care project — is seeking to develop a set of indicators to assess the appropriateness of clinical care in private hospitals. The project was initiated by the ACHS and is being funded by the Australian Health Insurance Association. Measures to promote appropriate high quality care in private hospitals are considered further in chapter 9.

6 The regulatory and legislative environment

This chapter outlines the main government regulations and legislation directly affecting private hospitals and their relationships with health funds and doctors.

6.1 State and Territory regulation

Licensing controls

Responsibility for licensing (or registering) private acute care and psychiatric hospitals and freestanding day hospitals lies principally with State and Territory governments. Where stated, the objectives of these controls primarily relate either to:

- ensuring the quality and safety of private hospital services; or
- encouraging the provision of the 'right' level of hospital services, including an appropriate geographical distribution of those services (see table 6.1).

Licensing controls are one of a number of mechanisms that operate in the industry to promote quality and safety. Others include:

- the two quality accreditation schemes for private hospitals (see chapter 5);
- contracts between health funds and private hospitals which typically contain quality requirements, including accreditation, that hospitals must meet (see chapter 7); and
- the strong commercial and ethical incentives for hospital operators and doctors to ensure that safety and quality standards are maintained.

Features of licensing controls

Through licensing controls, administering authorities can exercise significant control over the nature of private hospital services and hospital conduct. The controls cover a range of matters including:

Table 6.1 **Some stated objectives of licensing regulations**

Jurisdiction	*Objective*
NSW	To strengthen standards to ensure patient care and safety, to reduce economic regulation of the private health sector, to eliminate arbitrary and trivial bureaucratic interference, and to provide a sound legislative basis for day procedure centres ...
Vic	To strike a fair balance between the right of proprietors and developers to conduct their business dealings freely and the right of the community to ensure that necessary clinical services which are of high quality are available throughout the State.
	To achieve the orderly development, adequacy, improved distribution and avoidance of unnecessary and costly duplication of health services in the whole or part of Victoria.
WA	To provide maximum protection for patients by ensuring there are acceptable minimum standards of care.
SA	To rationalise, coordinate and provide health services.
Tas	To ensure that hospitals provide care within their staffing and structural capacity and that procedures or services are offered or undertaken only where appropriate support services are provided and safe and effective relevant care can be expected.

Source: Compiled from various Second Reading speeches, relevant health Acts and requirements specified in schedules to licences. As far as the Commission is aware, objectives are not documented in Queensland, the Northern Territory or the ACT.

- location, type of patient or service, and the number of patients or beds (see below);
- maintenance and improvements. For instance, in New South Wales, no alterations or extensions to hospitals can be undertaken unless approved;
- the type or character of the licensee. In South Australia, for example, the licensee must be of 'good character and repute', be a 'fit and proper person' and have 'sufficient material and financial resources'. In Queensland, the licensee must be a medical practitioner, an appropriately qualified nurse, a religious body or order, an approved society, or an approved body corporate;
- management and staffing. In Victoria, the hospital must comply with minimum nursing staff to patient ratios and mix of nursing staff requirements. In Queensland, a medical practitioner or an appropriately qualified nurse must be in charge of the hospital. And, if the licence is not held by such a person, there must be an 'adequate' number of registered nurses present at all times, having regard to the number of patients accommodated in the hospital;
- premises, facilities and equipment. For example, in South Australia, there are provisions relating to room access and size, as well as to ablution, electrical, cooking, ward, storage, cleaning, maternity and surgical facilities;
- registers and records. These requirements typically require a hospital to record each patient's medical history and supporting 'prescribed information'; and

- reporting and notification of information. In New South Wales, the licensee must furnish an annual statement detailing the chief nurse's authority to practise and his/her qualifications and the shareholdings of office bearers such as the director, chief executive and secretary; and a monthly statistical statement. In Queensland, the licensee must provide monthly reports on admissions, separations, patient type and occupied bed days, and information on individual patients.

Licensing provisions also typically include a range of miscellaneous requirements covering such things as: patient rights; fire safety and emergency evacuation; hospital administrative practices and policies; the storage and handling of drugs and chemicals; waste management and disposal; food safety; and infection control. They may also specify compliance with other legislation or regulations. For example, the schedule to licences issued in Tasmania requires compliance with certain standards prepared by the National Therapeutic Goods Committee, the National Health and Medical Research Council, the New South Wales Department of Health, the Australian Council on Healthcare Standards, the Society of Hospital Pharmacists of Australia, and the Pharmaceutical Society of Australia.

Table 6.2 summarises the key features of each jurisdictions' licensing controls. It is important to note, however, that some jurisdictions do not enforce particular requirements. For example, in Tasmania, there is no regular or periodic inspection of private hospitals despite there being provisions requiring such inspections. According to Tasmanian authorities, inspections instead occur whenever there is significant construction work — an arrangement which has apparently resulted in frequent contact with hospitals. Conversely, between 1994 and 1996, licence applications in Queensland were assessed against planning criteria, even though there were no express provisions authorising the administering authority to do so.

Once licensed, hospitals are still subject to inspection and to the reporting requirements noted above. Failure to comply can lead to cancellation of the licence, fines, or some other sanction (although an appeals process is usually available). Licences can be renewed, amended and, in most jurisdictions, transferred.

Planning controls

As set out in table 6.2, licensing arrangements in most jurisdictions include planning controls which may variously cover the location of private hospitals, the nature of services available in them, and the number of beds. Underlying these controls are concerns that relying solely on the market to determine the location and level of private hospital services could lead to inappropriate outcomes, such as:

Table 6.2 **Main features of licensing controls for private hospitals, by jurisdiction**

Area of conduct	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*ACT*[a]
Licensee	✔	✔	✔	✔	✔	✔	✔	✔
Planning								
location	✗	✔	✗	✔	✔[b]	✔[c]	✗[d]	✗
service/patient type	✔[e]	✔	✔[f]	✔	✔	✔[c]	✗[d]	✔
bed/patient number	✔	✔	✔[f]	✔	✔	✔[c]	✗[d]	✔
Staffing arrangements								
chief nurse or manager	✔	✔	✔	✔	✔	✔	✔	✔
medical or nursing staff	✔	✔	✔	✔	✔	✔	✔	✔
other staff	✔	✔	✔	✔	✔	✔	✗	✗
Premises, facilities and equipment	✔	✔	✔	✔	✔	✔	✔	✔
Maintenance	✔	✔	✔	✔	✗	✗[g]	✔	✗
Improvements	✔	✔	✔	✔	✔	✔	✔	✗
Records and registers	✔	✔	✔	✔	✔	✔	✔	✔
Reporting and notification	✔	✔	✔	✔	✔	✗[d]	✔	✗[d]

a ACT legislation requires private hospitals to be registered rather than licensed.

b Applies to Adelaide only.

c Although there is legislative provision to do so, controls are not applied in practice.

d Although there is no express legislative provision to do so, controls are applied in practice.

e The New South Wales Department of Health did not consider legislative reference to service/patient type to be a form of planning control. It said that an application for a licence or an amendment cannot be refused on these grounds.

f Queensland Health emphasised that these controls are based on quality/patient safety criteria, rather than planning criteria.

g The Tasmanian Department of Community and Health Services said that these matters are in part dealt with through the adoption of standards, which are 'not static requirements, but have ongoing obligations'.

Source: State and Territory principle Acts and sub-ordinate legislation: personal communications with State and Territory administering authorities.

- over-investment in, and use of, private hospitals, especially if those hospitals are owned by medical practitioners; and
- a geographical distribution of hospitals skewed in favour of metropolitan areas.

Among the sort of planning criteria that may be considered when assessing new licence applications are:

- the suitability of the location taking account of the availability of other community facilities and the safety and amenity of the environment; and
- whether a new facility would result in 'over-supply' of private hospital services in an area. Thus, for example, Victorian guidelines for the development of acute

care hospital services allow the Secretary of the Victorian Department of Human Services and Health to refuse a licence if this would result in more than 4.1 beds per 1000 of population becoming available in the area concerned (HSPR 1999, p. 54).

One effect of planning controls has been the creation of a market in bed licences, with trade between different hospital owners and within the same ownership group. Indeed, private hospital expansions in a number of jurisdictions have occurred through the purchase of existing licences, rather than through the issue of new licences. Anecdotal evidence indicates that, in 1998, the value of bed licences in individual jurisdictions ranged from negligible to around $20 000.

Views on the effectiveness of the licensing regime

There is widespread acceptance by the industry of governments' role in ensuring clinical services are of a high quality and are provided in an atmosphere of maximum safety. Moreover, private hospital operators told the Commission that while there are some problems with the current arrangements (and related regulations) — see box 6.1, in broad terms, they do not impose an excessive regulatory burden on operators.

These views may reflect a licensing regime which is working reasonably well.

But equally they could be consistent with a regime that was inadequate or not well enforced. Accordingly, the Commission sought further input from the administering authorities in the States and Territories on the effectiveness and enforcement of their licensing controls.

According to the administering authorities:

- Some jurisdictions undertake annual inspections. However, in New South Wales, there has been a move away from routine inspection towards 'a risk management needs based approach' focusing on such issues as admission of children, infection control, the history of concerns and complaints. And, as noted above, inspections in Tasmania only occur when a hospital wishes to undertake significant construction work.
- Formal refusal of new licensing applications is uncommon. Most problems tend to be addressed in early discussions between hospitals and administering authorities, thus clearing the way for administrative approval. Of those applications that have been formally refused, the grounds have included breach of a bed cap and an individual not being a 'fit and proper person'.

Box 6.1 **Industry anecdotes on licensing and related controls**

- 'The standards applied to private hospitals are more stringent than those for public hospitals. However, NSW Health is pretty flexible when it comes to planning issues.'
- 'There are some irritating, antiquated regulations still in existence. For example, there is a requirement to have an island bathroom in every hospital. In our case, it is never used for clinical needs and has become a storeroom for orthopaedic equipment. There is also a requirement to have a patient lounge on every floor, rather than one central lounge.'
- 'Changes in infection control regulations will impose costs of 'many hundreds of thousands' on the hospital.'
- 'The licensing system is irritating when amendments need to be made. For example, it was 12 months before a renal transplant unit was added to the licence.'
- 'There is a lack of interaction between States regarding regulatory matters. The different regulations in each State are irritating and a little costly to national hospital operators.'
- 'Inconsistency between States can lead to some ridiculous situations. For example, our group closed a hospital in one State and opened a new one just over the border (within sight of the old hospital). All the doctors and nurses moved across to the new hospital, but they then had to get used to a whole new set of regulations in areas such as sterilisation and infection control. It was a nightmare'.
- 'Regulatory variations between States are annoying and costly. For example, New South Wales has higher prescriptive standards for equipment sterilisation than other States (apparently as a reaction to a number of incidents). The average hospital in New South Wales faces capital costs of up to $150 000 to comply with sterilisation standards (plus $15 for each procedure). Some hospitals may never get their money back on this investment.'
- '[Commonwealth] drug regulations requiring private hospitals to have 150 beds before they can run their own pharmacy need amending. The regulation is geared towards the larger not-for-profit hospitals and is now outdated given the complex work being done by smaller and very competent for-profit hospitals.'
- 'The requirement to use a certain size paper for drug scripts and the regulation requiring an ink signature on scripts and drug charts prevents the computerisation of scripts. The system causes delays in obtaining scripts and in obtaining the required permission to dispense needed drugs.'

Source: Industry interviews

- Problems with breaches of existing licenses are usually addressed cooperatively before getting to the stage where the administering authority cancels licences or prosecutes the hospital. If a problem cannot be resolved, the licensee usually requests cancellation. For example, in New South Wales, the majority of cancellations over the last five years have been 'negotiated outcomes'. However,

no jurisdiction appears to publish information about breaches or the outcomes of inspections.

Licensing arrangements and planning controls are discussed further in chapter 9.

6.2 Commonwealth regulation of the private hospital industry

Regulation of both public and private health care is an important tool used by the Commonwealth to help ensure: the provision of quality health care; equitable access to services; the efficient delivery of services; and satisfaction for consumers and providers. Where the private sector is involved in service delivery, Commonwealth regulation also aims to reduce potential cost shifting to the Commonwealth, health funds and health fund members.

The main pieces of Commonwealth legislation directly relevant to the private hospital industry can be divided into three groups:

- legislation governing the 'declaration' of hospitals for health insurance purposes;
- legislation covering the relationships between private hospitals, doctors and health funds; and
- legislation designed to encourage membership of health funds.

Other relevant Commonwealth regulation includes the legislation specifying 'default' and 'second tier' benefits for 'non-contracted' hospital services and the provisions relating to the 'Private Patients Hospital Charter'. More general Commonwealth legislation relating to the taxation of non-profit organisations is also relevant to outcomes in the industry (see chapter 9).

Hospital declarations

While State and Territory governments are responsible for licensing or approving private hospitals and day hospital facilities, the *Health Insurance Act 1973* and the *National Health Act 1953* require that a hospital be 'declared' by the Commonwealth in order to receive health insurance benefits.

To obtain a declaration, a hospital licensed/approved by a State or Territory must comply with any Commonwealth guidelines in force under this legislation.

However, the general policy has been that the Commonwealth relies on State and Territory licensing mechanisms. At present, Commonwealth guidelines apply only to co-located private hospitals and day facilities. These guidelines state that, in considering a declaration, the Minister for Health and Aged Care should have regard to whether:

- the private facility would materially affect access by public patients to a reasonable range of services;
- there are adequate arrangements at the public hospital to ensure that patients are able to exercise freely their right to elect to be treated as public patients;
- there would be a transfer of costs from the State/Territory to any other party; and
- the State/Territory and hospital agree to supply data to allow the Commonwealth to monitor such things as access by public patients to a reasonable range of services, the adequacy of arrangements for patient election, and costs.

There are also requirements under this legislation relating to the provision by private hospitals of pharmacy services under the Pharmaceutical Benefits Scheme, and standards for special care nurseries in private hospitals.

The Commonwealth is currently investigating options to link a wider range of quality requirements — for example, credential arrangements and clinical pathways — to health fund benefit payments. The intention is to progressively introduce these additional requirements within two years. The Department of Health and Aged Care plans to issue a discussion paper on possible measures in the near future.

Relationships between hospitals, doctors and health funds

Commonwealth legislation has an important influence on agreements between the parties involved in the delivery of private hospital services. There are two main pieces of legislation involved — the *Trade Practices Act 1974* (TPA) and the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (subsequently referred to as the Amendment Act 1995).

The TPA is administered by the Australian Competition and Consumer Commission (ACCC) and addresses a range of competition and market power issues relevant in the private hospital industry. In particular, the formation of hospitals (or doctors) into negotiating groups risks contravening the restrictive trade practices provisions of the Act (see box 6.2). However, the ACCC can authorise joint negotiations by hospitals that are in competition with each other, where the public benefit outweighs the anti-competitive cost.

Box 6.2 **The Trade Practices Act and private hospitals**

General principles

The ACCC has concerns with relationships between health professionals, hospitals and health funds which may involve breaches of the TPA.

As the focus of the restrictive trade practices provisions in the Act is on preventing price agreements as a result of collusion or joint negotiation positions, and on preventing a reduction in competition, the formation of hospitals and doctors into negotiating groups is not generally allowed, unless it can be demonstrated through the authorisation process that the public benefit outweighs any anti-competitive cost. Health funds can jointly negotiate if the conduct does not substantially lessen competition.

Arrangements between private hospitals and health funds

Hospitals that compete, or that are in a position to compete, cannot collectively negotiate on price with health funds (nor appoint a negotiator) without risking breaching the price fixing provisions of the Act.

Arrangements between private hospitals

Arrangements between private hospitals that do not directly focus on price may still have substantial anti-competitive effects. An example would be an agreement between hospitals under which each hospital undertakes not to enter into supply arrangements with health funds for services outside its agreed part of the market.

Private hospitals with market power

Use of market power by private hospitals risks breaching the Act. Say, for example, a hospital has the only facilities in a region for carrying out a particular procedure and that it is uneconomic to duplicate those facilities. Suppose also that the hospital provides the procedure using in-house doctors and refuses to make its facilities available to other doctors. If the hospital has no spare capacity then the refusal would be a legitimate commercial decision. But, if the purpose is to prevent other doctors from competing with the hospital's preferred doctors, then the refusal may breach the Act.

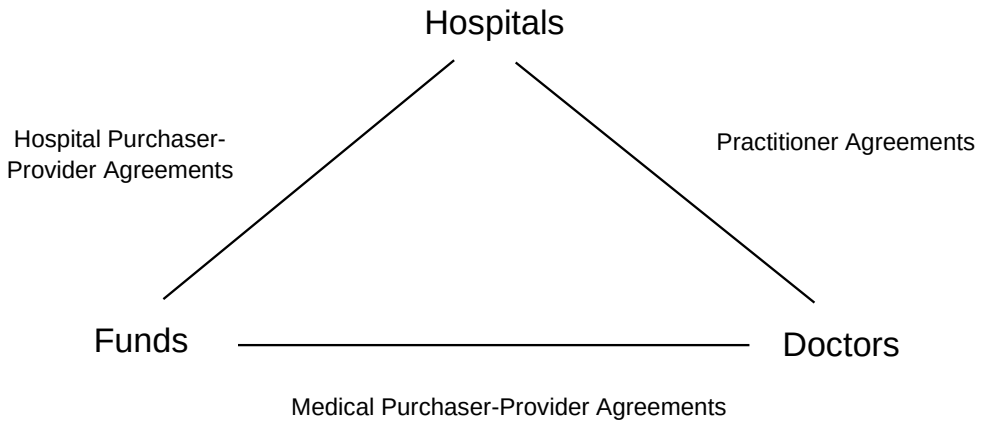
Source: ACCC 1995.

The Amendment Act 1995 makes provision for purchaser–provider contractual agreements between hospitals, health funds and doctors (figure 6.1). While contracting between health funds and hospitals began in the late 1980s, the Amendment Act added to this impetus by establishing an explicit contracting framework and by providing for the involvement of doctors. With contracts involving agreed charges by hospitals and doctors in place, the intention was that health funds could offer 100 per cent cover for both hospital treatment and the associated medical services.

Three specific forms of contractual arrangement are permitted under the Amendment Act 1995:

- *Hospital Purchaser-Provider Agreements* (HPPAs). These are contracts between health funds and hospitals (public and private acute care and/or day hospitals). Apart from any patient copayment, which must be specified in an HPPA, the hospital must accept the HPPA price as full payment by the fund for the episode of care for eligible contributors.

Figure 6.1 **The contracting framework**



- *Medical Purchaser-Provider Agreements* (MPPAs). These are contracts (or other forms of purchaser-provider agreement) between health funds and doctors covering the provision of medical services to contributors in hospitals. If an MPPA is in place, a health fund is able to pay medical benefits in excess of the MBS schedule fee, thus allowing for the elimination of out-of-pocket expenses for patients (or limiting them to a pre-determined copayment). Where no MPPA is in place, the health fund is restricted to paying the gap between the Medicare rebate and the schedule fee for the medical service concerned.
- *Practitioner Agreements* (PAs). These provide for hospitals and doctors to enter into agreements and for hospitals to receive payment under HPPAs for medical services provided by those doctors.

These legislated contractual arrangements have a number of objectives including to:

- promote competition in the delivery of private hospital services and thereby reduce the costs of hospitalisation and treatment;
- provide a stronger link between payments to private hospitals and the delivery of high quality services. (As noted in chapter 5, requirements relating to service quality have effectively become standard in most HPPAs);

- provide the opportunity for health funds to eliminate out-of-pocket expenses for patients treated in private hospitals; and
- simplify the billing and payment of benefits process by allowing hospitals to collate the separate medical bills and collect the medical benefits payable for them.

A number of amendments to the 1995 Amendment Act were legislated in April 1998 via the *Health Legislation Amendment Act (No. 2) 1998*. As a result:

- if a hospital has a PA with doctors for in-hospital medical services, health funds are now able to pay the hospital above the MBS fee for the medical component of treatment under an HPPA;
- MPPAs and PAs must include an undertaking by the health fund or hospital to maintain the professional freedom of doctors to identify the appropriate treatment for their patients within the scope of accepted clinical practice;
- any person may request copies of HPPAs, MPPAs or PAs; and
- patients are now able to assign their Medicare benefits to approved billing agents for in-hospital medical treatment (thus providing an alternative billing system to patients if hospitals do not have agreements with doctors and patients relating to out-of-pocket costs).

