Australian
Private Hospitals
Association

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Dear Professor Harper

Thank you for the opportunity to make a submission to the Competition Policy Review in response to the discussion paper released in April 2014.

The attached submission provides a brief response to selected questions posed by the Review Panel.

The Australian Private Hospitals Association (APHA) welcomes the specific attention given by the Review to the potential of further competition reform to contribute to increased productivity in the health sector. It is a sector in which the rights of the consumer warrant special protection to counter an inherent information asymmetry and to ensure that consumers retain a central role in partnership with their clinicians and carers in selecting appropriate healthcare options.

Overtime the Australian health sector has evolved as a complex managed market in which public and private providers operate within an overall policy commitment to the provision of universal health care. While reliant on a strong public hospital sector, successive governments have recognised that a vibrant private hospital sector is also essential to the challenge of meeting the health needs of Australians. APHA research shows that this is a view shared by consumers.

The private hospital sector has a demonstrated record of innovation and efficiency in servicing the needs of private patients. The private hospital sector also plays an important role in the provision of services to public patients, often through short-term contract arrangements with local health districts. In addition, there is an established history of private sector operators participating in public-private partnerships to build and or operate public hospitals.

Notwithstanding the above, Australia has yet to realise the full potential of competition to provide increased productivity in the provision of public patient services. The challenge of an ageing population and increasing demand for health services makes the goal of maximising productivity in hospital sector more important than ever.

It is from this perspective that the APHA is pleased to contribute observations regarding barriers to competition, particularly in the hospital sector, and recommendations as to how competition policy might further develop in the interests of Australian consumers.

Yours sincerely

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20 June 2014

Australian
Private Hospitals
Association

APHA submission to

The Competition Policy Review - 2014

Australian Private Hospitals Association ABN 82 008 623 809

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Response to Questions Raised in the Competition Policy Review Issues Paper

Executive Summary

The Australian Private Hospitals Association (APHA) is the peak industry association for the private hospital and day surgery industry, representing around 75% of the private hospital sector in Australia. The members of APHA run both for-profit and not-for-profit hospitals and day surgeries.

The APHA would nominate three key areas for further reform in competition policy:

- Consideration of the protections that ought to be given to service providers in markets where the purchasers of services are able to exercise market power owing to high levels of market concentration.

- Further evolution of markets currently dominated by government sector providers including the health sector to support increased competition to drive growth in productivity in the provision of services to consumers.

- Clarification the application of competitive neutrality in the Australian healthcare sector.

The APHA notes that the terms of reference of the Review are concerned with the principles upon which competition policy might be based rather than the application of competition policy to a particular industry. With this objective in mind, the APHA has provided a response to selected questions from the Issues Paper published by the Competition Review Panel in April 2014. The APHA has also offered several observations based on the sector's experience of working with the Australian Competition and Consumer Commission (ACCC) and, in particular, on issues raised in the context of the ACCC's obligation to report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance.

The ACCC's reports on the private health sector over a period of 14 years, and the consultations that have surrounded them, highlight the challenges of ensuring effective competition and the adequate protection of consumer rights. This history also highlights the important role of government regulation and policy settings in protecting public policy and consumer interests and resolving issues that have not been readily resolved through market processes. Finally this history also raises some interesting questions in relation to the influence of government policy in shaping opportunities for the exercise of market power and the impacts, both direct and indirect, of market power utilisation on consumers.

While hospitals and day surgeries form but a part of a much wider network of providers and suppliers within the Australian health sector, this submission is confined to comment on those aspects of competition within the health sector which most directly impact on the dynamism and productivity of the hospital sector.

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About the APHA and the Australian Private Hospital Sector

The APHA is the peak industry association for the private hospital and day surgery industry, representing around 75% of the private hospital sector in Australia. The members of APHA run both for-profit and not-for-profit hospitals and day surgeries.

In 2012-13, private hospitals and day surgeries accounted for:

- 2 in 5 (41%) of all separations.
- 1 in 3 (30%) overnight separations
- Nearly half (47%) of same day separations
- 1 in 3 (33%) of all licensed beds
- 2 in 5 (43%) of all separations where the patient was aged 65 or older
- 3 in 5 (59%) of all surgeries performed in Australian hospitals(1).

Unpublished community attitudes research conducted in 2013 for the APHA found that Australians considered both public and private hospitals as necessary for the Australian health system to function effectively. More than 4 in 5 (84%) of those surveyed acknowledged that the public system would not cope if private hospitals did not exist(2).