The impacts of these contracting arrangements on the private hospital industry are considered in the next chapter.

Assistance to health fund members

The bulk of private hospital revenue comes from treating privately insured patients (see chapter 3). Hence, government measures designed to assist health funds and their members can have a significant effect on demand for private hospital services and thereby hospitals' financial performance.

As noted, the Amendment Act 1995 aimed to make private health insurance more attractive by reducing the cost of private hospital services and providing scope for health funds to offer 100 per cent cover, thus eliminating medical gaps.

But with continuing upward pressure on premiums and declining fund membership, subsequent Commonwealth legislation took a more direct route, providing financial incentives for people to take out (or maintain) private health insurance.

- As part of its 1996 Budget, the Government announced that there would be means-tested rebates for people with private health insurance, and a Medicare

levy surcharge on those above (higher) specified income thresholds without private patient hospital cover.

These measures, which were enacted through the *Private Health Insurance Incentives Act 1997*, had a number of objectives:

- assisting people to keep private health insurance;
- relieving pressure on public hospitals;
- encouraging the private provision of hospital services; and
- providing choice of public and private hospital services. (IC 1997, p. 78)

- In 1998, the Government announced that the means-tested rebate would be replaced by a general (non-means tested) 30 per cent rebate on all health fund premiums. The objectives of the revised rebate scheme — introduced via the *Private Health Insurance Incentives Act 1998* — are similar to those of the previous rebate arrangements. The new arrangements, which took effect on 1 January 1999, are estimated to cost the Commonwealth between $1.4 billion and $1.7 billion a year.

  The legislation also includes provisions directed at reducing medical gaps. Under these provisions, health funds have until July 2000 to offer 'no gaps' or 'known gaps'. Funds that do not comply will be unable to provide their members with the 30 per cent rebate in the form of a premium reduction — the most popular means of accessing the rebate.

- The *Health Legislation Amendment Act 1999* incorporated a number of provisions to give health funds greater flexibility in packaging health insurance products — including amendments relating to discounts on contributions and loyalty bonus schemes.

- In the 1999–2000 Budget, the Government announced that a Lifetime Health Cover scheme will commence in July 2000. The aim of the scheme is to encourage people to maintain a lifetime commitment to private health insurance and thereby to prevent opportunistic opting in and out of cover. Specifically, the new arrangements provide for lifetime community rating of premiums, with those not taking out private health insurance by the age of 30 facing a 2 per cent premium surcharge for every year's delay thereafter. The surcharge is capped at 70 per cent. Those born on or before 1 July 1934 are automatically entitled to cover at base rates. *The National Health Amendment (Lifetime Health Cover) Bill 1999* to give effect to the new arrangements was passed by the Senate in September 1999.

The government has supported these financial measures with 'public education' campaigns.

Other Commonwealth regulation

Second tier and default insurance benefits

Under provisions in the *National Health Act 1953*, Government legislated default benefits are payable to insured patients treated in eligible private hospitals and day facilities that do not have an HPPA (or similar arrangement) with the health fund concerned. To attract second tier default benefits, a hospital must be able to demonstrate that it:

- has a simplified billing system in place;
- has a mechanism in place to inform patients of what expenses they are likely to incur;
- is quality accredited by either the Australian Council on Healthcare Standards, the International Standards Organisation, or other bodies agreed between the fund and the hospital; and
- meets quality criteria relating to the episode of care which the fund has specified in all HPPAs with comparable private hospitals.

Second tier benefits are set at 85 per cent of the average benefit paid by the fund for the episode of care in all comparable private hospitals with which the fund has an HPPA (or similar arrangement), in the State/Territory in which the treatment is provided.

If the health fund has no HPPAs in place in the State or Territory for that episode of care, or if the hospital fails to meet the second tier default criteria, then the basic default benefit is payable. This benefit, which is determined by the Minister for Health and Aged Care, is a little over $200 a day, although it varies somewhat across jurisdictions. Higher default benefits may apply for insured patients admitted to hospital in an emergency. As discussed in chapter 9, the default benefit effectively determines accommodation charges for private patients treated in public hospitals.

Consumer information

As well as establishing a contracting framework for the private hospital industry, the Amendment Act 1995 includes consumer information provisions — the 'Private Patients' Hospital Charter'. Under these provisions, the Minister can issue a statement informing private patients what they can expect from the doctors providing their treatment, the hospital where the treatment is provided and their

health fund. The statement may also provide advice on matters relevant to a consumer's decision on whether to purchase private health insurance.

The Charter was first published in January 1996 and is currently under review. A revised version, incorporating information on recent private health insurance changes, is expected to be released in early 2000.

7 Competition in the private hospital market

As noted in chapter 3, competition in the private hospital market is significantly influenced by the surrounding institutional arrangements:

- While private hospitals are in the business of providing services to patients, doctors generate much of that demand on behalf of their patients and health funds pay most of the bills for treatment on behalf of their contributors. Accordingly, hospitals must provide an environment in which doctors are willing to treat their patients, and supply their services at a price which is attractive to the health funds. The latter requirement has become increasingly important in recent years, with hospitals now having to compete for contracts with some of the funds.
- Private hospitals also compete with public hospitals — both directly for some private patients and indirectly through the availability of free treatment to public patients in the public system.

This chapter examines the nature of competition within the private hospital industry and, in particular, the relationships between the hospitals, doctors and the health funds. It also draws attention to a number of policy questions that arise from the analysis, which are explored further in the final chapter of the report. The final chapter also looks at some of the policy questions that arise in relation to competition between public and private hospitals.

7.1 The relationship between private hospitals and doctors

While doctors are not generally involved in the day to day management of private hospitals, they are an integral part of what hospitals do and how they operate:

- Doctors, typically in some form of group arrangement, own a significant number of private hospitals.
- More importantly, in consultation with their patients, doctors determine whether hospitalisation is required and, often, in which hospital treatment is provided. For example, a 1997 survey indicated that doctors determined the institution

used for 64 per cent of admissions (Quints and Marks 1997). This explains why private hospitals will sometimes go to great lengths to attract and retain doctors' patronage.

Hospitals compete for the custom of doctors in a number of ways.

Perhaps most importantly, hospitals use the quality of their facilities and equipment as a way of attracting doctors. Some have termed this the hospital 'arms race' (see box 7.1).

Box 7.1 **Some views on the hospital arms race**

Private hospitals told the Commission that doctors are continuously seeking new equipment so they can undertake more advanced surgical procedures. Even if investment in such equipment is not justified on normal commercial grounds, hospital management must take into account the risk of losing the business of its doctors if it does not agree to their requests.

The economics of Intensive Care Units (ICUs) provide a good illustration of these sorts of trade-offs. It is apparently difficult for private hospitals to make money directly out of ICUs. However, they are needed for surgery back-up. Hospitals therefore often view them as 'loss leaders' to attract the best doctors doing the most advanced procedures.

A number of hospitals pointed to the downsides of this form of competition between hospitals for doctors, noting the potential for wasteful duplication of equipment, particularly in the major cities.

Source: Discussions with private hospital operators.

Location can also provide a private hospital with an edge in attracting doctors. In particular, co-location of a private and a public hospital allows doctors to treat their public and private patients on the same site (see box 7.2). But some stand-alone private hospitals also have a competitive edge because of their location. The operator of a private hospital in Sydney, for example, pointed to the benefits that come from the hospital's location at both a catchment area crossroads and close to two public teaching hospitals.

Further, private hospitals can influence demand for their services by cultivating relationships with medical practitioners. In this regard, one new private hospital said that senior hospital representatives had visited numerous population centres in the catchment area to ensure that general practitioners and specialists were aware of the new hospital's credentials.

Box 7.2 **The impact of co-located private and public facilities**

New co-located private hospitals may cater for previously unmet demands, as well as drawing business from the adjacent public hospital and other private hospitals.

Competitors of co-located hospitals said that it has proved difficult to compete against their big drawcards for doctors of convenience and time savings. In this regard, smaller hospitals seem to be particularly vulnerable. One for-profit group said that the opening of a co-located private hospital would often result in 3 or 4 small hospitals closing.

These impacts have led some competitors to talk of 'unfair competition'. For example, one private hospital raised questions about 'special' financial relationships between co-located private and public hospitals. And, the ACT Legislative Assembly held an inquiry into the establishment of the co-located National Capital Private Hospital amid concerns that the hospital would gain an unfair advantage from service contracts with Canberra (public) Hospital. (The ACT government argued that competition from the new hospital would increase choice, service standards and efficiency in Canberra's private hospital sector.)

Source: Discussions with private hospital operators.

Agreements between private hospitals and doctors

As described in chapter 6, the Amendment Act 1995 includes provisions for Practitioner Agreements (PAs) between hospitals and doctors which allow hospitals to receive payments under Hospital Purchaser Provider Agreements (HPPAs) for medical services provided by those doctors.

Amongst other things, PAs are a vehicle for simplifying billing arrangements for patients. Yet, to date, there has been little enthusiasm for them. This may have partly reflected the provision under the original legislation that restricted reimbursement to a hospital under an HPPA for treatment provided by a doctor covered by a PA to the MBS fee. As described in section 6.2, that issue has now been addressed through the 1998 amendments to the legislation which allow for payments above the schedule fee. However, it is still too early to say whether the amended legislation will increase interest in PAs.

Implications for private hospitals

Given the integral nature of doctors to hospital services, private hospitals will struggle to survive unless they can obtain and maintain the custom of doctors. As discussed, to attract doctors, hospitals must provide acceptable terms of access, equipment and support staff. Also, the practices of doctors can have a significant

influence on a hospital's financial performance. Thus, hospitals will sometimes need to negotiate with doctors on the clinical services to be provided.

In cases where the practising doctors also own a hospital, any imbalance of negotiating power may be of little consequence. More generally, some of the largest hospitals may be able to negotiate with doctors in the knowledge they will not need to make concessions inimical to the hospital's interests. For example, one religious group said that the specialists who work in its hospitals tend to share its public-spirited values and are happy to be associated with the prestige teaching facilities. Similarly, a private hospital enjoying a regional monopoly will be in a stronger negotiating position than one operating in a market serviced by several providers.

That said, doctors will often be in a strong negotiating position — especially when dealing with small hospitals (see box 7.3). In this regard, one hospital manager said that his small hospital faced financial problems when its two regular surgeons took holidays or attended conferences. But it is also the case for larger hospitals in some regional centres and metropolitan areas like Central/East Melbourne where the population is not sufficient to fully support the available number of hospital beds.

Box 7.3 Views on the relationship between private hospitals and doctors

One private hospital likened the relationship with its doctors and patients to travel agents making block bookings in hotels for tourists. The tourists (patients) have fairly limited knowledge and rely on the agents (doctors) to sort out their accommodation. And hospitals, like hotels, rely on the agents to bring continuing business. If the odd tourist (patient) has an unpleasant stay at a hotel (hospital), this may not be a major problem. But the hotel (hospital) cannot afford to get the agents (doctors) offside as they might take their business elsewhere.

One for-profit hospital group observed that hospitals have to work hard to keep doctors, saying that ultimately they 'just have to give doctors everything they want to keep them sweet'. As noted, this can include purchasing high technology equipment. Another private hospital told of a plastic surgeon who wanted to perform a non-urgent operation on a public holiday. Notwithstanding the additional financial cost for the hospital, it went along with the surgeon's request because he supported the hospital throughout the year.

One large hospital that missed out on a contract with a major health fund noted how much more devastating it would be to lose the patronage of its doctors. Some hospitals also commented on the difficulties of dealing with doctors who spend much longer than average in surgery, or who consistently use more consumables than average, or who 'waste' prostheses.

Source: Discussions with private hospital operators.

In one sense, the often strong negotiating position of doctors reflects their very important role in the delivery of hospital services. In policy terms, an issue would only arise if there was evidence that doctors were misusing their bargaining power when dealing with the hospitals.

However, it is important to recognise that 'misuse' of market power could take forms other than demanding overly generous access to hospital facilities, or excessive equipment and staffing levels. For example, there would be legitimate concerns if, by virtue of their strong bargaining positions, doctors were able to provide sub-standard services without fear of challenge. This raises the question of whether enhanced clinical performance indicators would reduce the scope for any such problems to arise. And, there is the broader question of whether restrictions on the number of training positions and access for overseas trained specialists are artificially enhancing the negotiating power of some doctors (see chapter 9).

7.2 The relationship between private hospitals and health funds

Given that the bulk of private hospital revenue comes from treating insured patients, negotiations between a hospital and the health insurance funds can have a crucial bearing on the hospital's financial performance and its ongoing viability. Specifically:

- Negotiations will determine the rates a private hospital receives for various services provided to health fund members (such as accommodation and theatre), and for various patient types (advanced surgery, medical, obstetrics etc). Moreover, these rates will set charges for most self-paying patients.
- To secure contracts, hospitals may have to make changes to their service delivery. In particular, the funds can place significant pressure on hospitals to reduce costs and/or meet a range of quality requirements.
- Failure to obtain a contract from a health fund is likely to see many members of that fund seeking treatment in other, contracted, hospitals. As discussed in chapter 4, high occupancy levels are important for hospital profitability.

Importantly, there have been major changes in the contracting process in recent years.

Until the mid-1990s, private hospitals typically set their charges on a cost-plus basis with the health funds automatically passing on cost increases to members in the form of higher premiums. Moreover, the funds and hospitals worked together to sell the 'difference' between private and public care. This contributed to the switch by

many insured patients from subsidised beds in public hospitals to private hospitals — a major source of premium increases in the 1990s (IC 1997, pp. xxxvi).

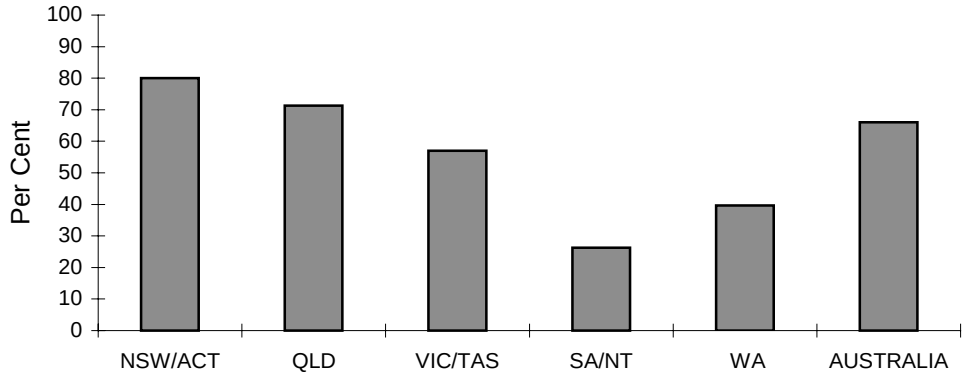
But, in the second half of the 1990s, against a backdrop of falling membership and rising premiums, the funds have become far more pro-active in rate negotiations with the hospitals. The new legislative contracting framework, introduced in 1995, has underpinned this shift in approach.

Agreements between private hospitals and health funds

Contracting between health funds and hospitals — which began in Victoria and South Australia in the late 1980s — was given significant impetus by the 1995 Amendment Act. This established an explicit contracting framework (see chapter 6) and has encouraged health funds to use their bargaining power to negotiate lower prices and more comprehensive services with hospitals and medical providers.

In September 1998, there were around 11 800 HPPAs in place across Australia. Reflecting this rapid uptake, around 66 per cent of insured separations in private hospitals were covered by these agreements in 1997–98 (although the shares varied considerably across the States (figure 7.1)). Across Australia, some 90 per cent of private acute care and day facilities have an HPPA with at least one health fund.

Figure 7.1 **Proportion of private hospital separations covered by HPPAs, by State, 1997–98**[a]



a Includes freestanding day hospitals.

Source: Hospital Casemix Protocol (DHAC, 1999).

Who contracts with whom?

Many of the major health funds have contracted with nearly all private acute care hospitals in their areas of operation.

This partly reflects legislative provisions which limit the grounds for health funds not entering into contracts with hospitals. For example, failure to contract cannot be based on the size of a hospital or its ownership.

More fundamentally, the funds have strong commercial incentives to contract with a broad range of hospitals. This is because failure to provide 100 per cent cover for accommodation costs in popular hospitals would see many members shift to funds that did have contracts with those hospitals. Also, it is clear that the funds regard contracting as a way of influencing the costs and quality of hospital services.

That said, commercial imperatives will not necessarily require a fund to enter into HPPAs with all hospitals in its area of operation. This is illustrated by AXA Health Insurance's policy of excluding a proportion of hospitals from its contracts. AXA uses a competitive tendering process to select private hospitals with which it will contract for 100 per cent cover (see box 7.4). In 1997–98, this process provided for 100 per cent cover for some 70 to 80 per cent of private hospital beds in Victoria and South Australia. Medibank Private and MBF also use a tendering approach.

Box 7.4 **AXA's Participating Provider Program**

In response to falling private health insurance membership and lower occupancy rates in private hospitals, AXA Health Insurance (then National Mutual) introduced the Participating Provider Program in 1997. An important objective of the program is to improve the value of health insurance to the fund's members by 'purchasing high quality health care services at an affordable price'. The Program involves:

- a move away from 'the adversarial model of negotiating annual price increases with all hospitals' towards a 'cooperative model of creating longer term relationships with select providers';
- the use of a competitive process to select participating hospitals; and
- entering into agreements with medical providers or 'medical purchaser provider agreements' (see section 7.3).

The competitive tendering process consists of a number of stages including an 'invitation to tender' and interviews. Eight criteria are used to assess tenders: location/demand; range of specialties; capacity; vision; performance; facilities; quality and price. Hospitals need to achieve a minimum score for each criterion to be offered a contract.

Source: Discussions with AXA Health Insurance.

The contract negotiation process and issues covered in HPPAs

Contract negotiations between health funds and private hospitals generally occur each year, although some funds are now entering into longer contracts. For example, AXA contracts are for three years and another major fund said it would sign two-year contracts if it was 'comfortable' with its relationship with a hospital.

While the issues covered in contract negotiations are extensive (see box 7.5), there are usually two distinct parts to the process:

- discussion of the main provisions; and
- negotiation of the rates to be paid by the health fund for accommodation, theatre, ICUs and so on.

The clauses and conditions are usually similar across HPPAs, but the negotiated rates can vary quite significantly.

Box 7.5 **Issues covered in a Hospital Purchaser-Provider Agreement**

A Reference Schedule
B Definition of Terms
C Main Provisions
1 Interpretation
2 Duration of Agreement
3 Agreement Services
4 Hospital Operator's Obligations
5 Charging
6 Invoicing
7 Payment
8 Audit
9 Quality
10 Communication
11 Confidentiality
12 Indemnity
13 Termination
14 Dispute Resolution
15 Notices
16 General
D Agreement Services — Basis For Charging
E Non–Agreement Services
F Quality and Outcomes
G Forms/Certificates
H Health Fund Members' Level of Cover
I Hospital Charges and Health Fund Benefits

Source: A major health fund.

For hospitals, the starting point for rate negotiations is typically the rates necessary to cover costs, having particular regard to the increases in those costs since rates

were last fixed. For the health funds, the concern is to provide good hospital coverage for members while minimising increases in premiums.

Within this framework, a range of factors can influence outcomes (see box 7.6). However, the underlying driver will be the relative bargaining strength of the two parties. As discussed in the next section, this is the subject of much discussion in the industry.

Box 7.6 **Factors determining private hospital rate outcomes**

According to the industry, the rates negotiated between a private hospital and a health fund will depend upon such factors as:

Hospital features and performance

- the standard of the hospital;
- the credibility of the hospital's doctors;
- the hospital's commitment to outcomes;
- benefits paid in the previous period;
- the hospital's ALOS outcomes; and
- whether the hospital is achieving cost efficiencies.

Local market factors

- how dominant the hospital is in the local market;
- what is happening to levels of demand in the market; and
- whether the market is high or low cost in terms of the mix of treatments provided.

Health fund specifics

- the hospital's patient volumes with the fund;
- how attractive the hospital is to the fund's members;
- whether the hospital has complied with previous contracts; and
- the historical rates paid to the hospital and how those compare with the average rates paid for that particular hospital type.

Source: Industry interviews.

Implications for private hospitals

There are widespread concerns in the private hospital industry about the current contracting process. Indeed, the private hospitals' peak body, the Australian Private

Hospitals Association (APHA), has been advocating the development of a code of practice for contract negotiations between hospitals and the funds.

The hospitals' primary concern is that the health funds have excessive bargaining power and that the rates negotiated under HPPAs are insufficient to cover legitimate cost increases. They also contend that the funds have imposed unreasonable contract clauses and employed inappropriate negotiation practices — for example, deferring contract re-negotiations, allegedly often for many months after the contract expiry date.

In contrast, insurers have argued that the health funds need contracts with hospitals as much as the hospitals need contracts with the funds. In particular, they contend that funds must have contracts with sufficient hospitals to ensure adequate geographic and clinical coverage for their members. Also, the funds claim that the requirement for them to pay a legislated minimum default benefit for the treatment of a member in a hospital not covered by an HPPA acts as an additional balancing force in negotiations (see, for example, IC 1997).

Outside the industry, the Senate Committee (SCALC 1996) reviewing the current contracting legislation found that the health funds are generally in a much stronger negotiating position than the hospitals. In contrast, the ACCC (1999c) has expressed the view that the balance of negotiating power will depend on the circumstances involved.

But even if there was unanimous agreement on where the balance of negotiating power lies, determining what constitutes a misuse of that power would still be difficult. This can be illustrated drawing on the following quotation attempting to define market power in the private hospital industry:

> The existence of market power can best be described by considering the position of the hospital. If acceptance of a price offered by a health fund places the hospital's future in jeopardy *and* not accepting a price offered by a health fund also places the hospital's future in jeopardy, then the health fund has market power.' (Herring Health and Management in evidence to the ACCC 1999a).

Some would argue that threatening a hospital's existence is a clear misuse of market power. But is it necessarily misuse of market power to force an inefficient hospital to improve its performance or exit the industry? And how should the benefits to consumers of lower premiums be set against reduced diversity of private hospital services? Moreover, as the ACCC (1998) noted in relation to an application by a group of private hospitals to negotiate jointly with health funds (see section 7.4), it is not necessarily anti-competitive for the funds to use negotiating power for the purposes of protecting their financial position.

Quantitative evidence

One indicator of the impact of contracting on the relative bargaining positions of the hospitals and the funds is movements in average benefits paid over time.

Between 1995–96 and 1997–98 — after the advent of the current contracting legislation — average daily benefits increased in real terms by about 4 per cent (table 7.1). Prima facie, this does not suggest a harder negotiating approach by the health funds. However, as noted in chapter 5, the average length of patient stay has recently been declining by 2 to 3 per cent a year, and the average casemix complexity increasing by around 2 per cent a year. Allowing for the impact of these changes would suggest that remuneration to hospitals was a little less generous in 1997–98 than two years earlier.

Table 7.1 **Patient revenue[a] and health fund benefits[b], private acute care hospitals, 1995–96 to 1997–98**

	Patient revenue per day	*Real change on previous year*	*Health fund benefits per day*	*Real change on previous year*
	$	%	$	%
1995–96	532	-	479	
1996–97	578	7.2	504	3.8
1997–98	578	0.0	505	0.2

a Based on patient revenue for private hospitals involved in the APHA's PICS benchmarking exercise.

b Benefits paid by health funds to all private acute care hospitals.

Source: PHIAC Annual Reports; APHA unpublished data.

Another possible indicator of the distribution of market power would be variations in (casemix-adjusted) rate outcomes for hospitals of different size and ownership. A common view is that these variables influence the bargaining strength of a hospital and hence the outcome of negotiations with the health funds:

- The 17 largest private hospitals (over 200 beds) account for 23 per cent of industry separations. Thus, the funds would risk losing a significant number of members if they did not reach agreement with these hospitals.
- Conversely, the lesser market presence of small hospitals might be expected to reduce their bargaining strength. Also, small hospitals have less scope to dedicate resources to the negotiating process. The private hospitals which did not receive contracts in AXA Health Insurance's 1998 Victorian tender were predominantly small facilities.
- Group hospital networks can have significant negotiating resources, as well as access to a data set covering all of the individual hospitals in those networks. And, unlike stand-alone hospitals, the contracting legislation and the Trade

Practices Act (TPA) allows them to pool information on negotiated rates for their individual hospitals.

Somewhat surprisingly, data for 1996–97 on average casemix-adjusted accommodation benefits by hospital ownership show relatively little variation between for-profit group, independent for-profit and religious/charitable hospitals (table 7.2). Similarly, there was little variation in average casemix-adjusted benefits for hospitals of more than 50 beds. (While average benefits were significantly lower for small hospitals, particularly for those of less than 25 beds, these facilities tend to have a much higher proportion of day surgery patients).

Table 7.2 **Average private hospital[a] accommodation benefits, by hospital ownership and size, 1996–97 ($)**

Hospital type	*Average accommodation benefits per day*	*Casemix-adjusted accommodation benefits per day*
Ownership categories		
For-profit group	347	342
For-profit independent	332	338
Religious/charitable	361	346
Other not-for-profit	306	310
Size categories		
0–25 beds	196	209
26–50 beds	303	312
51–100 beds	345	346
101–200 beds	349	345
Over 200 beds	377	347

a Private acute care and psychiatric hospitals.

Source: DHFS Hospital Casemix Protocol (unpublished data).

One interpretation of these relatively uniform rate outcomes is that the health funds are not 'driving to the limit' when negotiating with individual hospitals.

However, because the data in table 7.2 are aggregated across Australia, they could conceal significant variations in outcomes in regional and local markets. As noted in box 7.5, the funds indicated they are likely to pay a higher rate to a hospital if it has a strong position in the local market.

Few private hospitals in major Australian cities could consider themselves to have a dominant market position — most treatments are available in several private and public hospitals (see chapter 3).

On the other hand, some hospitals offering highly specialised services, or meeting a substantial part of demand in a particular market, may be in stronger bargaining position when dealing with health funds. For example:

- In Queensland, large private hospitals in regional centres such as Mackay, Rockhampton and Toowoomba attract patients from surrounding areas. This suggests they may have some bargaining power when dealing with the funds (although this will vary by treatment and according to public hospital competition).
- In Western Australia, the St John of God hospital chain provides 40 per cent of the private hospital beds in that State. Failure of a health fund to negotiate contracts with this chain could therefore severely compromise its ability to offer acceptable hospital coverage to members.

Summing up

While the quantitative indicators reported above provide a somewhat mixed picture, they are not inconsistent with the view that there has been a shift in the balance of negotiating power towards the health funds. But, of itself, this does not advance the debate all that far. The real policy questions are whether negotiating power is being misused and whether there are changes that could be made to the negotiating framework to deliver more efficient outcomes.

In this regard, some hospitals said that the trend towards case-based payments has increased the complexity of negotiations and made them more adversarial. They also raised concerns about the quality and amount of data they receive from the health funds.

An adequate two-way flow of information between the parties is essential for an effective negotiating process. Indeed, information flows will become even more important if selective tendering by the health funds becomes more widespread. For example, access to information on 'indicative' prices required to secure a contract might help hospitals determine how much they need to reduce their costs to be competitive. This in turn raises questions about the provisions in the current contracting legislation which prohibit stand-alone hospitals from sharing information on the outcomes of recent rate negotiations. This issue is explored further in chapter 9.

7.3 The relationship between health funds and doctors

Contracts negotiated between health funds and doctors practising in private hospitals generally lie outside the hospitals' sphere of influence.

Nonetheless, these contracts can have significant implications for hospitals. In particular, medical gaps are a major concern for fund members and affect the take-up of health insurance and thereby the demand for private hospital services. (In 1997–98, insured patients met an average of just over 20 per cent of the costs of medical treatments provided in private hospitals (DHAC 1999)). Also, any provisions in contracts relating to clinical practice can similarly affect a hospital's operating procedures or occupancy levels.

Contracting between doctors and health funds occurs within a broader system under which doctors usually specify the treatment that patients receive. Thus, as noted earlier, in consultation with their patients, doctors generally decide whether hospitalisation is required and the length of stay, and often which hospital is used. This means they effectively control the level of benefits paid out by health funds for the treatment of individual patients.

The efficacy of Australia' fee-for-service approach has been subject to much debate. Suffice it to say that most parts of the medical profession are strongly opposed to changes that would lessen their control over patient treatment and fees charged.

Agreements between health funds and doctors

As described in chapter 6, the Amendment Act 1995 provides for contracts between health funds and medical providers known as Medical Purchaser Provider Agreements (MPPAs). (Prior to this legislation, such contracts were prohibited). Where an MPPA (or other form of purchaser provider agreement) is in place, a health fund can pay medical benefits in excess of the schedule fee. This provides an opportunity to eliminate out-of-pocket expenses for private patients for medical services received in hospital (or to limit them to a pre-determined copayment). While eliminating gaps will put upward pressure on premiums, it can make private health insurance a more attractive product.

Because of resistance from doctors to contracting with health funds, relatively few have signed MPPAs. According to the Department of Health and Aged Care, only 53 agreements were in place in February 1999, involving only AXA Health Insurance and Medibank Private.

While individual MPPAs can cover treatment provided by a number of doctors, information on payments by health funds to doctors above the schedule fee reinforces the point that uptake of these contracts has been low. In the June Quarter of 1998, services paid at over the schedule fee represented less than two per cent of all medical services and benefits paid by the health funds (table 7.3).

Table 7.3 **Medical services and benefits paid above the schedule fee, September 1996 to June 1998**

	Services up to schedule fee	*Benefits up to schedule fee*	*Services above schedule fee*	*Benefits above schedule fee*
	No. (000)	$000	No. (000)	$000
September Quarter 1996	2 812	59 771	<1	13
June Quarter 1997	2 722	58 711	10	256
June Quarter 1998	2 630	57 537	48	968

Source: PHIAC, Annual Report 1997–98.

It is also important to note that much of the strong percentage growth in the payment of benefits above the schedule fee apparent in table 7.3, appears to be due to the impact of AXA Health Insurance's Mediplus EzyClaim scheme (see box 7.7), rather than to the uptake of MPPAs. Under this scheme, doctors have an agreement (not a contract) with AXA whereby they can be paid above the schedule fee for treating the fund's patients (who are left with no out-of-pocket costs). Within a year of the scheme commencing in February 1998, it accounted for approximately 40 per cent of all AXA's medical claims. AXA believes that, by the end of 1999, EzyClaim might account for 70 to 80 per cent of its medical claims.

With the Commonwealth's 30 per cent health insurance rebate legislation placing an onus on health funds and doctors to eliminate medical gaps for insured patients (see chapter 6), there is likely to be growth in agreements between doctors and the funds. In this regard, Medibank Private has recently announced the introduction of its GapCover scheme, which will apparently operate in a similar way to EzyClaim.

Implications for private hospitals

As noted, private hospitals have a strong interest in the outcomes of negotiations between the health funds and doctors, particularly in relation to eliminating or reducing gap payments. The adequacy of the supply of doctors — which in turn can influence the level of gap payments — is therefore an issue of some relevance to the private hospital industry. Supply-side issues are canvassed in chapter 9.

Box 7.7 **AXA Health Insurance's Mediplus EzyClaim scheme**

Mediplus EzyClaim is a 'no medical gap' scheme that allows specialists to bill any number of claims to AXA at an agreed rate. It was established in December 1997 with the first trials commencing in February 1998, supported by the National Association of Obstetricians and Gynaecologists.

EzyClaim operates on a doctor-by-doctor basis with no interference from the health fund in the doctor-patient relationship. Participating doctors can choose whether to charge a patient under EzyClaim or outside the scheme. AXA evaluates what total payment for a particular procedure will be attractive to most doctors, and then pays doctors the difference between that rate and the Medicare payment of 75 per cent of the schedule fee.

EzyClaim has widespread clinical coverage including cardiac surgery and obstetrics. However, the fund said it still prefers to have pathology and radiology providers covered by MPPAs as it is important that all members are assured of no gaps in these areas.

Source: AXA Health Insurance (personal communication).

It is also important to note that the often strong negotiating position of doctors when dealing with the funds may have flow-on effects for contracts between the hospitals and the funds. A case in point is the way that the funds have sought to address the control that doctors have on the volume of hospital admissions and thus on the total benefits payable for private hospital services. In essence, the funds have looked to indirectly limit patient volumes by constraining payments to hospitals. For example:

- Medibank Private places volume caps on total benefit payments for services in some hospitals. If a hospital exceeds the cap, Medibank Private reduces the daily benefit on extra services to the basic default level.
- The selective hospital tendering process adopted by some funds is partly aimed at reducing total benefit payments by limiting the number of hospitals able to offer 100 per cent hospital cover to fund members.

Such 'external influences' on contracts between health funds and private hospitals are likely for as long as fee-for-service arrangements for doctors continue to dominate.

7.4 The Trade Practices Act and the ACCC

As noted in chapter 6, contracting in the private hospital industry must also comply with the relevant provisions of the TPA. In particular, the formation of hospitals or doctors into negotiating groups is not allowed under the Act, although the ACCC

can authorise joint negotiating arrangements that reduce competition if it judges them to be in the public interest. The ACCC has previously recognised the 'promotion of equitable dealings in the market' as one potential public benefit.

Prima facie, authorisation of joint negotiations is a mechanism for giving private hospitals more negotiating power in their dealings with health funds. But, as the 1998 application by five Queensland private hospitals for authorisation of an inter-hospital agreement (see box 7.8) shows, this route is likely to be time consuming and uncertain in outcome.

The principal objectives of this agreement included:

- sharing and collective presentation of cost and price information;
- wider dissemination of cost reduction strategies amongst members; and
- increased efficiency of purchaser provider contracts entered into by members.

The proposed arrangement was similar to the approach taken by large hospital networks, such as HCOA and Ramsay.

As set out in box 7.8, the ACCC changed its position on the application on three occasions. And, while ultimately granting a conditional authorisation for the proposed agreement, it has attached conditions that, amongst other things, limit the capacity of the five hospitals to share price information.

Whatever the merits of this particular application, it points to the differential impacts of the TPA across ownership structures. Group hospital networks have a significant advantage over stand alone private hospitals because their integrated ownership means they can share information (including on rates) in their dealings with health funds, without any TPA concerns. This issue is canvassed further in the final chapter.

7.5 Other competitive aspects of the private hospital market

Competition between private hospitals for patients

While the fortunes of private hospitals depend heavily on their ability to attract doctors and to secure workable contracts with health funds, there is still some scope for them to compete directly for patients.

Box 7.8 **Application to the ACCC for an inter-hospital agreement**

In June 1998, the Friendly Society Private Hospital Bundaberg, St Stephen's Private Hospital Maryborough, St Andrew's Private Hospital Toowoomba, St Andrew's War Memorial Hospital Brisbane and the Wesley Hospital Brisbane applied to the ACCC for authorisation of an agreement which would permit them to:

- exchange fee and non-fee related information; and
- establish a common agent to facilitate the exchange of aggregated data and to assist in the negotiation of HPPAs.

In support of their application, the five hospitals submitted that the exchange of information would allow them to improve efficiency and service quality, and that a common agent would assist in redressing an imbalance of negotiating power between health funds and the individual hospitals. They also argued that the agreement would not result in a substantial lessening of competition.

The health funds argued against authorisation, principally on the grounds that there is no imbalance in negotiating power between hospitals and the funds, and that the exchange of price-related information is contrary to the Amendment Act 1995.

In an initial draft determination in December 1998, the ACCC concluded that the proposed agreement would not substantially lessen competition and would assist the hospitals to improve their efficiency and quality of service. The ACCC also said there would be public benefit in the provision of countervailing negotiating power to the hospitals. It granted a draft authorisation for five years, subject to certain conditions (ACCC 1998).

However, following a subsequent pre-decision conference in February 1999 and taking account of further submissions, the ACCC reversed this decision in a second draft determination (ACCC 1999b). It said that, in the light of the additional input, it was concerned that the agreement would not deliver a public benefit sufficient to outweigh its anti-competitive effects.

In its final determination in September 1999, the ACCC again modified its position. It said that for the purposes of the determination it had revised its definition of the relevant markets and concluded that the proposed conduct would not result in a substantial lessening of competition in either the hospital-patient or private hospital-health insurer markets. The ACCC did, however, argue that some aspects of the proposed arrangement could potentially negate the arrangement's public benefits. It therefore granted a conditional authorisation for three years. Some of the attached conditions will restrict the sharing of price information by the five hospitals (ACCC 1999c).

Source: ACCC 1998, 1999a,b,c.

Notably, such competition is not normally price-based. For insured patients, charges are usually set by the contracts negotiated with health funds. Those negotiated rates

also have a strong influence on charges for the relatively small number of self-paying patients. Indeed, health funds generally discourage hospitals from offering discounts to self-paying patients (see appendix A).

However, around one-third of patients decide the hospital in which they will receive treatment (Quints and Marks 1997). Hence, hospitals can compete for custom through marketing their:

- location and thereby ease of access for patients and their visitors;
- facilities;
- range of services and procedures;
- prestige and reputation; and/or
- contracts with health funds.

In many respects, the way hospitals compete for patients is little different from the way they compete for the custom of doctors. Just as hospitals expend resources to market themselves to specialists and general practitioners, they will often seek to inform potential patients about their services and facilities. In some cases, this will involve advertising in the media. In others, it will involve a lower key approach. For example, one small for-profit surgical hospital in Victoria told the Commission that it markets itself to the general public through letter box drops. It went on to say that this marketing takes on a different dimension around Christmas when the few surgeons who bring in the bulk of business take leave. At this time of the year, the hospital more actively seeks medical and respite care patients.

Competition between private and public hospitals

In 1997–98, some 19 per cent of insured private patients across Australia received their treatment in public hospitals (AIHW, *Australian Hospital Statistics, 1997–98*). Prima facie, this suggests that there is considerable competition between the two hospital sectors in the treatment of private patients.

However, views differ on the actual extent of such competition.

Some consider that private and public hospitals operate in largely different markets. They contend that the focus of the public system is on treating the acutely and seriously ill and those with chronic conditions, whereas the focus of the private system is on treating those with less-urgent clinical needs, including elective surgery. (See, for example, Hall 1999). Some go on to argue that insured patients will usually seek to avoid public hospital waiting lists for non-urgent treatments by using the private hospital system. To support this point, they note that a significant

proportion of private patients treated in public hospitals initially enter as 'emergency' patients and/or receive treatments not available in nearby private facilities.

But while there is a much greater emphasis on elective treatments in private hospitals, this does not mean there is no competition for private patients with public hospitals. Many private hospitals are now offering services and treatments that were previously only available at major public teaching hospitals. Thus, insured patients and/or their doctors will often have a choice of hospital provider. One result has been that the public sector's share of the private patient market has been declining steadily (19 per cent of insured separations in 1997–98 compared with 36 per cent in 1993–94).

The commonality in the leading DRG groups for insured patients treated in public and private hospitals is another indication of the scope for some competition between the two sectors. As indicated in table 7.4, four of the top 10 DRGs for insured patients are common to public and private acute care hospitals.

Table 7.4 **Top 10 DRGs by number of insured separations, private acute care hospitals and private patients in public hospitals, 1996–97**

Private acute care hospitals	*Private patients in public hospitals*
332 Gastroscopy (non–digestive diseases)	678 Post abortion diagnoses
335 Colonoscopy	**572 Renal dialysis**
780 Chemotherapy	**332 Gastroscopy (non–digestive diseases)**
572 Renal dialysis	**335 Colonoscopy**
674 Vaginal delivery	943 Other factors influencing health status
099 Lens procedures	349 Oesophagitis, gastroent & mdd
421 Knee procedures	353 Digestive system diagnoses
128 Dental extractions & restorations	**674 Vaginal delivery**
843 Major affective disorders	941 Rehabilitation
484 Skin, subcut. tissue & breast procedures	939 Aftercare of malignancy

Source: DHFS, Hospital Casemix Protocol 1996–97 (unpublished data).

Overall, there is little doubt that there is competition between private and public hospitals for some private patients. And, any extension of current initiatives to contract out the delivery of some public patient services to private hospitals could, in future, lead to greater competition between the two sectors. Such competition raises a number of issues in relation to the application of the competitive neutrality principles specified in the National Competition Policy. These issues are discussed in chapter 9.

8 Broad drivers of demand for private hospital services

The fortunes of individual private hospitals will depend on a range of sector-specific factors discussed in previous chapters, including their location and facilities, their capacity to attract doctors, and their cost efficiency.

However, there are also two groups of broader factors that will influence overall demand for private hospital services:

- policy factors such as the level of funding for the public hospital system, and regulatory and policy arrangements affecting the cost and quality of private hospital services and the affordability of private health insurance; and
- non-policy drivers of demand such as income levels and dispersion, population growth and the age structure of the population, and technological capacity.