The survey also found that in the 12 months prior to the survey, 40% of respondents had received hospital treatment:

- 9% were treated in a private hospital only
- 6% were treated in both a private and a public hospital
- 25% were treated in a public hospital only(2).

These findings support the fact that Australia needs a health system that supports people's movement across both sectors and the technology that supports this variety of treatment.

The ABS reports that in 2011-12 there were 281 licenced private hospitals and another 311 stand alone day surgeries(3). The sector is characterised by great diversity ranging from large acute hospitals providing a similar range of services to 'tertiary hospitals' in the public sector through to small independent hospitals and day surgeries catering for a more narrowly focused case-mix. These private hospitals and day surgeries are predominantly involved in the treatment of private patients, most of whom pay for the services received through private health insurance. They also provide services to clients of the Department of Veteran's Affairs, to compensable patients and through short-term contracts with jurisdictions to provide public patient services. In addition there are 10 major hospitals and several smaller facilities which are variously contracted on a long term basis to principally provide public hospital services[1].

While the private hospital sector is dominated by two major corporations, Ramsay Health Care and Healthscope, no other for-profit or not-for-profit group would account for more than 10% of the market. Independent hospitals and day surgeries continue to play a major role. Consequently while the private hospital sector has been subject of significant consolidation, it remains characterised by a significant degree of fragmentation.

[1] These hospitals are essentially entirely devoted to the provision of public hospital services. Many more private hospitals accept short term contracts or to treat public patients. These short term arrangements are often negotiated at the local level in response to service level demands.

What should be the priorities for a competition policy reform agenda to ensure that efficient businesses, large or small, can compete effectively and drive growth in productivity and living standards?

The APHA would nominate three key areas for further reform in competition policy:

- **Consideration of the protections that ought to be given to service providers in markets where the purchasers of services are able to exercise market power owing to high levels of market concentration.**

  Currently legislation provides protections to the purchasers of services but does not provide protections to service providers. Consequently, in the relationships between private hospitals and the private health insurance sector, private health insurers (purchasers) have access to protections but hospitals (providers) do not.

  Hospitals cannot share information on prices or negotiate collectively unless they are part of a group corporate structure or group granted authorisation by the ACCC. In an environment where the top two largest insurers account for 56% of all polices held in Australia and jurisdictional markets are subject to even high levels of concentration(4), this places small independent facilities at a competitive disadvantage. The private health insurance sector (including premium rebates provide by the Commonwealth government) accounts for 68% of expenditure on services provide by private hospitals and funds 82% of private hospitals admissions.

  While applications for authorisation have been sought from time to time within the private hospital sector, the expense involved in seeking and exercising such authorisations has generally been prohibitive for small hospitals and day surgeries. It is also questionable whether such ACCC authorisation for collective bargaining would by itself provide enough market power to overcome the disadvantages faced in the current negotiating environment. It is notable that large corporate groups can also face a challenging negotiating environment in which not only size but also the geographic placement and strategic importance of facilities owned can also be important factors in determining negotiating strength.

  The issue of competition and contestability in relation to private health insurance is discussed in greater detail in the APHA's response to the paper *Competition in the Australian Private Health Insurance Market* (see Appendix A)(5). Related issues are also discussed on page 18 with reference to enforcement powers under existing legislation.

- **Further evolution of markets currently dominated by government sector providers including the health sector to support increased competition to drive growth in productivity in the provision of services to consumers.**

  Currently private hospitals care for 41% of all hospital admissions but only three percent of private hospital admissions for public patients[2]. This is despite the fact, as concluded by the Productivity Commission, that the private sector has demonstrated its ability to provide significantly greater efficiencies than the public sector in the provision of many hospital services (see Appendix C)(6).

[2] The figure of three percent excludes services provided by private hospitals which are wholly devoted to the provision of public patient services and/or managed as public hospitals.

The private hospital sector offers almost all of the services that are available in the public sector. The only areas of service which are not available are:

- multiple trauma
- burns
- organ transplantation, and
- forensic psychiatry.

Although the majority of private hospitals are found in major cities, 89 are located in regional and rural communities(1).

On the grounds of efficiency, expertise and capacity, the private hospital sector has the potential to play a significantly greater role within a genuinely contestable market. Additional comment on this area of reform can be found on pages 12 and following.

- **Clarification the application of competitive neutrality in the Australian healthcare sector.**

The Australian healthcare sector is reliant on a complex mix of public and private sector providers. As a matter of policy all Australians eligible for Medicare are entitled to treatment as public patients in public hospitals. At the same time, those who choose to purchase private health insurance or to meet the full cost of treatment may also be treated as private patients. Furthermore Medicare eligible patients admitted to a public hospital are entitled to elect whether they will be treated as a private or as a public patient.