This chapter looks at some of the key non-policy drivers of demand for private hospital services. Some of the more important policy-related influences on demand are canvassed in the final chapter.

8.1 Income growth and distribution

It is widely accepted that health services are 'luxury' goods meaning that, as incomes rise, spending on these services increases more than proportionately. One consequence is that spending on health care as a proportion of GDP tends to increase over time:

- Expenditure on health services in Australia is currently equivalent to around 8.5 per cent of GDP. This share is 10 per cent higher than a decade ago, and almost 50 per cent higher than in 1971 (AIHW, *Australia's Health*, various years).
- While inflation in health costs over and above the general rate of inflation helps to explain some of this growth in expenditure share, there has also been a significant increase in consumption of health care services. Between 1975–76 and 1995–96, real per capita expenditure on health care rose by around 2.2 per cent a year (AIHW *Australia's Health, 1998*), compared with an average

increase in real per capita income of around 1.5 per cent a year over the same period.

Some commentators have suggested that the luxury good status of health care primarily reflects the impact of increases in government spending rather than spending by individuals. In this regard, Richardson and Robertson (1999) argue that:

> … personal income elasticities are very low… While poorly articulated in the literature there is clearly an 'institutional income effect' which operates through the growth of budgetary allocations to health authorities that are roughly improportional to income growth and adjusted upwards or downwards by either a 'betterment' or an 'efficiency' factor. (p. 350)

But this is not to deny the possibility that future increases in income may lead to proportionately larger increases in non-government spending on private hospital services. This is particularly the case given the significant discretionary component of many private hospital treatments — some treatments may be genuinely optional from a health perspective, while in other cases, treatment at some personal cost in a private hospital is a way of avoiding queues in the public hospital system, or accessing a higher standard of accommodation.

The increasing share of health care expenditure going to private hospital services over the last decade serves to illustrate this point. Between 1984–85 and 1995–96, expenditure on private hospital services as a share of total recurrent expenditure on health care rose from 5.6 to 8.2 per cent (AIHW, *Australia's Health, 1998*, p. 167). Moreover, the ABS (1995) found that high income households were five times more likely to have private health insurance than those on low incomes. This suggests that, other things equal, income growth may lead to higher health fund membership and thereby greater use of private hospital services.

At the same time, the impacts of income growth on the demand for private hospital services are likely to depend partly on how that growth is dispersed across the population:

- There is evidence to suggest that income growth over the past twenty years in Australia has been concentrated at the upper end of the income distribution. (See, for example, Harding 1997). Many higher income earners will already have private health insurance. Thus, if the recent pattern of income growth continues, the resulting increase in demand for private hospital services is likely to be lower than if income growth were more evenly distributed across the population.
- Against this, incomes of older people have been increasing faster than for the population generally (Whiteford and Bond 1999). Factors such as greater

superannuation coverage and higher female workforce participation are likely to see this trend continue in the future. As discussed below, older Australians are the highest users of the health care system. Hence, any improvement in their relative income status is likely to result in proportionately higher spending on private hospital and other health care services.

8.2 Population growth and ageing

Two aspects of demographic change are of particular relevance to demand for health care services in general and private hospital services in particular.

First, and most obviously, population growth will increase demand for these services. While an unremarkable observation in an aggregate sense, the precise effects of population growth will depend on the composition and distribution of that growth. For example, the availability of private hospital services is significantly lower in rural and regional areas than in the major cities (see chapter 2). Hence, the more any overall increase in population is focussed in rural and regional areas, the smaller may be the total increase in demand for private hospital services. Similarly, population growth associated with migration may have less of an impact on demand for hospital services than natural population growth — at least in the short to medium term. Apart from the hospital services often involved in child birth, the first year or so of life is usually a period of relatively high usage of health care services.

Second, in common with most other developed countries, Australia's population has been ageing over the last 25 years. This has seen a change in the age profile of the population with a larger proportion of Australians aged 45 and older. If, as expected, this trend continues, by the middle of the next century the majority of Australians could be older than 50 and a significant proportion older than 70 (McDonald and Kippen 1999).

The impact of ageing on the demand for health services has been the subject of considerable debate.

Some — for example, the National Commission of Audit (1996) — have suggested that the effect will be very significant. Such views are premised on the observation that per capita health expenditures rise significantly from about the age of 65. In this regard, Commission estimates based on AIHW hospital usage data show that the per capita number of patient days in private hospitals in the 75 and over age cohort is more than 2.5 times that in the 55–64 cohort. And even in the 65–74 cohort, per capita usage is nearly 60 per cent higher than in the 55–64 cohort. Similarly, consultants to a recent review of NSW Health by the Independent Pricing and

Regulatory Tribunal indicated that people aged over 65 are 4.5 times more likely to require a hospital stay than those under 65. (IPART 1998, p. 78)

But other commentators suggest that, of itself, increased longevity is likely to reduce per capita expenditures on health care services in the older age cohorts. They contend that the period of highest health expenditure for individuals is usually the last few years of their lives. In this regard, US statistics indicate that, on average, 40 per cent of health expenditures are in the last two years of life with 30 per cent in the last year alone (Fuchs 1984). The implication is that, outside of this two-year sunset period, the major impact of increased longevity on health care expenditure is to delay the onset of the period of high expenditure.

Modelling by Richardson and Robertson (1999), which makes adjustments for this effect, suggests that the impact of ageing on health care expenditures may be quite small (see box 8.1). Indeed, Richardson and Robertson conclude that:

> Application of the simple needs model suggests that the impact of future ageing on the need for medical services will be so small that, in the absence of other factors, the size of the health sector would diminish in relation to GDP. (p. 348)

Prima facie, there is some tension between the assumption underlying this conclusion — namely that greater longevity will reduce per capita health care expenditures in older age cohorts — and the increase in these expenditure levels in recent years. (As noted in box 8.1, the Richardson and Robertson modelling indicates that there would be a substantial increase in the health expenditure share of GDP if the recent growth in expenditure levels in the older age cohorts continues).

However, there is widespread agreement that recent increases in expenditure on health care services in the older age cohorts have reflected a number of factors additional to the 'pure ageing' effect. In particular:

- Improvements in treatments used primarily by older people — for example, better joint replacement therapies and prostheses — are likely to have encouraged greater spending on health care and hospital services by this age group. (The impact of technological change on demand is considered in the next section).
- Greater uptake of these treatments by older people will have been facilitated by their faster than average income growth in recent years (see above).
- Some have also suggested that supplier-induced demand has been a contributing factor to higher per capita expenditures (see chapter 9).

More generally, these observations highlight the high degree of interaction between the key non-policy drivers of demand for health care services.

Box 8.1 **Estimating the impact of ageing on the demand for health care services**

Using a model made available through the Australian Private Hospitals Association website, Richardson and Roberts (1999) examined the impacts of ageing on health care expenditures under a number of different scenarios. Under each of the scenarios, adjustments were made to allow for reductions in per capita age cohort expenditures as a result of increased longevity (see text).

Amongst, other things, the modelling suggested that:

- If the only source of expenditure growth on health care was ageing of the population, and holding GDP constant, expenditure as a percentage of GDP would rise from a little over 8 per cent to about 10.4 per cent in 2006 and to 11.8 per cent in 2051.
- If population and GDP growth (ranging from 2.1 to 3.6 per cent a year) are added to the ageing effect, expenditures on health care as a percentage of GDP would decline.
- If age cohort expenditures continue to grow, then total health care expenditure as a percentage of GDP could rise markedly in the next century. For example, under a 'limiting case' scenario where expenditures in under 65 age cohorts continued to grow at the same rate as between 1981 and 1994, and those in the over 65 cohorts grew at double their rate over that period, expenditure on health care as a percentage of GDP could be more than 20 per cent by 2051.

Richardson and Robertson went on to test their hypothesis that the pure effect of ageing on health care expenditures is quite small with reference to historical and cross sectional health care expenditure data for Australia and a number of other countries. They concluded that the results of these analyses also '… cast very significant doubt on the belief that age/sex based need has been or will be a significant determinant of demand for health services'.

Source: Richardson and Robertson 1999.

8.3 Technological developments

Technological developments over the last few decades have greatly increased the capacity to treat illness and disabling conditions.

Some of these have provided for completely new treatment options, for example:

- organ transplants;
- hip and knee replacements;
- micro-surgery; and

- gene therapy.

But equally important have been developments that have improved the safety of treatments and the likelihood of successful outcomes. For instance, advances in anaesthetics have reduced the risk of most operations. And, perhaps even more importantly, there have been dramatic improvements in diagnostic techniques — for example, the development of magnetic resonance scanners and better resolution ultrasound scanners.

While the benefits of these sorts of technological improvements have come at a considerable financial cost to patients and the community, some other developments have had the added bonus of reducing treatment costs. A case in point is minimal access surgery, performed through small incisions. Apart from involving less pain for patients, it facilitates shorter hospital stays and recovery times than traditional surgery methods. A range of procedures can be performed in this way, including the removal of gall bladders and appendixes, bladder surgery, ulcer repair, hysterectomies, and bowel and knee operations. Similarly, advances in pharmacology have eliminated the need for surgery in the treatment of some forms of cancers and ulcers.

Such technological developments have had significant impacts on the level of demand for private hospital services:

- They have allowed private hospitals to offer a wide range of new and improved treatments.
- They have extended treatment options to a wider range of patients. For example, improvements in anaesthetics and diagnostic techniques, and the introduction of minimal access surgery, have made it possible to treat increasingly frail older people.

They have also been an important factor underlying the changing composition of services in the private hospital sector. For example, minimal access surgery and improved lens procedures have been major contributors to the significant growth in day procedures (see chapter 2). In this regard, one CEO of a private hospital commented that:

> New technology is providing a lot of opportunities, especially in day surgery. Day surgery [now] accounts for 60 per cent of our patients ...

Looking to the future, technological change will undoubtedly continue to have significant impacts on the private hospital industry. While it is obviously impossible to specify precisely what these impacts will be, it seems likely that future developments will underpin a continued shortening of treatment times and greater

demand for day procedures. This is particularly the case, given the more general trend away from institutionalised health care (see next section).

Such changes may, in turn, reduce the rate of growth in expenditure on hospital and other health care services. In this regard, Robertson and Richardson note that:

> It should not … be assumed that the inflationary pressures from technologies of the past will continue. Technology in the US is an endogenous variable and the US market has been undergoing a significant shift from one which rewards cost creation to one which rewards cost cutting. (p. 350)

8.4 Community attitudes to health care

Changing community preferences in regard to health care treatment and the effects of health care education will be further broad influences on demand for public and private hospital services alike.

As noted, lengths of stay in hospitals have been decreasing and day surgery is growing rapidly.

While cost pressures and advances in technology may have been the primary drivers of these changes, a concern to minimise time spent out of the home environment has also been a factor. Greater emphasis on home-based treatment has been very much evident in palliative health care. But in areas like child birth, the trend to minimise time spent in an institutional environment has also been apparent.

A greater emphasis on community and home-based services has also been evident in the provision of medical care to the elderly. There is now a focus on the elderly being able to choose to live in a supportive environment that is as close to their social and geographic community as possible (OECD 1996). Partly as a result of this, nursing homes are increasingly providing medical care that would previously have been provided by the hospital sector.

A continuation of these sorts of developments will have obvious ramifications for the nature and level of demand for private hospital services.

This will particularly be the case if governments move to integrate funding for various forms of community, aged and hospital care. In Australia and a number of other developed countries, governments have begun to canvass funding options which would allow people to move more easily between what are currently quite separate components of the care system.

Private health insurers are also beginning to look at similar sorts of initiatives. For example, three early discharge trials are currently being conducted in Victoria and South Australia. Each trial involves an agreement between the participating private

health insurers and hospitals to substitute outreach services for in-hospital care for an agreed daily benefit. The ultimate objective of these trials is to assess the scope to extend private health insurance to cover clinically appropriate (and potentially cheaper) alternatives to in-hospital care.

Health care education

Much health care education is designed to help individuals monitor and improve their state of health and thereby reduce their subsequent need to access 'remedial' health care services. Examples include:

- the skin cancer awareness campaign initiated in the early 1980s. The program emphasises the importance of prevention and early detection and treatment of melanoma and other types of skin cancer;
- the provision of information on the role of nutrition and exercise in preventing osteoporosis;
- various anti-smoking campaigns; and
- the campaign emphasising the importance of regular screening to assist early detection of breast and cervical cancer.

While successful campaigns of this sort will often reduce demand for private hospital and other remedial health care services, this will not always be the case. For instance, skin cancer campaigns may encourage people to seek treatment for conditions that they would not previously have done so.

9 Some future policy issues

The main aim of this report has been to describe the Australian private hospital industry and to look at some of the factors affecting its performance.

Some of these are beyond the power of governments to influence directly. Developments in medical technology and other non-policy drivers of demand for private hospital services as described in chapter 8, are cases in point.

But equally, future government health care policies and regulations governing the operation of private hospitals will have a critical bearing on outcomes in the industry. While it is not the purpose of this report to pronounce on what future policy settings should be, the discussion in earlier chapters raises a range of issues in relation to the current policy framework. This chapter explores a number of these issues further.

9.1 Industry-specific issues

Licensing controls

Restrictions on the number of beds

As set out in chapter 6, planning controls in most States and Territories restrict the number of private hospital beds. There are several related rationales for these controls, including:

- facilitating 'orderly' industry development, particularly through reducing the level of unused bed capacity in private hospitals;
- promoting equitable access to private hospital services;
- guarding against supplier-induced demand; and
- containing health care costs by limiting access to expensive, high technology equipment.

However, questions arise in relation to all of these:

- In most markets, the possibility of substantial unused capacity is accepted as a price worth paying for the efficiency benefits that usually come from competition between suppliers.
- It seems unlikely that bed controls improve access to private hospital services in 'disadvantaged' areas. The controls limit access in areas where demand for services exceeds the number of beds made available through the planning process. However, it is not apparent why any such capping effect should be matched by improved access in those areas and regions that do not have the economic capacity to support the number of beds that would be allowed under the planning controls. In this regard, a discussion paper released for the current review of Victoria's Health Services and related Acts (see box 9.1) concludes that bed licensing has manifestly failed to promote equitable access to private hospital services in Victoria (HSPR 1999, p. 56).
- The supplier-induced demand hypothesis — which postulates that, in response to an increase in the total number of medical providers, individual providers will supply more services to patients so as to maintain income levels or workloads — has been questioned by some commentators (see section 9.2). In any event, hospitals in their capacity as the providers of beds would seemingly have less scope than doctors to influence levels of demand.
- As noted in the HSPR discussion paper (p. 56), there are now various market pressures on private hospitals to contain costs. Indeed, the hospitals argue that the current market environment places undue pressure on their costs (see chapter 7).

While the benefits of bed controls seem questionable, equally, the direct costs do not appear to be large. As noted in chapter 6, in some jurisdictions the value of a bed licence is negligible, with the *maximum* cost of a licence in any individual jurisdiction being around $20 000. Using a discount rate of 10 per cent, this equates to an annual 'leasing' cost of $2000 or less than 2 per cent of average revenue per bed. The implication of these low values is that, in most parts of Australia, the controls are not significantly reducing the available number of private hospital beds.

Moreover, trade in bed licences (see chapter 6) will mitigate any tendency of the controls to reduce efficiency in the delivery of private hospital services. In essence, a market for bed licences provides less efficient operators with financial incentives to sell their licences to those who can deliver services more efficiently. That said, it would be unrealistic to expect this mechanism to work perfectly — particularly given the significant role of not-for-profit hospitals.

In sum, the need to retain bed controls is far from clear. Significantly, the Victorian Health Services Policy Review has proposed that this component of that State's

licensing arrangements be dismantled (see box 9.1). A number of other jurisdictions are currently reviewing their licensing arrangements for private hospitals.

Box 9.1 Some proposals for legislative reform in Victoria

In March 1999, a review team commissioned to look at the Victorian Health Services and related Acts released a discussion paper. In accordance with National Competition Policy legislative review requirements, the paper addresses a range of constraints on competition in public and private health care markets. Some of the key proposals in the paper are set out below.

Planning controls: The Review argues that controls on the number of private hospital beds provide little or no benefit in terms of containing health care costs, ensuring equitable access to private hospital services, or limiting the market power of health funds. In contrast, it contends that the controls increase hospital costs by a small amount and impede industry restructuring. It has proposed the controls be abolished.

Licensing of private hospitals: While supporting the need for licensing, the Review argues that many of the current requirements do not advance patient safety and can be dealt with in other ways. It has proposed a simplified licensing regime.

Taxation of private hospitals: The Review argues that not-for-profit private hospitals have an unfair competitive advantage over their for-profit counterparts by virtue of their exemption from paying sales tax, payroll tax, land tax, local rates and charges, stamp duty and financial transactions taxes. It has proposed that these exemptions end.

Competition between public and private hospitals: The Review documents a range of competitive advantages and disadvantages for public hospitals in treating private patients. It has proposed various measures to address these, including: requiring public hospitals to set commercial fees for private patients and removing controls which can prevent them from doing so; allowing public hospitals to retain private fee income; treating public and private hospitals equally for health insurance purposes; and removing exemptions for public hospitals from input taxes. (The Review specifies that, as an adjunct to the last proposal, there should be increased funding for services provided to public patients to offset the loss of input tax exemptions on those services.)

Day procedure private centres: The Review proposes that registration requirements for day procedure centres should be the same as for acute care private hospitals, and that there should be a redefinition of what constitutes a centre.

Promoting consumer choice and confidence: The Review proposes: consideration be given to establishing a 24 hour call centre in Victoria to provide health information to consumers; the publication of risk-adjusted, clinical performance indicators for public and private hospitals and day procedure centres; enhanced measures to guard against sub-standard performance by health care providers; and giving consumers right of access to their health care records.

Source: HSPR 1999.

Other licensing issues

During the Commission's discussions with the industry, a number of concerns about other aspects of the licensing arrangements emerged, including:

- delays in the processing of licence variations, antiquated requirements and inconsistencies in requirements across jurisdictions. As set out in box 6.1, these can sometimes entail not insignificant costs for hospital operators;
- less restrictive inspection requirements for day procedure facilities than for acute care hospitals. In this regard, the ACT Government (1998, p.8) said that:

  > Once a private day surgery facility has met the initial approval requirements of the Department, it is not subject to routine re-inspection unless required under other public health legislation ... Therefore, a day surgery facility could, while remaining in the same premises, change its practices (eg from ophthalmology to plastic surgery) without ever being subject to further clinical inspection. There is no mechanism to ensure that clinical protocols, practices and the quality of patient care are being maintained and suited to the procedures conducted. Private hospitals, by comparison are required to be inspected annually.

- restrictions limiting day procedure hospitals to treating patients who enter and exit the hospital on the same calendar day, rather than who are treated for less than 24 hours.

The Commission notes that the Victorian Health Services Policy Review has proposed changes to align the registration procedures for acute care and day care hospitals, and to simplify licensing arrangements for private hospitals more generally (see box 9.1). Such initiatives may also be relevant to licensing regimes in other jurisdictions.

Taxation arrangements for private hospitals

The efficient delivery of goods and services will usually require that individual providers are neither advantaged nor disadvantaged by government policies or regulations. The National Competition Policy embodies formal 'competitive neutrality' requirements where government business activities compete with private businesses. However, the underlying principles can be equally relevant to competition between private providers, or where the delivery of core government services involves an element of competition with the private sector.

This section looks at some competitive neutrality issues raised by the different tax treatment of particular types of private hospital. The broader competitive neutrality issues arising in relation to competition between public and private hospitals are canvassed in section 9.2.

Input tax exemptions

Exemptions from input taxes such as the Fringe Benefits Tax (FBT), payroll tax, sales tax and financial transactions taxes have given not-for-profit hospitals an advantage over for-profit hospitals in competing for patients. Impending changes to some of these taxes will reduce this advantage:

- The Goods and Services Tax (GST), to take effect from 1 July 2000, will be accompanied by the abolition of sales tax and some financial transaction taxes. Services provided by private hospitals — whether for-profit or not-for-profit — will not generally attract the GST.
- Not-for-profit hospitals are to be subject to FBT, although a tax free threshold for fringe benefits provided to employees will apply.

Nonetheless, there is still the question of whether the remaining input tax exemption advantages for not-for-profit private hospitals are justified.

The major argument put in favour of exemptions is that they help not-for-profit hospitals to provide a more caring environment and services to disadvantaged patients, and to support other community services:

- Staffing levels are higher in not-for-profit hospitals than in for-profit facilities (see appendix tables B.22 and B.23), although it is not clear to what extent these higher levels translate to greater levels of care.
- Some religious groups said their hospitals provide a range of services for which there is no fee — services which governments would have to take over if the tax concessions were abolished.
- Another religious group noted that not-for-profit hospitals contribute significantly to community services such as aged care facilities.

The same sorts of arguments have been put for input tax exemptions for charitable institutions (see IC 1995) and not-for-profit nursing homes (see PC 1999a).

However, while the financial savings from the exemptions could be used to promote these aims, they could also be used to compensate for inefficiencies in not-for-profit hospitals. Alternatively, they could allow not-for-profit hospitals to increase remuneration levels for staff, thereby giving these hospitals a competitive edge in attracting and retaining staff. In this regard, one for-profit group said that salary packaging made possible by the current exemption from FBT potentially allows not-for-profit hospitals to set their nursing salaries 15 per cent higher than in for-profit hospitals. The Victorian Health Services Policy Review (1999, p. 64) said that salary packaging in the not-for-profit sector has been increasing with inflationary effects across the whole of the industry.

Assessing the extent to which input tax exemptions have been used to underwrite inefficiencies in not-for-profit hospitals, or to bolster their competitiveness against the for-profit sector, is well nigh impossible. While unit costs in the not-for-profit sector are generally higher than in the for-profit sector, determining the causes of these cost differences is difficult (see chapter 5).

Suffice it to say that input tax concessions create the potential for resource misallocation to arise. Reflecting this concern, the Victorian Health Services Policy Review has proposed an end to input tax exemptions for not-for-profit private hospitals (p. 64).

However, if support provided to not-for-profit organisations by input tax concessions is significant and governments wish to continue that support, it may be difficult to identify alternative mechanisms that do not involve even higher efficiency costs (IC 1995, pp. xxxv). And, as the Commission noted in its report on nursing homes, if the value of the exemptions is very small, even the administrative costs of taking action to remove them might exceed the ensuing efficiency gains (PC 1999a, p. 101).

Aside from data on payroll tax payments by for-profit hospitals, information indicating the value of the input tax concessions received by not-for-profit hospitals is limited:

- Some years ago, Health Care of Australia estimated that input tax exemptions reduced the total costs of not-for-profit hospitals by around 5 per cent (IC 1995).
- It appears that payroll tax exemptions would have accounted for about half of this cost reduction. According to unpublished ABS data, all but two of the 177 for-profit hospitals paid payroll tax in 1996–97. The average tax paid as a share of total hospital expenditure ranged from 2.1 per cent for the very largest facilities to more than 3 per cent for some smaller and medium sized facilities (table 9.1).

As noted above, the introduction of the GST and the changes to FBT arrangements will remove a significant part of the non-payroll tax component of the advantage currently enjoyed by not-for-profit private hospitals. This, in turn, suggests that payroll tax exemptions should be the focus of any future initiatives to address non-neutralities in the input tax treatment of the two sectors.

Table 9.1 **Payroll tax paid by for-profit private hospitals[a], by hospital bed size, 1996–97**

	Average tax paid per hospital	*Average tax paid as a share of total expenditure per hospital*
	$000	%
0–25 beds	35	3.2
26–50 beds	108	3.1
51–100 beds	260	3.2
101–200 beds	614	2.9
Over 200 beds	1 119	2.1
All for–profit hospitals	250	2.6

a Private acute care and psychiatric hospitals.

Source: Unpublished ABS data.

Income tax exemptions

Exemption from income tax might be seen as providing not-for-profit private hospitals with a further competitive advantage over their for-profit rivals. For example, a common contention is that the capacity of not-for-profit hospitals to use untaxed surpluses to invest in improved facilities and infrastructure gives them an advantage in attracting doctors and patients.

However, the extent of any such advantage and the scope to address it, is far from clear:

- For tax paying entities, interest costs are an allowable deduction from income. Hence, for the component of private hospital infrastructure funded by debt, the income tax exemption would seemingly have no impact on the relative competitive position of the two sectors.
- Addressing any competitive advantage for not-for-profit hospitals from their capacity to fund infrastructure (or subsidise charges) from untaxed earnings or donations, could be administratively complex. In particular, not-for-profit entities will always spend money so as to report a zero taxable profit. Thus, without deeming or similar measures, it would be difficult to collect income tax from a not-for-profit hospital. The Commission's report on Charitable Organisations (IC 1995, pp. 274-275) elaborates further on the difficulties of defining and measuring 'income' for not-for-profit organisations.

In the face of these considerations relating to significance and practicality, addressing any competitive advantage for not-for-profit hospitals from income tax exemptions may not be a high priority.

Contracting frameworks

Contracting between hospitals and health funds

As discussed in chapter 7, private hospitals argue that the current contracting framework gives health funds too much bargaining power which they are using to unfairly reduce rates paid to hospitals. Apart from compromising their financial performance, the hospitals contend that this pressure on rates has flow-ons for the quality of care they can deliver.

However, in the Commission's view, there would be little merit in returning to an approach which effectively allowed hospitals to automatically pass on cost increases to health funds and their customers. Rather, the more relevant policy question is whether the new contracting framework needs to be modified to produce better outcomes for the community from the negotiating process.

In this regard, one aspect of the current policy framework that warrants further attention is the prohibition on private hospitals (other than those within the one ownership group) voluntarily sharing information on the outcomes of recent rate negotiations. While this prohibition may help to prevent collusion between hospitals, it may also impose costs. For example, as discussed in chapter 7, some of the major health funds are no longer offering contracts to all private hospitals. In these circumstances, the sharing of information on prices may help individual hospitals determine what performance improvements are necessary to secure contracts. As the ACCC noted in relation to the application by the five Queensland hospitals for authorisation of a joint negotiating agreement:

> ... the exchange of price related information may enable [the hospitals] to improve their overall cost efficiency (1999b, p. 50).

In effect, the current arrangements disadvantage stand-alone hospitals given that hospitals in the one ownership group can readily and legally share price information.

As well as revisiting this aspect of the current legislative framework, there may also be value in implementing a voluntary code of conduct for rate negotiations between hospitals and the health funds. This could be a low cost way of ameliorating some of the hospitals' concerns about the negotiating practices of the funds.

Contracting between hospitals and doctors

As the discussion in chapter 7 indicates, medical specialists have considerable power in negotiations about their terms of access to private hospitals and the

equipment a hospital purchases. Hospitals also have only limited scope to influence the clinical practices of specialists operating on their premises.

An issue for future policy is whether this influence is excessive and impedes efficient hospital management. Such problems are more likely to arise if there are inadequate numbers of specialists. Some policy considerations pertaining to the supply of medical specialists are discussed in section 9.2.

The Trade Practices Act

To guarantee they do not breach the price fixing provisions of the TPA, doctors and hospitals (or hospital groups) must negotiate with the funds on an individual basis. While the ACCC can authorise joint negotiations, the limited experience to date (see section 7.4) suggests that this may be a time consuming and uncertain process.

Also, like the current contracting legislation, the TPA gives group hospitals a negotiating advantage over stand-alone hospitals. This is because, for the purposes of the TPA, group hospitals are treated as single entities, thereby allowing them to share information (including on rates) in their dealings with health funds, without risking being in breach of the Act.

The impact of different ownership structures on the incidence of the TPA is not an issue for the private hospital industry alone. However, it may warrant consideration in a wider context. (See, for example, PC 1996, pp. 69–70).

Quality of service and consumer information issues

Traditionally, quality objectives in the private hospital industry have been pursued primarily through licensing requirements for hospitals and the professional staff working in them. Word of mouth and the reluctance of doctors to treat patients in sub-standard facilities also provided a discipline on quality. More recently, the accreditation regime and the need for hospitals to secure contracts with health funds have sharpened the incentives for them to provide quality services.

In some markets, benchmarking of service quality is used to complement explicit quality assurance mechanisms. For example, the Steering Committee for the Review of Commonwealth/State Service Provision collects and tabulates performance indicators for services such as education, health and justice (see SCRCSSP 1999).

Such indicators can help individual providers identify areas where there is scope to improve performance, as well as inform consumers about the quality of services

available. Increasing the capacity of consumers to make informed choices promotes competition and thereby increases the onus on providers to operate efficiently and effectively.

As discussed in chapter 5, performance indicators for the hospital sector generally, and private hospitals in particular, are at an early stage of development. Indeed, there are divergent views amongst some of the main players about the nature and form of appropriate indicators.

However, there is general recognition that better information on outcomes is required and that more information should be available to prospective patients and their families. To this end, there are a range of initiatives underway. For example, in addition to the EQuIP clinical indicators and the Measures of Appropriate Clinical Care project noted in chapter 5:

- a range of work has been undertaken or is in train for the National Hospitals Outcomes Program; and
- there have been various initiatives at the State Government level (see, for example, HSPR 1999, chapter 11).

Those working in this area face many challenges in developing widely accepted indicators. Part of the problem is that outcomes from hospital treatment must be targeted through clinical indicators of successful treatments and misadventures. Yet, even if these are tabulated for individual DRGs, differences in outcomes across hospitals can reflect variations in the complexity of cases rather than in clinical practice. Also, such indicators will not directly identify whether performance differences are attributable to the input of hospitals or of doctors, or even of patients.

To address these challenges, the Victorian Health Services Policy Review has proposed that the Commonwealth and the States collaborate to develop a set of risk-adjusted clinical performance indicators (HSPR 1999, p. 137). Cross tabulating results for doctors who operate in several hospitals would potentially allow separation of their contributions to observed outcomes from those of the hospitals.

Of course, developing better indicators is only the first step. There is the related question of how they should be used. In some states of the USA, for example, there are published 'scorecards' for doctors and hospitals. And in the UK, 'league tables' comparing various National Health Service facilities are now published (HSPR, pp. 128–32).

While such scorecards have a number of attractions, they also have drawbacks. Apart from opposition from the medical profession who may become reluctant to

treat high-risk patients, there is a problem in balancing the objective of simplicity with the need for indicators to be meaningful. For example, a scorecard showing a hospital's performance averaged across all treatments might provide little information to a patient seeking cardiac treatment. Hence, published information may need to differentiate between procedures — a quite complex output for many consumers. Finding the right balance between simplicity and useful information will not be easy. As part of this process, the Commonwealth Government's Consumer Benchmarking Project is aiming to provide consumers with information on the quality of both private hospital and health insurance products and services.

Another possible use of clinical indicators is to assist health funds, hospitals and health departments deal with sub-standard performance by doctors. This could build on the peer review systems already in place in the private hospital industry. Thus, the Victorian Health Services Policy Review has raised the prospect that, where a practitioner's results against clinical indicators are significantly below average, he or she could be counselled, required to undertake additional training, or even prevented from performing certain procedures (HSPR 1999, p. 137). However, doctors have argued that such proposals amount to interference in the patient doctor relationship and are a harbinger of 'managed care'.

Future policy initiatives will need to be sensitive to these divides. But, at the same time, such divides should not be allowed to jeopardise efforts to improve information on the quality of service provided in either the private or public hospital systems. Importantly, the absence of good information on service quality could hamper broader initiatives to improve the delivery of hospital services through initiatives such as competitive tendering for the delivery of public patient services (see next section).

9.2 Some broader health policy issues

In addition to the sort of sector-specific issues discussed above, a range of broader health care policies will influence future outcomes in the private hospital industry. Some of these — for example, funding for public hospitals and the general framework for private health insurance — have been widely addressed in other contexts, including by the Commission in its report on private health insurance (IC 1997).

This section looks at two less widely canvassed health policy issues of relevance to the private hospital industry — namely competition between the public and private hospital systems and the supply of medical specialists. It also comments briefly on

the recent Commonwealth initiatives to encourage people to take out, or retain, private health insurance.

Competition between private and public hospitals

The principle of competitive neutrality discussed above in relation to competition between different types of private hospital, is equally relevant to competition between private and public hospitals.

Traditionally, competition between the two hospital sectors has mainly been for private patients.

However, the role of the private sector in treating public patients is increasing (see chapter 2). In some cases, this involves governments funding existing private hospitals to deliver some public patient services. More recently, governments have involved the private sector in the financing, construction and operation of new public patient facilities through BOO/BOOT type arrangements. In the future, competitive neutrality issues may arguably be more important in these areas than in the delivery of services to private patients.

Competition for private patients

A number of regulatory/policy arrangements advantage public hospitals in competing with private hospitals for private patients. For example:

- As discussed above, private hospitals face additional, though relatively small, costs from the bed licensing system. For-profit private hospitals also pay a range of taxes from which public hospitals are exempt.
- Accommodation charges for private patients in public hospitals have been set at levels which have not generally covered costs. This is because charges higher than the benefits paid by health funds — generally equal to the minimum default benefit set by the Commonwealth of a little over $200 a day — would see many of these private patients instead opt for treatment as public patients to avoid out-of-pocket costs. Suffice it to say that, on average, accommodation charges for private patients in public hospitals are only about half those in private hospitals, providing an incentive for self-paying private patients in particular, to seek treatment in public facilities.

Equally, public hospitals also suffer disadvantages in competing for private patients. For instance:

- Their capacity to actively compete for private patients is constrained. In particular, they do not have access to capital market funding for refurbishment of facilities, in order to match the quality of facilities available in the private sector. And, they have not been allowed to give fee-paying private patients preference over public patients.
- The financial incentive for them to treat more private patients, or to seek to negotiate accommodation benefits with health funds that more closely reflect the costs of treating their private patients, may be limited. One concern is whether higher private patient income might lead to reduced levels of Commonwealth hospital funding. Also, unlike private hospitals, they cannot access the Pharmaceutical Benefits Scheme for inpatients, meaning that the cost of drug treatments provided to private patients must come from their general drug budgets. (However, proposed Commonwealth arrangements which will extend PBS subsidies for pharmaceuticals provided by public hospitals to all non-admitted patients and to admitted patients on discharge, and for chemotherapy drugs provided to public and private day-only admitted patients, would partially address this disadvantage.)

The Commission's report on Private Health Insurance (IC 1997) and the discussion paper for the Victorian Health Services Policy Review elaborate on these and other competitive non-neutralities.

However, the pursuit of competitive neutrality in this area is likely to prove complicated.

At a practical level, while public hospitals are the responsibility of the States and Territories, some of the possible policy changes would have implications for Medicare arrangements and Commonwealth taxes. Hence, cooperation between the States and the Commonwealth Government would be required.

More fundamentally, it is important that the pursuit of competitive neutrality objectives has regard to the broader social goals underlying the operation of the public hospital system. For example, queue jumping by private patients in public hospitals would challenge a key tenet of the Medicare system, namely equity of access to public hospital and other basic health care services. The need to temper efficiency goals with broader social considerations is the reason why the National Competition Policy makes provision for a public interest test in determining whether to apply competitive neutrality policies to a particular market.

Yet in the absence of a major change to the *raison de'etre* of the public hospital system, it is a moot point whether reforms that made it more financially attractive for public hospitals to treat private patients would have a significant impact on their

private patient volumes. Similarly, the high proportion of private patients who already receive their treatment in private hospitals suggests that addressing competitive advantages currently enjoyed by public facilities may also have only a limited impact on the distribution of patients across the two hospital sectors.

Treatment of public patients by the private sector

As noted, the increasing role of the private sector in delivering public patient services again raises the spectre of competitive neutrality. Indeed, failure to take account of any significant non-neutralities is likely to confuse assessments of whether the public or private sector can deliver particular services more efficiently and effectively.

The increasing role of the private sector in the delivery of public patient services also puts a much greater premium on governments having access to good information on the quality of services and clinical outcomes in both public and private hospitals. In addition, further research and evaluation of policy experimentation will be necessary to help determine which forms of private sector involvement are best suited to particular circumstances.

In this latter regard, the Victorian Health Services Policy Review compared and contrasted a number of different approaches:

- opening up opportunities 'at the margin' for private operators to tender for public patient funding;
- opening up large parts of funding for public patients to competition ('the core business competition model'). The discussion paper identifies two variants of this option — wider application of the BOO/BOOT approach where capital replacement or augmentation is required, and shorter term contracting potentially involving the transfer of public infrastructure to the private sector; and
- allowing private operators to compete for the right to manage public facilities. (HSPR 1999, chapter 9).

The Review pointed to weaknesses in all of these approaches. In relation to the large scale tendering approach, it raised particular concerns about high transactions costs and the need to ensure 'that the public sector thrives as an alternative service delivery model'. It also argued that, in Victoria, a significant amount of competition at the sub-contractor level occurs under current arrangements. The Review went on to conclude:

> ... we believe that there is insufficient evidence at this stage to support the wholesale tendering of public patient services in Victoria ... The next few years should provide rich evidence of the success or otherwise of that model of service delivery as privately

operated hospitals are established and placed under the social microscope. Further, tendering under that model should await the outcome of rigorous evaluation. (HPSR 1999, p. 108).

Incentives to take out private health insurance

As set out in chapter 6, in the last few years, there have been several Commonwealth Government initiatives to try to stem the flow away from private health insurance. These have included rebates that have reduced the cost of private health insurance and the introduction of lifetime community rating arrangements. By increasing the potential number of private hospital patients, these initiatives will, in turn, benefit the private hospital industry.

The lifetime community rating arrangements are broadly in line with proposals in the Commission's report on private health insurance (IC 1997). As noted in chapter 6, the arrangements provide for higher premiums for those taking out health insurance later in life. As such, they will reduce hit and run entry to fund membership, as well as the more general 'adverse selection' problems associated with the community rating of premiums. The latter has led to an ongoing cycle of lower risk consumers abandoning private health insurance, an increase in premiums to reflect the higher risks of those continuing to hold insurance, leading to further declines in membership.

The latest rebate to those holding private health insurance is projected to cost between $1.4 billion and $1.7 billion a year. Given the large budgetary cost involved, it will be important for the government to monitor the impacts of the rebate over time.

The supply of medical specialists

The supply of specialists has an important impact on outcomes in both the public and private hospital systems. As well as influencing the cost of hospital services, the availability of specialists influences access to services. Some of the particular implications for private hospitals were described in chapter 7.

The supply of medical specialists is controlled in the first instance by limits on the number of training places in professional medical colleges. The colleges set numbers of places having regard to such things as indicative specialist to population ratios and the availability of training places in teaching hospitals. There are also restrictions on the accreditation of specialists trained in other countries.

There are several rationales for these controls on supply, including to:

- ensure that specialists are appropriately qualified and trained;
- balance the number of trainees with the capacity of teaching hospitals to provide the necessary practical training; and
- guard against problems with over-servicing of patients, or so called supplier-induced demand.

However, there have been longstanding concerns that some of the colleges have unduly restricted supply to increase specialists' incomes and general bargaining power. Paterson (1994) provided a range of evidence suggestive of such outcomes for a number of the specialties at that time.

From a policy perspective, more research on supplier-induced demand seems particularly important. As well as providing a major rationale for arrangements that have the potential to indirectly increase the cost of hospital services, the theory of supplier-induced demand influences policies in a number of other health care areas.

Yet the theory, and the supporting empirical evidence, remain controversial:

- Critics argue that conventional economic analysis can explain much of the supplier-induced demand phenomenon. For example, Paterson (1994) contends that where consumers value medical services sufficiently to contribute to their cost, an expansion in services in response to increased numbers of suppliers may be no more than the market operating efficiently to satisfy unmet demand.
- However, others argue that this line of reasoning depends on an assumption that consumers of medical services are well informed about their treatment needs. They go on to contend that if this is not the case, there is likely to be scope for doctors to over-service, even when consumers are prepared to contribute to the costs of their treatment.

In terms of future policy, the key issue may not be whether there is scope for supplier-induced demand in the provision of medical services, but rather the extent to which it is a significant determinant of demand. It will also be important to establish whether any observed 'supplier-induced demand' for particular services can be explained in terms of a normal market response to insurance rebates set at levels which obviate the need for a patient contribution to the cost of treatment, as distinct from a genuine market failure.

A Private hospital revenues, charges and costs

A.1 Revenue

Sources of revenue

Table A.1 shows the sources of private hospital revenue for 1991–92 and 1996–97. The data include day hospital revenues which accounted for a little over 3 per cent of total private hospital revenue in 1996–97.