Doctors treating patients in public hospitals can elect to exercise the 'right of private practice' and negotiate the extent to which they can devote their time to private practice either in the private hospital sector or within the public hospital sector as part of their terms of engagement with a public hospital.

As a consequence of these arrangements, private patients (either patients using private health insurance or patients paying the full cost of their treatment directly) accounted for more than 13% of all public hospital separations in 2012-13. In some States private patients account for up to 20% of public hospital separations and in some individual hospitals the percentage is far higher(1). This outcome would not necessarily be problematic in a genuinely contestable market, what is problematic however is:

- the lack of competitive neutrality in the Australian healthcare sector; and, at the same time,
- the persistent failure of the public hospital sector to meeting public policy objectives and agreed targets for improvement over time(7).

This issue is discussed further at pages 10 and following.

Are there unwarranted regulatory impediments to competition in any sector in Australia that should be removed or altered?

The health sector is highly regulated and in some respects this may be seen as desirable, for example, to prevent patient harm and ensure minimum standards of safety and quality. As will be discussed later, regulation can also play a useful role within a competitive market in creating a level playing field and addressing issues that are not amenable to resolution through contractual negotiation. However, the involvement of multiple layers of government results in a regulatory regime which is unnecessarily complex, duplicative and inconsistent across jurisdictions. Areas of regulation which are particularly problematic in this regard include:

- state licensing requirements for private hospital facilities
- occupational restrictions, for example, in relation to enrolled nurses, and
- a lack of consistency across jurisdictions in relation to State regulation on a diversity of issues ranging from poisons, occupational health and safety through to building regulations.

Not only are these regulations complex, the burden of regulation also falls disproportionately on the private sector.

Recently there has been welcome progress towards correcting the imbalance between the levels of regulation applied to the private sector and public sectors. Since 1 January 2013, public and private hospitals have been subject to accreditation against a common set of National Safety and Quality Health Service Standards. However this welcome development has yet to result in harmonisation of separate jurisdictional requirements that impose an additional burden of regulatory compliance and reporting on the private hospital sector that is not imposed on public sector counterparts. For example, public hospitals, unlike private hospitals, are not subject to any State licencing requirements.

The complexity of these regulatory arrangements stifles innovations and prevents attainment of efficiencies that could be passed on to consumers. It also creates a significant barrier to entry to the private hospital market.

Is there a case to regulate international price discrimination? If so, how could it be regulated effectively while not limiting choice for consumers or introducing other adverse consequences?

International price discrimination is widespread in the health sector particularly in relation to pharmaceuticals, prostheses and implantable devices and other consumables. It is in the interests of Australian consumers to see this issue carefully considered and addressed.

In regulating this area it is essential that care is taken to preserve consumer choice and access to an acceptable range of clinical alternatives and the ability to select devices and therapies appropriate to the clinical requirements of particular patients in order to achieve the best possible clinical outcome and to avoid additional down-stream costs due to adverse reactions or device failure. One particular challenge for the health sector is that there will always be small populations of patients for whom first lines of treatment or more frequently used techniques, drugs or devices are not clinically appropriate or effective.

The economic value of health technology needs to be assessed not only in terms of the costs directly associated with a given therapy or intervention measured against the quality of life afforded to the

patient, but also against the avoidance of the need for further clinical interventions and the ability of the patient to regain/maintain their own economic productivity. These factors are of increasing importance as the Australian workforce ages and expectations of working life lengthen.

In the context of the hospital sector and competition between public and private sectors it is important to ensure that the policy solutions devised to address the issues identified above do not unfairly disadvantage either sector. Equally, consideration must also be given to the ongoing health and viability of the Australian medical technology, research and pharmaceutical industries.

Should any current restrictions of parallel importation be removed or altered in order to increase competition?

When considering the issue of parallel importation with regard to the health sector the advantages of providing access to a wider range of providers needs to be balanced against the essential need to ensure that standards of quality and safety are not compromised.

Are there regulations governing the sale of goods for health and safety or environmental reasons whose purpose could be achieved in a manner more conducive to competition?

As already discussed the health sector is necessarily subject to significant regulation to ensure the safety and quality of care. However, there are a number of areas where the level and method of regulation warrants review.