Table A.1 **Sources of private acute care and day hospital revenue, 1991–92 and 1996–97**

	1991–92	*Share*	1996–97	*Share*
	$m	%	$m	%
Commonwealth Government	107	4.8	354	10.1
Health funds	1 635	73.3	2 437	69.8
Individuals	346	15.6	288	8.2
Other[a]	143	6.4	415	11.9
Total expenditure	**2 232**		**3 493**	

a 'Other' includes expenditure by workers' compensation and compulsory third party motor vehicle insurers, as well as non-patient sources of private hospital income, such as investment income.

Source: AIHW Health Expenditure Bulletin, 1997–98

Revenue from the Commonwealth Government

The Commonwealth Government's contribution to revenue comes through funding for Department of Veterans' Affairs (DVA) patients treated in private hospitals. This source of revenue has become increasingly important for private hospitals during the 1990s. Between 1991–92 and 1996–97, the number of private hospitals providing services to DVA patients increased from 193 to 275, DVA separations rose from 39 000 to 109 000, and DVA bed days rose from 240 000 to 600 000. DVA separations and bed days in private hospitals increased again in 1997–98 to

135 000 and 715 000, respectively (AIHW, *Australian Hospital Statistics, 1997–98*).

Revenue from the health funds

The health funds are by far the largest contributors to private hospital revenue, accounting for some 70 per cent of total revenue in 1996–97. However, the health funds' share of total revenue has declined somewhat during the 1990s, despite an increase of over 50 per cent in the number of insured patients treated in private hospitals.

Revenue from individuals

Payments made by individuals to private hospitals fall into two categories — copayments made by insured patients and payments by self-paying patients:

- DHFS data for 1996–97 indicate that gap payments by insured patients represented around 6 per cent of hospital charges (DHFS, *Hospital Casemix Protocol, 1996–97*).
- Unpublished ABS data for 1996–97 indicate that self-paying patients accounted for 4.3 per cent of private hospital patient days. If payments by this group of patients are broadly in proportion to their share of patient days, then they would have accounted for about 4 per cent of private hospital revenue in 1996–97.
- The implied total contribution from individuals to revenue of 10 per cent is broadly consistent with the 8.2 per cent share for individuals reported in table A.1.

As shown in table A.1, payments by individuals to private hospitals fell in absolute as well as share terms between 1991–92 and 1996–97. However, a significant increase in gap payments in 1997–98 to around 7.7 per cent of total private hospital charges (DHAC 1999), suggests that total payments by individuals may well have grown in the last couple of years.

Revenue from compensable patients

Growth in revenue from compensable patients was the major contributor to the increased revenue share reported in table A.1 for the 'other' category. The number of compensable separations rose from around 53 000 in 1991–92 to more than 73 000 in 1997–98, an increase of close to 40 per cent (AIHW, *Australian Hospital Statistics, 1997–98*).

Patient revenue components

There are a number of components to private hospital patient revenue (table A.2). The significance of these in relation to individual patients will depend on the nature of the treatment provided.

Table A.2 **Key patient revenue components**

Component	*Factors affecting the overall charge*
Overnight patients	
Accommodation	Patient type (eg surgical, medical) Room type (single, shared room) Special needs (eg ICU, CCU, neonatal)
Theatre	Theatre band
Other hospital services/supplies	Pharmaceuticals, prostheses
Same day patients	
Accommodation/theatre	Same day band (1–4), unbanded
Other hospital services provided	Pharmaceuticals, prostheses

Over 90 per cent of revenue in acute care and day private hospitals comes from accommodation and theatre charges.

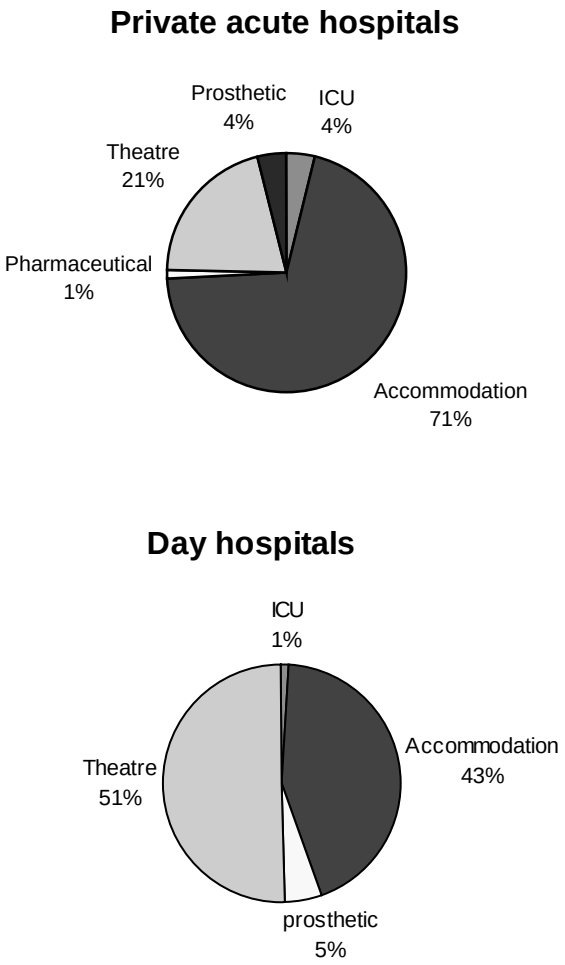
However, as shown in figure A.1, the balance between these two components varies across the two sectors:

- In acute care facilities, accommodation charges provide around 70 per cent of total revenue.
- In day facilities, theatre charges provide around 50 per cent of total revenue.

Revenue by DRG group

In 1996–97, the top 15 Diagnosis Related Groups (DRGs) accounted for about one-quarter of total patient revenue earned by private acute care hospitals (table A.3). Confinement was the top revenue earner — accounting for over 3 per cent of all revenue — followed by hip replacements. Both of these DRGs involve significant hospital stays for patients. However, lens procedures which ranked fourth typically have very short lengths of stay. Their high revenue ranking reflects the large number of procedures performed.

Figure A.1 **Share of revenue from accommodation, theatre and other services, private acute care and day hospitals, 1996–97**



Note: Accommodation charges in acute care hospitals include labour ward charges. Pharmaceuticals account for 0.2 per cent of revenue in day hospitals. ICU revenue covers the payments received from all critical care units, including coronary care units and combined ICU/CCUs. As noted in chapter 3, a small, but growing number of private hospitals have these facilities.

Source: DHFS Hospital Casemix Protocol (unpublished data).

Revenue profiles by hospital ownership and size

Revenue shares for broad types of treatment, by ownership group and hospital size are shown in tables A.4 and A.5. The key feature for all ownership and size groups is the increasing importance of advanced surgery and the declining share of more routine surgery.

Table A.3 **Top 15 DRG revenue episodes[a], private acute care hospitals, 1996–97**

DRG	*Revenue*	*Share of total revenue)*
	$m	%
674 Vaginal delivery without complications	103	3.27
405 Hip replacement	72	2.29
421 Knee procedures	62	1.96
099 Lens procedures	62	1.95
843 Major affective disorders	60	1.90
407 Joint and limb reattachment	59	1.87
297 Cardiac intervention	52	1.60
656 Uterine, adnexa procedures	48	1.51
291 Coronary bypass	45	1.42
367 Cholecystectomy	44	1.39
670 Caesarean delivery	40	1.28
274 Circulation disorders	39	1.24
320 Hernia procedures	33	1.04
335 Colonoscopy	28	0.89
332 Gastroscopy	24	0.77
Total Top 15	771	24.4
Balance	2 392	75.6
Total	3 163	100.0

a Top 15 DRGs by total hospital charges for insured patients only.

Source: Commission estimates based on DHFS Hospital Casemix Protocol (unpublished data); DHFS Australian Casemix Report on Hospital Activity 1996–97; and ABS Private Hospitals 1996–97.

Table A.6 provides a breakdown of leading DRG revenue earners according to hospital ownership and size.

Because for-profit group and religious/charitable hospitals between them account for the bulk of industry revenue (84 per cent in 1996–97), their DRG rankings are similar to the industry as a whole. However, for both groupings, more complex coronary and cardio procedures are a more important revenue earner than for the industry as a whole. In contrast, for-profit independent and other not-for-profit hospitals earn a much greater share of their revenue from rehabilitation than does the industry as a whole.

Cardiac and coronary procedures again feature prominently as revenue earners in the over 200 bed category. Also, the very smallest hospitals (0–25 beds) have a very different clinical revenue profile from the other hospital types. Indeed, the only DRG in common with any other hospital type is major affective disorders. These small hospitals are primarily bush nursing hospitals in Victoria and the small community hospitals in South Australia and the Northern Territory.

Table A.4 Private hospitals[a] clinical revenue profile[b], by ownership group, 1991–92 and 1996–97

	Revenue share, 1991–92 (%)				*Revenue share, 1996–97(%)*			
Patient type	*For-profit group*	*For-profit Ind.*	*Religous/ charitable*	*Other not-for-profit*	*For-profit group*	*For profit Ind.*	*Religous/ charitable*	*Other not-for-profit*
Advanced Surgery	16	16	24	17	24	20	28	18
Surgery	30	33	28	28	25	25	25	23
Obstetrics	5	4	9	9	6	2	8	7
Medical and minor surgery	25	31	31	40	23	19	25	30
Psych/rehab	18	11	2	..	11	22	3	8
Nursing Home Type	0.3	0.1	0.7	0.6	0.1	..	0.4	1.2
Day bands	6	5	6	6	12	13	11	13
Patient revenue ($m)	665	240	950	220	1 296	238	1 372	256

a Private acute care and psychiatric hospitals.

b Based on average HCF charges for each patient type.

Source: Commission estimates based on unpublished ABS data and HCF Charges Survey 1996.

Table A.5 Private hospitals[a] clinical revenue profile[b], by hospital bed size, 1991–92 and 1996–97

	Revenue share, 1991–92 (%)					*Revenue share, 1996–97 (%)*				
Patient type	0–25	26–50	51–100	101–200	Over 200	0–25	26–50	51–100	101–200	Over 200
Advanced Surgery	5	12	15	23	27	9	19	20	28	31
Surgery	12	31	31	29	27	12	25	26	26	24
Obstetrics	5	4	7	8	8	1	2	8	7	7
Medical and minor surgery	45	28	28	29	33	40	21	22	26	26
Psych/rehab	19	18	13	6	1	12	20	13	4	1
Nursing Home Type	7	0.3	0.3	0.2	0.2	3	1	..	0.1	0.2
Day bands	6	5	7	5	5	23	12	11	11	11
Patient revenue ($m)	64	283	634	578	516	70	327	810	1 067	890

a Private acute care and psychiatric hospitals.

b Based on average HCF charges for each patient type.

Source: Commission estimates based on unpublished ABS data and HCF Charges Survey 1996.

Table A.6 **Top 5 DRG revenue episodes[a], private acute care hospitals, by ownership group and hospital bed size, 1996–97**

Ownership categories	*Bed size categories*
For-profit group	*0–25 beds*
674 Vaginal delivery	846 Eating disorders
843 Major affective disorders	252 Heart failure and shock
405 Hip replacement	843 Major affective disorders
421 Knee procedures	056 Dementia & related disturbances
291 Coronary bypass	942 Other factors influencing health status for persons aged over 79
For-profit independent	*26–50 beds*
941 Rehabilitation	843 Major affective disorders
674 Vaginal delivery	941 Rehabilitation
843 Major affective disorders	421 Knee procedures
421 Knee procedures	099 Lens procedures
656 Uterine, adnexa procedures	656 Uterine, adnexa procedures
Religious/charitable	*51–100 beds*
674 Vaginal delivery	674 Vaginal delivery
405 Hip replacement	941 Rehabilitation
297 Cardiac intervention	843 Major affective disorders
291 Coronary bypass	656 Uterine, adnexa procedures
407 Joint and limb reattachment	099 Lens procedures
Other not-for-profit	*101–200 beds*
674 Vaginal delivery	674 Vaginal delivery
099 Lens procedures	405 Hip replacement
656 Uterine, adnexa procedures	407 Joint and limb reattachment
405 Hip replacement	656 Uterine, adnexa procedures
941 Rehabilitation	367 Cholecystectomy
	Over 200 beds
	297 Cardiac intervention
	674 Vaginal delivery
	291 Coronary bypass
	274 Circulation disorders
	405 Hip replacement

a Top 5 DRGs by total hospital charges for insured patients only.

Source: DHFS Hospital Casemix Protocol (unpublished data***).***

Decomposition of recent revenue growth

As noted in chapter 4, increased numbers of admissions have been responsible for most of the growth in private hospital revenues during the 1990s. Indeed, the Commission estimates that, between 1991–92 and 1997–98, admissions growth

accounted for more than 90 per cent of the increase in real patient revenues (table A.7)

Table A.7 **Decomposition of changes in real patient revenue[a], private hospitals[b], 1991–92 to 1997–98[c]**

	Real change in patient revenue	*Usage component*	*Average charge component*
	$m	%	%
1992–93	128	65	33
1993–94	102	83	17
1994–95	160	111	-10
1995–96	164	118	-17
1996–97	191	82	17
1997–98	77	108	-8
1991–92 to 1997–98	822	93	7

a Estimated by holding charges per admission constant and calculating the effect on revenue over a defined period if only hospital usage had changed (and vice versa).

b Private acute care and psychiatric hospitals.

c 1991–92 prices. Components may not add to 100 per cent due to rounding and the existence of an 'interaction' factor. 'Interaction' factors were evenly distributed between the two components.

Source: Commission estimates based on ABS Private Hospitals, various issues.

The contributions of changes in usage and average charges to revenue growth for different ownership and hospital size categories are shown in table A.8. By and large, the results are the same as for the industry as a whole — greater usage explains most of the growth in revenue. Only for hospitals in the 51–100 bed category were increases in average charges the major contributor to revenue growth.

A.2 Charges

Charging and health fund benefit arrangements

Insured patients in contracted hospitals

For most insured separations, the patient's health fund and the hospital will have a contract arrangement. As part of this arrangement, they will have agreed on the fees and charges applicable to the full range of hospital services and treatments.

There are six principal service categories for charging purposes — accommodation, theatre, critical care, single use items, prostheses and pharmaceuticals. As noted

above, the first two are by far the most important, accounting, on average, for more than 90 per cent of total private hospital revenue.

Table A.8 **Decomposition of changes in real patient revenue, private hospitals[a], by ownership group and hospital bed size, 1991–92 to 1996–97[b]**

Hospital type	*Real change in patient revenue*	*Real growth in patient revenue*	*Usage component*	*Average charge component*
	$m	%	%	%
Ownership categories				
For-profit group	491	74	80	20
For-profit independent	-27	-11	96	5
Religious/charitable	274	29	114	-14
Other not-for-profit	9	4	212	-111
Size categories				
0–25 beds	-2	-2	[c]	[c]
26–50 beds	9	3	[c]	[c]
51–100 beds	88	14	41	56
101–200 beds	374	65	86	9
Over 200 beds	277	54	111	-7

a Private acute care and psychiatric hospitals.

b 1991–92 prices. Components may not to 100 per cent due to rounding and the existence of an 'interaction' factor. 'Interaction' factors were evenly distributed between the two components.

c The decomposition for hospitals with up to 50 beds results in very high numbers due to a large increase in separations and large decrease in the average charge component. These results are meaningless in the context of real revenue remaining virtually the same over the period.

Source: Commission estimates based on ABS unpublished data.

The traditional basis for private hospital accommodation charges and the accompanying health fund benefits is a daily rate:

- Charges and benefits for overnight patients vary according to the patient type — such as advanced surgical, surgical, and medical. Step-down benefits after a specified period of hospitalisation usually apply to each patient classification, while discounted rates sometimes apply to pre-surgical bed days.
- Separate charging arrangements apply to same day patients, with health fund benefits dependent on the procedure performed.

While the items included in the accommodation charge vary somewhat between health funds, the coverage in a major fund's standard HPPA contract shown in box A.1 is broadly representative.

Theatre charges cover:

- theatre staff salaries and related charges;

- equipment maintenance and depreciation charges;
- all theatre consumables and specified single use items; and
- specified pharmaceuticals.

Hospitals and health funds usually base theatre charges and benefits on the National Procedure Banding Committee's recommended theatre banding of MBS Item Numbers.

Box A.1 **Representative components of an accommodation charge**

Accommodation is charged on an all inclusive basis including, but not limited to, the following:

- all nursing salaries and related charges, including the charge for extra nursing as required;
- allied health services;
- specified pharmaceuticals;
- all consumables;
- rehabilitation therapy and associated salaries and charges provided as part of approved rehabilitation programs;
- psychiatric therapy and associated salaries and charges provided as part of approved psychiatric programs;
- housekeeping type services, including all meals, television, local telephone calls and hospital linen and laundry (excluding personal laundry) services; and
- general hospital overhead charges (including administration and hotel services).

Source: A major health fund

Case payments

As noted in the body of the report, a recent development in contracts between health funds and private hospitals has been the emergence, on a limited scale, of episodic or 'case' payments.

These case payments are based on DRGs — usually high volume surgical procedures with limited historical variation in length of patient stay and costs. However, some health funds also include medical and same day treatments. Box A.2 provides an example of the coverage of episodic payments in an HPPA negotiated by one of the major funds.

Box A.2 **Examples of private hospital DRG episodes subject to case-based payments**

The HPPA states that case-based payments will apply to:

(1) An **obstetrics episode of care** where the admission is classified into one of the following nine AN–DRGs:

- 670 Caesarean delivery without complicating diagnosis
- 671 Caesarean delivery with moderate complicating diagnosis
- 672 Caesarean delivery with severe complicating diagnosis
- 687 Caesarean delivery with multiple complicating diagnosis, at least one severe
- 674 Vaginal delivery without complicating diagnosis
- 675 Vaginal delivery with moderate complicating diagnosis
- 676 Vaginal delivery with severe complicating diagnosis
- 677 Vaginal delivery with complicating operating room procedures
- 688 Vaginal delivery with multiple complicating diagnosis, at least one severe

(2) A **hip replacement episode of care** where the admission is classified into one of the following two AN–DRGs:

- 404 Hip replacement with complications
- 405 Hip replacement with uncomplicated procedures

(3) A **knee replacement episode of care** where the admission is classified into one of the following two AN–DRGs:

- 406 Other major joint and limb reattachment procedures with complications
- 407 Other major joint and limb reattachment procedures, uncomplicated procedures

(4) A **coronary artery bypass graft episode of care** where the admission is classified into one of the following five AN–DRGs:

- 287 Coronary artery bypass graft with invasive procedure and major complications
- 288 Coronary artery bypass graft with invasive procedure age > 64, or with non–major complications
- 289 Coronary artery bypass graft with invasive procedure age < 65, or without complications
- 290 Coronary artery bypass graft without invasive procedure with major complications
- 291 Coronary artery bypass graft without invasive procedure without major complications.

Source: A major health fund

In most cases, all of the relevant services normally associated with the episode of care are bundled into the one payment. A case-based payment for a hip replacement might, thus, cover costs incurred for accommodation, theatre, critical care, pharmaceuticals, prostheses and physiotherapy services.

However, one major health fund keeps accommodation and theatre fees separate in its case-based payments. It told the Commission that a case-based accommodation benefit provides the hospital with sufficient incentive to treat patients efficiently. It went on to comment that, if an episode calls for a theatre visit, there is usually little the hospital can do to reduce this component of costs.

Insured patients in non-contracted hospitals

If a hospital does not have a contract with a health fund as a 'preferred provider', there are three options for the payment of benefits to insured patients treated in the hospital:

- supplementary benefits;
- second tier default benefits; and
- basic default benefits.

Supplementary benefits, sometimes known as 'brochure rates', are paid to insured patients treated in hospitals that are not preferred providers under an HPPA, but which have a contract in place with the health fund. For example, AXA Health Insurance pays supplementary benefits for treatment in those hospitals in Victoria and South Australia that were not successful in its selective tender process (see chapter 7). Supplementary benefits are a little higher than second tier default benefits (see below).

Government legislated default benefits are payable to insured patients treated in eligible private hospitals and day facilities that do not have an HPPA (or similar arrangement) with the health fund concerned. To attract second tier default benefits, a hospital must be able to demonstrate to the fund that it:

- has a simplified billing system in place;
- has a mechanism in place to inform patients of what expenses they are likely to incur;
- is quality accredited by either the Australian Council on Healthcare Standards, the International Standards Organisation, or other bodies agreed between the fund and the hospital; and

- meets quality criteria relating to the episode of care which the fund has specified in all HPPAs with comparable private hospitals.

Second tier benefits are set at 85 per cent of the average benefit paid by the fund for the episode of care in all comparable private hospitals with which the fund has an HPPA (or similar arrangement), in the State/Territory in which the treatment is provided.

If the health fund has no HPPAs in place in the State or Territory for that episode of care, or if the hospital fails to meet the second tier default criteria, then the basic default benefit is payable. This benefit, which is determined by the Minister for Health and Aged Care, is a little over $200 a day, although it varies somewhat across jurisdictions. Higher default benefits may apply for insured patients admitted to hospital in an emergency.

Self-paying patients

As noted above, self-paying patients account for nearly 9 per cent of private hospital separations and some 4 per cent of hospital revenue.

Charges for these patients are generally set by charges/benefit rates for insured patients. The health funds discourage discounting because it 'sends the wrong signals' to members. Indeed, some funds apparently look to penalise hospitals found to be offering discounts to self-paying patients. The penalty will generally take the form of a lower rates offer at the next round of negotiations.

Nevertheless, some private hospitals (both not-for-profit and for-profit) discount charges for self-paying pensioners and other low income patients. One large religious group said that while only around one per cent of patients receive free treatment, a much larger number benefit from discounted fees.

Other patients

Charges for treatment provided to eligible veterans and war widow/widowers through the Repatriation Private Patient Scheme (RPPS) are negotiated between the Department of Veterans Affairs and hospitals. These arrangements can include provision to tender for the supply of treatment to eligible veterans and their spouses.

Treatment for most compensable patients is covered by workers' compensation or third party motor insurance. The usual basis for payment by the insurance company is a lump sum according to the nature of the injury or illness.

The level of charges

Charges for accommodation, theatre and other hospital services

As noted in chapter 4, in 1997–98, the average charge per private hospital episode was around $2050 and the average daily charge around $550.

However, charges vary considerably for individual episodes, depending on whether surgery, critical care and prostheses are involved. As shown in table A.9, these components can add considerably to the total charge.

Table A.9 **Average charge per episode[a] for accommodation, theatre and other services, private acute care hospitals, 1996–97 ($)**

Accommodation	1465
Theatre	737
Critical care (ICU, CCU etc)	1994
Prostheses	862
Pharmaceuticals	97
All services	2054

a Average charge for those episodes involving the provision of a particular service. While virtually all episodes will involve charges for accommodation and pharmaceuticals, many will not involve surgery or prostheses components. Even fewer will involve critical care. Hence, the sum of the individual service components reported in the table greatly exceeds the average charge for all services.

Source: DHFS Hospital Casemix Protocol (unpublished data).

As noted, accommodation charges are usually levied on a daily basis and vary across the different patient types. Table A.10 shows a major health fund's average daily agreed charges for its contracted private acute care hospitals during the second half of 1997. Significantly, the accommodation charge for an advanced surgery patient was 14 per cent higher than for a standard surgical patient and 25 per cent higher than for a medical patient. While these relativities presumably reflected differences in treatment costs, the Commission was told that it is financially advantageous for private hospitals to attract advanced surgery patients.

Theatre charges also vary according to the complexity of the procedure. In 1997–98, they ranged from around $125 to in excess of $5000. The highest volume theatre band is 'Band 2' — which includes procedures such as treating dislocations and fractures, and the removal of adenoids. The average theatre charge for Band 2 procedures was around $325 in 1997–98. Bands 5 and 6 — which include such procedures as hysterectomy, lens extraction and knee reconstructions — are the next most common bands and account for the largest proportion of health fund benefits. Average theatre charges for Band 5 and 6 procedures in 1997–98 were $795 and $980, respectively.

Table A.10 **Average daily charges for accommodation[a] by patient type, private acute care hospitals, 1997[b] ($)**

Advanced surgery	454
Surgery	398
Obstetrics	408
Rehabilitation	373
Medical	361
Psychiatric	351
Nursing home type patient	73
Same day patients	156
All patients	370

a Shared room basis. The average private room supplement was $35 a day.

b Six months to December 1997.

Source: A major health fund.

Total charges by clinical profile

Indicative private hospital charges per admission by patient category are provided in table A.11. These show that average total charges for advanced surgery patients are considerably greater than for other surgery and medical patients. However, average total charges for psychiatric/rehabilitation patients are even higher than for advanced surgery patients because of the much longer ALOS.

Table A.11 **Average private hospital charges[a], by patient category, 1992 and 1996**

	Average charge per admission			*Average charge per day*		
	1992	*1996*	*Change*	*1992*	*1996*	*Change*
	$	$	%	$	$	%
Advanced surgery	5 490	7 005	28	654	887	36
General surgery	2 027	2 604	28	579	789	36
Obstetrics	3 075	3 379	10	496	563	14
Medical	2 375	2 659	12	325	391	20
Psych/rehab	9 084	8 950	-1	377	384	2
All overnight patients	**2 912**	**3 628**	**25**	**470**	**585**	**24**
Same day patients	455	581	28	455	581	28
All patients	**1 832**	**2 008**	**10[b]**	**470**	**591**	**26**

a Insured patients in private acute care and day hospitals.

b The fact that this increase is much lower than the increase in the average charges for both overnight and same day patients, reflects the significant growth in the share of same day patients over this period (see chapter 4).

Source: HCF Annual Charges Survey 1996.

Average total charges for the most common DRGs are shown in table A.12. Apart from confinement, the most common DRGs have an average length of stay of one to two days.

Table A.12 **Average private acute care hospital charges by top 10 DRG episodes[a], 1996–97 ($)**

	Average charge per admission	*Average charge per patient day*
332 Gastroscopy (non–digestive diseases)	444	358
335 Colonoscopy	530	430
099 Lens procedures	1601	1232
780 Chemotherapy	260	232
128 Dental extractions & restorations	699	657
421 Knee procedures	1430	933
572 Renal dialysis	229	214
674 Vaginal delivery	3224	563
683 Abortion, curettage or hysterotomy	626	571
484 Skin, subcut. tissue & breast procedures	925	638

a Top 10 DRGs by separations for insured patients in private acute care hospitals.

Source: DHFS Hospital Casemix Protocol (unpublished data); DHFS Australian Casemix Report on Hospital Activity 1996–97.

It is also interesting to note that total charges for day procedures are lower on average in day facilities than in private acute care hospitals (table A.13). However, caution is required in drawing conclusions about the relative efficiency/charging practices of the two hospital types given the potential for variations in the complexity of treatment within specific DRGs.

Table A.13 **Comparison of day and private acute care hospital charges for top 10 day hospital DRG episodes[a], 1996–97 ($)**

	Day hospitals	*Acute hospitals*
332 Gastroscopy (non–digestive diseases)	350	444
335 Colonoscopy	456	530
099 Lens procedures	1358	1601
683 Abortion	526	626
484 Skin, subcutaneous tissue & breast procedures	535	925
330 Gastroscopy (digestive diseases)	346	632
128 Dental extractions & restorations	585	699
421 Knee procedures	996	1430
505 Skin grafts & debridement	673	1295
318 Anal & stomach procedures	599	1310

a Top 10 DRGs by separations for insured patients in freestanding day hospitals.

Source: DHFS Hospital Casemix Protocol (unpublished data); ABS unpublished data.

Charges by hospital ownership and size

As noted in chapter 2, real average charges in private acute care hospitals have increased by little more than 2 per cent during the 1990s. Moreover, this small increase has primarily reflected increased charges by for-profit group hospitals. Indeed, between 1991–92 and 1996–97, real average charges for the other ownership groups fell (table A.14).

As table A.14 also indicates, average charges tend to increase with hospital size (although this was not the case in the early 1990s). In a statistical sense, this reflects the fact that for-profit groups and religious charitable organisations — which have the highest average charges — own most of the larger hospitals. However, one underlying driver is the greater average complexity of procedures performed in larger hospitals. When allowance is made for differences in casemix, there is a flattening in the variations in average charges across hospital ownership and size groups (table A.15), although the adjustments do not alter the relative charge rankings in either category.

Table A.14 **Average charges[a], private acute care hospitals, by ownership group and hospital bed size, 1991–92 and 1996–97**

Hospital type	*Average charge 1991–92*	*Average charge 1996–97*	*Real change*
	$	$	%
Ownership categories			
For-profit group	1620	2027	11.6
For-profit independent	1677	1870	-0.6
Religious/charitable	2020	2184	-3.6
Other not-for-profit	1652	1775	-4.2
Size categories			
0–25 beds	2214	1510	-39.1
26–50 beds	1712	1734	-9.7
51–100 beds	1570	1897	7.8
101–200 beds	1712	2034	6.0
Over 200 beds	2329	2518	-3.6
All hospitals	1793	2054	2.2

a Patient revenue per separation.

Source: Commission estimates based on ABS Private Hospitals 1991–92 and 1996–97 and unpublished ABS data.

Another perspective on the impact of casemix is obtained by comparing charges across hospital types for individual DRGs (tables A.16 and A.17). Significantly, the correlation between charges and hospital ownership and size is weaker, again

pointing to the role of variations in casemix complexity in explaining differences in average charges across the industry.

Table A. 15 **Casemix-adjusted average charges[a], private acute care hospitals, by ownership group and hospital bed size, 1996–97 ($)**

Hospital type	*Average charge*	*Casemix adjusted charge*
Ownership categories		
For-profit group	2027	1997
For-profit independent	1870	1906
Religious/charitable	2184	2092
Other not–for–profit	1775	1800
Size categories		
0–25 beds	1510	1608
26–50 beds	1734	1785
51–100 beds	1897	1905
101–200 beds	2034	2009
Over 200 beds	2518	2315

a Patient revenue per separation.

Source: Commission estimates based on ABS Private Hospitals 1991–92 and 1996–97, unpublished ABS data and DHFS Australian Casemix Report on Hospital Activity 1996–97.

Table A.16 **Private acute care hospital charges for top 10 DRG episodes[a], by ownership group, 1996–97 ($)**

DRG	*For-profit group*	*For-profit independent*	*Religious/ charitable*	*Other not-for-profit*	*All hospitals*
674 Vaginal delivery without complications	3 209	3 146	3 252	3 205	3 224
405 Hip replacement	10 859	11 331	10 560	9 822	10 706
421 Knee procedures	1 461	1 405	1 421	1 389	1 430
099 Lens procedures	1 681	1 657	1 584	1 416	1 601
843 Major affective disorders	2 699	3 089	3 073	3 034	2 850
407 Joint and limb reattachment	9 688	9 602	9 980	9 517	9 856
297 Cardiac intervention	9 198	9 091	9 563	8 882	9 400
656 Uterine, adnexa procedures	2 768	2 750	3 092	2 733	2 899
291 Coronary bypass	12 475	11 113	11 854	11 272	11 989
367 Cholecystectomy	3 066	2 983	3 153	2 807	3 073
Average charge for top 10 DRGs	5710	5617	5753	5408	5703

a Top 10 DRGs by revenue for insured patients in private acute care hospitals.

Source: DHFS Hospital Casemix Protocol (unpublished data); DHFS Australian Casemix Report on Hospital Activity 1996–97.

Table A.17 **Private acute care hospital charges for top 10 DRG episodes[a], by hospital bed size, 1996–97 ($)**

DRG	*0–25 beds*	*26–50 beds*	*51–100 beds*	*101–200 beds*	*Over 200 beds*
674 Vaginal delivery without complications	2 295	2 859	3 181	3 167	3 413
405 Hip replacement	na	10 496	11 080	10 567	10 651
421 Knee procedures	1 039	1 444	1 425	1 422	1 445
099 Lens procedures	1 263	1 611	1 690	1 519	1 561
843 Major affective disorders	1 550	2 858	2 653	3 062	6 784
407 Joint and limb reattachment	6 657	8 425	10 193	9 724	10 370
297 Cardiac intervention	na	na	8 915	9 448	9 464
656 Uterine, adnexa procedures	1 698	2 569	2 798	3 006	3 052
291 Coronary bypass	na	na	12 096	11 959	11 967
367 Cholecystectomy	na	2 832	3 015	3 053	3 328
Average charge for top 10 DRGs	na	na	5 705	5 693	6 204

na not available.

a Top 10 DRGs by revenue for insured patients in private acute care hospitals.

Source: DHFS Hospital Casemix Protocol (unpublished data); DHFS Australian Casemix Report on Hospital Activity 1996–97.

A.3 Costs

As noted in section 4.2, greater usage of private hospitals has been responsible for the bulk of the increase in total private hospital costs. The Commission estimates that, between 1991–92 and 1997–98, greater usage accounted for some 78 per cent of total growth in real recurrent expenditure in the industry (table A.18).

Table A.18 **Decomposition of changes in real recurrent expenditure, private hospitals[a], 1991–92 to 1997–98[b]**

	Real change in recurrent expenditure	*Usage component*	*Average cost component*
	$m	%	%
1992–93	74	103	-3
1993–94	137	60	39
1994–95	193	86	13
1995–96	195	95	5
1996–97	201	76	23
1997–98	128	64	36
1991–92 to 1997–98	928	78	22

a Private acute care and psychiatric hospitals.

b 1991–92 prices.

Source: Commission estimates based on ABS Private Hospitals, various issues.

A similar story emerges from a decomposition of changes in real recurrent expenditure by hospital size and ownership group (table A.19). In all bar the 51–100 bed category, increased usage has been a more important contributor to cost growth than increases in average costs per admission.

Table A.19 **Decomposition of changes in real recurrent expenditure, private hospitals[a], by ownership group and hospital bed size, 1991–92 to 1996–97[b]**

Hospital type	*Real change in recurrent expenditure*	*Real growth in recurrent expenditure*	*Usage component*	*Average cost*
	$m	%	%	%
Ownership categories				
For-profit group	455	77	78	22
For-profit independent	-10	-5	235	-134
Religious/charitable	347	37	91	9
Other not-for-profit	7	3	241	-141
Size categories				
0–25 beds	-4	-6	[c]	[c]
26–50 beds	19	7	185	-85
51–100 beds	107	19	33	68
101–200 beds	384	71	82	18
Over 200 beds	292	58	102	-1

a Private acute care and psychiatric hospitals.

b 1991–92 prices. Usage and average charge components may not add to 100 per cent due to rounding and the existence of an 'interaction' factor. 'Interaction' factors were evenly distributed between the two components.

c The decomposition for hospitals with 0–25 beds results in very high numbers due to a large increase in separations and a large decrease in the average charge component. These results are meaningless in the context of real recurrent expenditure remaining virtually the same over the period.

Source: Commission estimates based on ABS unpublished data.

Changes in input costs

Section 4.2 of the report provides information on increases in average costs per separation during the 1990s. Table A.20, indicates that, for the industry as a whole, higher non-labour costs have accounted for the bulk of these increases in unit costs. However, the experience varies considerably across hospital ownership and size groupings.

Tables A.21 and A.22 provide a further disaggregation of the data to show the contributions of increases in different types of labour and non-labour costs.

Table A.20 **Disaggregation of real changes in recurrent expenditure per separation, private hospitals[a], 1991–92 to 1996–97**

	Real change in recurrent expenditure per separation	*Labour input contribution*[b]	*Non-labour input contribution*
	$	%	%
All hospitals	100	32	68
Ownership categories			
For-profit group	193	65	35
For-profit independent	102	50	50
Religious/charitable	56	-61	161
Other not-for-profit	-75	78	22
Size categories			
0–25 beds	-995	79	21
26–50 beds	-92	92	8
51–100 beds	175	63	37
101–200 beds	159	32	68
Over 200 beds	-15	-280	180

a Private acute care and psychiatric hospitals.

b Wages and salaries, superannuation, payroll tax and other labour on-costs.

Source: Commission estimates based on ABS unpublished data.

Table A.21 **Percentage changes in real costs, private acute care hospitals, by ownership group, 1991-92 to 1996-97**

	For-profit group	Other for-profit	Religious/ Charitable	Other not-for-profit	Total	Contribution to growth
Wages and salaries	78.5	-6.9	26.8	-1.1	34.3	45.7
Medical & surgical supplies	155.7	7.0	78.7	16.8	90.4	15.9
Contract services	235.4	13.5	79.4	54.7	111.8	9.2
Depreciation	138.3	71.7	65.6	42.2	79.1	8.7
Admin expenses	29.2	-10.5	58.3	9.0	33.5	7.4
Superannuation	86.1	73.5	139.0	170.9	143.2	6.0
Pharmaceuticals	114.2	19.2	92.9	32.0	85.3	5.0
Other on-costs	45.1	-25.2	30.5	-6.4	26.1	2.1
Repairs and maintenance	64.1	-24.2	39.1	0.8	35.1	1.8
Payroll tax	155.8	-13.3	-15.0	-75.5	46.8	1.6
Food supplies	52.2	-23.3	9.9	6.1	18.7	1.1
Fuel, light and power	47.7	-19.6	12.4	-21.7	16.3	0.7
Patient transport	89.2	5.4	371.2	161.4	123.2	0.1
Other domestic services	-26.0	-47.5	10.2	-40.4	-16.3	-0.4
Other recurrent expenses	38.5	-35.8	-97.3	-91.6	-47.8	-1.0
Interest payments	-69.9	-22.2	-16.3	-52.8	-39.9	-4.1
Total	**76.5**	**-4.8**	**37.4**	**3.4**	**40.9**	**100.0**
Contribution to growth	**56.9**	**-1.3**	**43.4**	**0.9**	**100.0**	

Source: Commission estimates based on unpublished ABS data.

Table A.22 **Percentage changes in real costs, private acute care hospitals, by hospital bed size, 1991-92 to 1996-97**

	0–25 beds	26–50 beds	51–100 beds	101–200 beds	Over 200 beds	Total	Contribution to growth
Wages and salaries	-16.3	2.3	17.2	62.2	47.7	34.3	45.7
Medical & surgical supplies	32.9	45.7	68.1	128.2	92.9	90.4	15.9
Contract services	na	55.7	84.8	na	na	111.8	9.2
Depreciation	51.0	51.1	80.2	111.3	61.9	79.1	8.7
Admin expenses	23.2	1.7	-7.1	104.7	52.3	33.5	7.4
Superannuation	39.8	91.0	102.5	204.7	175.5	143.2	6.0
Pharmaceuticals	57.6	56.4	29.7	160.7	88.2	85.3	5.0
Other on-costs	0.7	-14.1	16.5	22.2	87.5	26.1	2.1
Repairs and maintenance	16.8	0.3	13.4	47.5	63.5	35.1	1.8
Payroll tax	12.8	16.2	9.7	71.2	na	46.8	1.6
Food supplies	-9.1	0.0	-1.4	42.6	39.1	18.7	1.1
Fuel, light and power	-19.5	-3.1	-4.1	34.0	41.9	16.3	0.7
Patient transport	na	-69.7	na	na	na	123.2	0.1
Other domestic services	3.3	-36.7	-33.0	-7.1	12.8	-16.3	-0.4
Other recurrent expenses	na	-69.9	na	-35.1	-50.0	-47.8	-1.0
Interest payments	-73.1	-44.6	-54.1	-32.9	-25.0	-39.9	-4.1
Total	**-6.0**	**7.4**	**18.6**	**70.8**	**58.4**	**40.9**	**100.0**
Contribution to growth	**-0.5**	**2.4**	**13.5**	**48.1**	**36.5**	**100.0**	

na Not available

Source: Commission estimates based on unpublished ABS data.

B Additional hospital performance and state-based structural data

List of tables

Table B.1 **Private hospital[a] number and size, by State, 1991–92**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
No. of hospitals	92	111	49	38	21	8	319
Capital city	70	78	18	32	19	4	221
Rest of State or Territory	22	33	31	6	2	4	98
Hospital size							
0–25 beds	2	39	11	12	2	2	68
26–50 beds	42	35	7	12	3	1	100
51–100 beds	38	23	14	8	12	3	98
101–200 beds	8	9	14	4	3	2	40
Over–200 beds	2	5	3	2	1	—	13
Available beds	6037	6014	4090	2280	1774	550	20 745
Capital city	4558	4979	2045	2162	np	np	15 690
Rest of State or Territory	1479	1035	2045	118	np	np	5055
Approved beds	6421	6256	4397	2424	1965	667	22 130

np Not published

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92.