Regulations pertaining to the Pharmaceutical Benefits Scheme include a number of sources of restriction that are problematic and in need of review. These include:

- licencing restrictions on pharmacies which impose geographical and trading restrictions,
- restrictions on the use of electronic technology for prescribing, ordering and claiming purposes, and
- complex differences in the regulatory arrangements applicable to public and private sectors, particularly in relation to the dispensing of highly specialised drugs.

The impact of licencing regulations for pharmacy arguably extends beyond their original intended purposes. Distinctions between Section 90 (community based) and Section 94 (hospital based) licences create an uneven playing field by directly impacting the PBS rebates payable to either licence type for the provision of drugs and pharmaceutical services. They also impact directly on the eligibility of providers to participate in government programs and initiatives. These and other related restrictions mean that most hospital pharmacy services are constrained despite having specialised expertise, capacities and opportunities to provide efficient and innovative responses to consumer need and government policy objectives. The distinctions between these two types of pharmacy licences should be removed.

Regulation of the use of electronic technology stifles efficiency and innovation to the detriment of service viability and the availability of improvements in quality and price to the benefit of both government and consumers. Recent commitments in the 2014-15 Federal Budget to address some of these issues have been warmly welcomed by the private hospital sector.

Distinctions between regulatory arrangements applicable to public and private sectors not only work against competitive neutrality but also limit private sector patient access to affordable and appropriate treatment options. Again recent commitments by the Federal Government to review some of these provisions are welcome.

As discussed further on page 14, regulatory reform is also need to enable adequate response to the impact of globalisation and tele-health.

Are there occupational-based restrictions, or restrictions on when and how services can be provided, that have an unduly adverse impact on competition? Can the objectives of these restrictions be achieved in a manner more conducive to competition?

The health sector is characterised by a high level of occupational-based restrictions. Many of these restrictions are necessary to ensure consumer protection. Gradual moves towards national consistency in requirements and registration processes have reduced costs to business and have supported a productive and more mobile workforce. The Australian Health Practitioner Regulation Agency (AHPRA) is currently subject to an independent review.

Scope for improvement remains in the following areas:

- occupations currently subject to state regulation but not registered through APHRA
- streamlined recognition of applicants seeking registration/licencing on the basis of skills and experience gained in other countries.
- removal of barriers to professionals gaining training/experience in the private sector, eg restrictions imposed by specialist medical colleges on approval of private sector appointments for specialists from overseas (see Attachment B – Correspondence to Minister Dutton).

Are government-provided goods and services delivered in a manner conducive to competition, while meeting other policy objectives?

The Australian health sector is composed of a complex range of public and private sector health service providers. The APHA's comments are confined to those aspects of the health sector in which the private hospital and day surgery sector directly participate.

The public hospital sector varies from jurisdiction to jurisdiction in the extent to which competition reform has been embraced and opportunities opened up for genuine competition between public and private providers. The issue is of competition in the provision of hospital services is also subject to an additional layer of complexity owing to the fact that public and private hospitals compete in two distinct markets:

- the provision of services to private patients, and
- the provision of services to public patients.

Each of these markets presents a distinct set of policy problems with regard to competition policy although the coexistence of these markets also raises concerns for the wider issue of the provision of publically funded health services. For this reason the discussion which follows immediately below will focus on the provision of services to private patients. The role of competition in the provision of services to public patients is discussed under the question: "Would there be a public benefit in encouraging greater competition and choice in sectors with substantial government participation (including education, health and disability care and support)?"(page 12).

Does competitive neutrality policy function effectively, and does it apply to the appropriate government business activities?
Has the method of implementing competitive neutrality principles improved competition and productivity?
What are the disadvantages that private businesses face when competing with government business activities?
Could the mechanism for dealing with competitive neutrality complaints be improved?

Public hospitals do not generally meet the criteria for application of competitive neutrality policy because their primary purpose is the provision of public patient services. However public hospitals are also able to provide services to private patients and in doing so, public hospitals compete openly and directly with private hospitals.