Table B.2 **Private hospital[a] number and size, by State, 1997–98**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
No. of hospitals	91	97	51	41	26	11	317
Capital city	62	68	20	31	23	5	209
Rest of State or Territory	29	29	31	10	3	6	108
Hospital size							
0–25 beds	5	26	10	15	6	4	66
26–50 beds	34	31	5	12	4	1	87
51–100 beds	37	22	16	8	9	3	95
101–200 beds	12	13	15	5	4	3	52
Over 200 beds	3	5	5	1	3	—	17
Available beds	6476	6133	5008	2269	2409	796	23 091
Capital city	4547	5125	2520	2105	np	np	16 968
Rest of State or Territory	1929	1008	2488	164	np	np	6123
Approved beds	6683	6403	5384	2425	2716	892	24 503

np Not published

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1997–98.

Table B.3 **Private hospital[a] activity, length of stay and occupancy, by State, 1991–92**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Separations (000)	339	325	227	131	99	37	1157
Bed days (000)	1313	1478	1015	573	378	136	4891
Average length of stay (days)	3.9	4.5	4.5	4.4	3.8	3.7	4.2
Occupancy rate (%)	59	67	68	69	58	67	64

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92.

Table B.4 **Private hospital[a] activity, length of stay and occupancy, by State, 1997–98**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Separations (000)	446	438	339	147	165	51	1585
Bed days (000)	1592	1629	1338	560	551	188	5859
Average length of stay (days)	3.6	3.7	4.0	3.8	3.3	3.7	3.7
Occupancy rate (%)	67	73	73	68	63	65	70

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1997–98.

Table B.5 **Private hospital[a] separations, bed days and beds per 1000 population, by State, 1991–92 and 1997–98**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
			1991-92				
Separations per 1000 (No.)	55	73	76	90	60	79	68
Bed days per 1000 (No.)	214	333	338	394	229	289	285
Beds per 1000	0.99	1.35	1.36	1.57	1.07	1.17	1.21
			1997-98				
Separations per 1000 (No.)	68	95	100	88	92	108	86
Bed days per 1000 (No.)	242	354	394	336	307	398	316
Beds per 1000	0.98	1.33	1.47	1.36	1.34	1.68	1.25

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92 and 1997–98, 1999 Year Book Australia.

Table B.6 **Private hospital[a] revenues, by State, 1991–92 ($m)**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Patient revenue	591	662	367	218	175	62	2075
Recoveries	15	14	6	4	5	2	45
Other	17	19	10	6	5	1	58
Total	622	695	383	227	185	65	2177

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92.

Table B.7 **Private hospital[a] revenues, by State, 1997–98 ($m)**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Patient revenue	950	932	684	259	310	114	3249
Recoveries	58	51	24	14	21	6	175
Other	29	25	20	4	14	1	93
Total	1037	1008	728	277	344	121	3517

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1997–98.

Table B.8 **Expenditure by private hospitals[a], by State, 1991–92 ($m)**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Wages and salaries including on-costs	317	403	209	127	97	36	1189
Drug, medical and surgical supplies	64	55	29	19	16	5	188
Food supplies	14	17	8	5	4	1	49
Other domestic services	19	16	10	6	6	2	58
Administrative expenses	60	58	27	16	12	5	177
Repairs and maintenance	11	13	7	6	3	1	41
Other	68	81	45	29	21	8	252
Total	553	642	335	208	159	58	1955

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92.

Table B.9 **Expenditure by private hospitals[a], by State, 1997–98 ($m)**

	NSW and ACT	*Victoria*	*Qld*	*SA and NT*	*WA*	*Tas*	*Aust*
Wages and salaries including on-costs	533	544	403	158	188	74	1900
Drug, medical and surgical supplies	153	121	78	34	43	13	442
Food supplies	19	22	14	5	7	2	70
Other domestic services	20	16	16	5	8	3	69
Administrative expenses	79	84	52	21	24	10	270
Repairs and maintenance	20	19	14	5	5	2	65
Other	126	121	75	39	41	13	416
Total	950	928	653	267	316	117	3232

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1997–98.

Table B.10 Private hospital[a] revenue, by ownership group, 1991–92 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Revenue/separation	1680	1737	2143	1736	1882
Revenue/day	434	403	480	395	445
Revenue/bed	95 533	87 559	123 844	90 612	104 943
Revenue/employee	80 661	74 469	64 984	62 438	70 007

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.11 Private hospital[a] revenue, by ownership group, 1996–97 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Revenue/separation	2140	1927	2373	1871	2192
Revenue/day	572	491	627	464	576
Revenue/bed	143 763	109 194	168 922	113 593	146 925
Revenue/employee	91 948	81 254	77 018	73 932	82 485

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.12 Private hospital[a] patient revenue, by ownership group, 1991–92 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Patient revenue/separation	1620	1677	2020	1652	1793
Patient revenue/day	419	389	452	376	424
Patient revenue/employee	77 783	71 868	61 256	59 401	66 716

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.13 Private hospital[a] patient revenue, by ownership group, 1996–97 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Patient revenue/separation	2027	1870	2184	1775	2055
Patient revenue/day	542	476	577	440	540
Patient revenue/employee	87 108	78 856	70 893	70 159	77 313

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.14 Private hospital[a] recurrent expenditure, by ownership group, 1991–92 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Expenditure/separation	1448	1490	1976	1633	1689
Expenditure/day	374	345	442	372	400

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.15 Private hospital[a] recurrent expenditure, by ownership group, 1996–97 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Expenditure/separation	1840	1786	2278	1747	2006
Expenditure/day	492	455	602	433	527

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.16 **Private hospital[a] staff costs per separation, by ownership group, 1991–92 ($)**

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Total staff recurrent expenditure	853	874	1224	1038	1028
Total staff wages & salaries	720	771	1132	955	921
Total staff on-costs (excluding super & payroll tax)	57	37	56	66	55
Superannuation	29	24	34	15	29
Payroll tax	47	41	3	2	23
Nursing staff wages & salaries	448	475	655	590	552
Medical officers & other diagnostic staff salaries	26	25	62	27	41
Admin and clerical staff wages & salaries	81	85	123	96	100
Other staff wages & salaries	165	186	292	242	228

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.17 **Private hospital[a] staff costs per separation, by ownership group, 1996–97 ($)**

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Total staff recurrent expenditure	1096	1037	1334	1098	1188
Total staff wages & salaries	925	903	1205	977	1042
Total staff on-costs (excluding super & payroll tax)	60	35	61	64	59
Superannuation	52	53	68	57	59
Payroll tax	60	46	0	0	28
Nursing staff wages & salaries	587	509	687	608	623
Medical officers & other diagnostic staff salaries	49	70	77	53	63
Admin and clerical staff wages & salaries	103	117	146	110	122
Other staff wages & salaries	186	207	295	206	234

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.18 Private hospital[a] non-staff costs per separation, by ownership group, 1991–92 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Total non-staff recurrent expenditure	595	616	752	595	662
Medical & surgical supplies	113	103	140	105	122
Administration	164	176	150	107	153
Depreciation	46	39	114	72	76
Interest payments	71	76	71	61	70
Contract services	45	57	68	56	57
Other	156	165	209	194	184

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.19 Private hospital[a] non-staff costs per separation, by ownership group, 1996–97 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Total non-staff recurrent expenditure	744	749	945	649	817
Medical & surgical supplies	207	138	210	127	195
Administration	152	198	200	121	172
Depreciation	79	85	159	106	115
Interest payments	15	74	50	30	36
Contract services	108	81	103	90	102
Other	183	173	223	175	197

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.20 Private hospital[a] capital expenditure ratios, by ownership group, 1991–92 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Capex/separation	78	96	281	261	184
Capex/bed	4412	4826	16 226	13 616	10 235
Land & buildings/separation	30	31	180	139	104
Land & buildings/bed	1714	1577	10 422	7258	5793
Medical equipment/separation	20	25	35	23	27
Medical equipment/bed	1113	1258	2013	1191	1495
Plant & other equipment/separation	19	20	41	52	32
Plant & other equipment/bed	1090	996	2387	2736	1788

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.21 Private hospital[a] capital expenditure ratios, by ownership group, 1996–97 ($)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Capex/separation	169	218	202	310	200
Capex/bed	11 336	12 368	14 353	18 853	13 375
Land & buildings/separation	75	95	116	229	108
Land & buildings/bed	5037	5406	8256	13 912	7228
Medical equipment/separation	43	44	37	44	41
Medical equipment/bed	2886	2497	2653	2681	2737
Plant & other equipment/separation	36	62	29	25	34
Plant & other equipment/bed	2423	3533	2089	1505	2308

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.22 **Private hospital[a] staffing, by ownership group, 1991–92**

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
FTE staff/1000 separations	20.8	23.3	33.0	27.8	26.9
FTE staff/occupied bed	2.0	2.0	2.7	2.3	2.3
FTE nursing staff/1000 separations	11.9	13.1	17.1	15.2	14.5
FTE nursing staff/occupied bed	1.1	1.1	1.4	1.3	1.3
FTE medical officers & other diagnostic staff/1000 separations	0.5	0.7	1.3	0.6	0.9
FTE admin and clerical staff/1000 separations	2.4	2.8	3.9	3.1	3.2
FTE domestic and other staff/1000 separations	4.8	5.4	8.8	7.6	6.9

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.23 **Private hospital[a] staffing, by ownership group, 1996–97**

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
FTEstaff/1000 separations	23.3	23.7	30.8	25.3	26.6
FTE staff/occupied bed	2.3	2.2	3.0	2.3	2.6
FTE nursing staff/1000 separations	13.6	12.3	15.7	14.4	14.4
FTE nursing staff/occupied bed	1.3	1.1	1.5	1.3	1.4
FTE medical officers & other diagnostic staff/1000 separations	0.9	1.6	1.4	0.9	1.1
FTE admin and clerical staff/1000 separations	2.9	3.2	4.0	3.1	3.4
FTE domestic and other staff/1000 separations	5.0	5.2	8.0	5.8	6.3

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.24 Average length of stay in private hospitals[a], by ownership group, 1991–92 (days)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
All patients	3.87	4.31	4.47	4.39	4.23
Overnight patients	na	na	na	na	na
Advanced surgery patients	6.97	7.43	8.36	8.15	7.83
Surgery patients	2.38	2.43	2.98	2.82	2.66
Medical patients	6.28	7.38	5.28	6.34	5.95
Obstetrics patients	5.89	6.10	6.86	6.52	6.49

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.25 Average length of stay in private hospitals[a], by ownership group, 1996–97 (days)

	For-profit groups	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
All patients	3.74	3.93	3.79	4.03	3.80
Overnight patients	5.98	6.81	5.73	6.67	6.00
Advanced surgery patients	7.01	5.04	7.64	7.46	7.21
Surgery patients	3.14	2.75	3.49	3.39	3.28
Medical patients	6.85	8.53	6.07	6.79	6.62
Obstetrics patients	na	na	5.91	5.85	5.86

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.26 Private hospital[a] occupancy rates, by ownership group, 1991–92 (percentage of capacity)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Occupancy – all patients	60	60	71	63	65
Occupancy – overnight patients	na	na	na	na	na
Average theatre time/week	38	44	43	30	40

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.27 Private hospital[a] occupancy rates, by ownership group, 1996–97 (percentage of capacity)

	For-profit group	*Other for-profit*	*Religious and charitable*	*Other not-for-profit*	*Total*
Occupancy – all patients	69	61	74	67	70
Occupancy – overnight patients	61	53	66	59	62
Average theatre time/week	39	28	44	32	39

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.28 Private hospital[a] revenue, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Revenue/separation	2349	1769	1636	1802	2473	1882
Revenue/day	277	366	431	449	571	445
Revenue/bed	64 275	77 263	93 122	113 415	158 056	104 841
Revenue/employee	51 002	69 197	73 933	68 707	70 670	70 007

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.29 Private hospital[a] revenue, by hospital bed size, 1996–97 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Revenue/separation	1624	1823	2013	2159	2727	2192
Revenue/day	341	463	529	611	682	576
Revenue/bed	76 018	98 954	122 275	165 636	207 661	146 925
Revenue/ employee	65 306	77 630	84 744	83 302	83 107	82 485

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.30 Private hospital[a] patient revenue, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Patient revenue/separation	2214	1712	1570	1712	2329	1793
Patient revenue/day	261	355	413	427	538	424
Patient revenue/employee	48 058	66 986	70 917	65 291	66 557	66 716

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.31 Private hospital[a] patient revenue, by hospital bed size, 1996–97 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Patient revenue/separation	1510	1734	1897	2034	2518	2055
Patient revenue/day	317	441	498	576	629	540
Patient revenue/employee	60 722	73 837	79 859	78 452	76 722	77 313

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.32 Private hospital[a] recurrent expenditure, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Expenditure/separation	2419	1587	1433	1611	2257	1689
Expenditure/day	285	329	377	401	521	400

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92.

Table B.33 Private hospital[a] recurrent expenditure, by hospital bed size, 1997–98 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Expenditure/separation	1501	1675	1803	1979	2695	2039
Expenditure/day	338	439	504	571	663	552

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1997–98.

Table B.34 Private hospital[a] staff costs per separation, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Total staff recurrent expenditure	1705	971	851	980	1375	1028
Total staff wages & salaries	1568	846	749	869	1282	921
Total staff on-costs (excluding super & payroll tax)	63	65	44	64	54	55
Superannuation	56	26	25	25	40	29
Payroll tax	17	33	33	22	0	23
Nursing staff wages & salaries	894	499	462	548	715	552
Medical officers & other diagnostic staff salaries	17	7	27	23	91	41
Admin and clerical wages & salaries	159	89	81	92	149	100
Other staff wages & salaries	498	251	179	206	327	228

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.35 Private hospital[a] staff costs per separation, by hospital bed size, 1996–97 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Total staff recurrent expenditure	1035	994	1077	1156	1495	1188
Total staff wages & salaries	922	851	931	1017	1331	1042
Total staff on–costs (excluding super & payroll tax)	45	55	54	56	71	59
Superannuation	55	50	54	56	77	59
Payroll tax	14	38	38	27	16	28
Nursing staff wages & salaries	521	491	566	631	766	623
Medical officers & other diagnostic staff salaries	56	40	49	53	99	63
Admin and clerical staff wages & salaries	113	109	108	114	160	122
Other staff wages & salaries	232	211	208	219	306	234

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.36 Private hospital[a] non-staff costs per separation, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Total non-staff recurrent expenditure	714	615	583	630	881	662
Medical & surgical supplies	63	93	96	122	197	122
Administration	186	169	162	120	173	153
Depreciation	61	55	50	75	141	76
Interest payments	93	71	54	83	78	70
Contract services	67	61	47	59	68	57
Other	244	166	174	171	224	184

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.37 Private hospital[a] non-staff costs per separation, by hospital bed size, 1996–97 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Total non–staff recurrent expenditure	561	682	726	828	1018	817
Medical & surgical supplies	58	133	172	201	267	195
Administration	161	169	159	177	185	172
Depreciation	65	82	96	115	161	115
Interest payments	18	39	26	40	41	36
Contract services	92	93	92	99	124	102
Other	167	166	181	196	240	197

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.38 Private hospital[a] capital expenditure ratios, by hospital bed size, 1991–92 ($)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Capex/separation	221	120	138	277	167	184
Capex/bed	6047	5241	7855	17 434	10 673	10 250
Land & buildings/separation	142	43	64	205	64	104
Land & buildings/bed	3886	1878	3643	12 902	4090	5794
Medical equipment/separation	28	19	28	20	41	27
Medical equipment/bed	766	830	1594	1259	2620	1504
Plant & other equipment/separation	30	47	na	na	47	32
Plant & other equipment/bed	821	2052	na	na	3004	1783

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.39 **Private hospital[a] capital expenditure ratios, by hospital bed size, 1996–97 ($)**

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Capex/separation	70	234	167	228	196	200
Capex/bed	3257	12 686	10 117	17 458	14 955	13 375
Land & buildings/separation	33	125	81	130	109	108
Land & buildings/bed	1555	6767	4906	9937	8304	7228
Medical equipment/separation	11	48	35	45	42	41
Medical equipment/bed	520	2607	2098	3482	3177	2737
Plant & other equipment/separation	16	40	35	41	24	34
Plant & other equipment/bed	749	2184	2131	3119	1806	2308

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.40 **Private hospital[a] staffing, by hospital bed size, 1991–92**

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
FTEstaff/1000 separations	46.1	25.6	22.1	26.2	35.0	26.9
FTE staff/occupied bed	2.0	1.9	2.1	2.4	2.9	2.3
FTE nursing staff/1000 separations	23.2	13.5	12.5	14.9	17.3	14.5
FTE nursing staff/occupied bed	1.0	1.0	1.2	1.4	1.5	1.3
FTE medical officers & other diagnostic staff/1000 separations	0.2	0.1	0.6	0.4	1.9	0.9
FTE admin and clerical staff/1000 separations	5.1	2.7	2.6	3.0	4.5	3.2
FTE domestic and other staff/1000 separations	12.1	5.9	5.4	6.6	9.5	6.9

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.41 **Private hospital[a] staffing, by hospital bed size, 1996–97**

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
FTEstaff/1000 separations	24.9	23.5	23.8	25.9	32.8	26.6
FTE staff/occupied bed	1.9	2.2	2.3	2.7	3.0	2.6
FTE nursing staff/1000 separations	12.7	12.4	13.0	14.7	16.9	14.4
FTE nursing staff/occupied bed	1.0	1.2	1.3	1.5	1.5	1.4
FTE medical officers & other diagnostic staff/1000 separations	1.5	1.1	0.9	0.9	1.8	1.1
FTE admin and clerical staff/1000 separations	3.4	3.1	3.0	3.2	4.4	3.4
FTE domestic and other staff/1000 separations	5.5	5.5	5.6	6.1	8.0	6.3

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.42 **Average length of stay in private hospitals[a], by hospital bed size, 1991–92 (days)**

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
All patients	8.48	4.83	3.80	4.01	4.33	4.23
Overnight patients	na	na	na	na	na	na
Advanced surgery patients	6.60	6.18	7.26	8.12	8.56	7.83
Surgery patients	2.29	2.50	2.57	2.62	3.10	2.66
Medical patients	9.49	8.32	5.97	4.71	4.96	5.95
Obstetrics patients	6.44	5.68	6.36	6.49	7.02	6.49
Minor surgery patients	na	1.56	1.36	1.63	na	1.48

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.43 **Average length of stay in private hospitals[a], by hospital bed size, 1996–97 (days)**

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
All patients	4.76	3.93	3.81	3.53	4.00	3.80
Overnight patients	11.24	6.63	6.00	5.33	6.25	6.00
Advanced surgery patients	4.77	4.83	6.24	7.48	8.41	7.21
Surgery patients	2.55	2.78	3.06	3.26	3.91	3.28
Medical patients	8.98	8.59	6.90	5.38	6.98	6.62
Obstetrics patients	4.55	na	5.98	na	na	5.86
Minor surgery patients	na	na	na	na	na	na

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.44 Private hospital[a] occupancy rates, by hospital bed size, 1991–92 (percentage of capacity)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Occupancy – all patients	64	58	59	69	76	65
Occupancy – overnight patients	na	na	na	na	na	na
Average theatre time/week	12	29	40	44	49	40

na Not available

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1991–92; unpublished ABS data.

Table B.45 Private hospital[a] occupancy rates, by hospital bed size, 1996–97 (percentage of capacity)

	0 to 25	*26 to 50*	*51 to 100*	*101 to 200*	*Over 200*	*Total*
Occupancy – all patients	61	59	63	74	83	70
Occupancy – overnight patients	53	51	56	66	74	62
Average theatre time/week	15	31	31	44	54	39

a Private acute care and psychiatric hospitals.

Source: ABS, Private Hospitals, 1996–97; unpublished ABS data.

Table B.46 Medical services and charges for top 12 DRGs, by private hospital[a] ownership group and hospital bed size, 1996–97[b]

	Medical services per episode	*Average charge per service*	*Total charge per episode*
	No.	$	$
Ownership			
For-profit group	5.06	183	924
For-profit independent	4.65	186	868
Religious/charitable	4.89	199	973
Other not-for-profit	4.74	194	922
Bed size			
0–50	4.35	212	920
51–100	4.71	185	873
101–200	5.08	186	946
Over 200	5.20	198	1029
All hospitals	4.89	191	934

a Private acute care and psychiatric hospitals.

b Based on 12 of the leading 15 revenue DRGs for all private acute care hospitals. Excluded are DRGs 274 (circulation disorders), 291 (coronary bypass) and 297 (cardiac intervention).

Source: DHFS Hospital Casemix Protocol 1996–97 (unpublished data).

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