In the current environment a lack of competitive neutrality in the hospital sector acts to the direct disadvantage of both patients and tax-payers. This problem is outlined further below:

- Since 2006/7 the number of private patient separations[3] treated in public hospitals has increased from 382,085 to 686,078 in 2012/13 an increase of 80%, faster than any other patient group. They now account for more than 13% of all public hospital separations. At the same time, key performance measures continue to indicate that the public hospital sector is failing to meet core expectations:
  - In 2012-13 waiting times for public elective surgery remained high, 36 days at the 50th percentile.
  - recurrent crises in 'bed-block' which delay hospital admissions putting emergency patients at risk and preventing efficient delivery of care.
- Private patients in public hospitals are subsidised by more than $650 million per annum in Commonwealth government funding over and above subsidisations that would also be provided to private patients in private hospitals[4]. This equates to a subsidy of around $950 per separation.
- Scarce government resources are used to treat private patients, many of whom could be more efficiently cared for in the private sector as demonstrated by the Productivity Commission in 2009(6), see Attachment C.
- High private patient admissions increase demand for capital funding for public hospital facilities. Recent developments, for example the new Royal Children's Hospital, Melbourne (334 beds, $1.074 billion) and the new Gold Coast University Hospital (750 beds, $1.76 billion) in Queensland show that capital expenditure in the public hospital sector is between two and three million dollars per bed(8, 9). By contrast, construction costs in the private sector are far more efficient, for example, Australia's first digital hospital will be built in Hervey Bay, by UnitingCare Queensland for an estimate cost of $87.5million, or less than $912,000 per bed (construction and e-health costs)(10).
- Medicare eligible patients with private health insurance cover risk having their freedom of choice compromised through lack of access to impartial advice and sometimes active pressure to use their insurance to fund admission to public facilities.
- Most significantly, pursuit of private patients and the 'other source' revenue they generate directs public funds away from the achievement of public policy objectives. Elective surgery

[3] Throughout this paper the term 'private patients' is used to refer to Medicare eligible patients funded by private health insurance benefits. Separations as defined by AIHW are used as a proxy for the number of patients.
[4] NHRA payments reported exclude funds for private patient services delivered in smaller hospitals and sub-acute and non-acute services that are 'block funded'.

waiting lists lengthen and targets for improvement remain un-addressed at the expense of the public patients the public hospital sector is intended to serve.

The ACCC expressed concern at the risk of staff at public hospitals acting unconscionably in order to gain a patient's agreement to be treated as a private patient as early as 2000(11). Concerns regarding the potential misuse of the election process were again noted in 2003 although the ACCC concluded that this issue was a matter for the jurisdictions to address(12). Since then however, the level of private patient services provided in public hospitals have only risen, and risen faster than the private patient market as a whole; suggesting that the concerns raised by the ACCC have not been resolved.

Public hospitals actively seek to 'recruit' private patients. In doing so public hospitals act anti-competitively by drawing upon competitive advantages:

- using public funds to subsidise private patients by paying Front End Deductibles (ie excess payments)
- using public funds to significantly subsidise private patients treated in public hospitals by waiver of out of pocket costs not covered by private health insurance (eg medical gaps
- use of the purchasing power of State-wide purchasing arrangements (for prostheses and consumables)
- cross-subsidisation of publicly funded overheads and infrastructure, and
- taxation exemptions available only to government owned entities that reduce the cost base of these services.

Public hospitals also benefit by receiving admissions through public emergency departments whom they then actively seek to recruit as private patients. While some 28 private hospitals have emergency departments, only 7 receive patient flows comparable with the public sector and they are attached to privately owned/managed public hospitals operating under essentially the same conditions as their public sector counterparts. The remaining 21 private emergency departments are at a competitive disadvantage because they are routinely by-passed by ambulance services and because private health funds are prohibited by law from covering the services that they provide.

Public and private hospitals also compete in the provision of services to compensable patients (paid for through jurisdictional workers compensation and motor vehicle third party insurance provisions), services to clients of the Department of Veterans Affairs (through competitive tender with the Department of Veteran's Affairs) and services to self-funded patients. The table below shows the number of separations for each of these categories of patient in both public and private hospitals for the financial year 2012/13.

	Public Hospitals	**Private Hospitals**	**Total**	**Public:Total**
Self-funded	53,318	290,799	344,117	16%
Workers compensation	21,660	61,745	83,405	26%
Motor vehicle	27,820	6,349	34,169	81%
Dept of Vet's Affairs	104,154	184,807	288,961	36%
Other	29,332	28,237	57,569	51%

The relatively high share of motor vehicle third party insurance patients treated in public hospitals is because such patients would often require care for multiple trauma injuries which are not typically treated in private hospitals. Patients categorised as 'other' would include patients from the armed

forces and patients from correctional facilities who might similarly be more likely to require services that are less commonly provided in the private sector such as forensic psychiatric services.

These figures indicate that when competing on a fair and transparent basis, such as through tenders let by the Department of Veterans Affairs, private hospitals are the preferred provider. This emphasises the anti-competitive nature of public hospital's involvement in providing private patient services.

Would there be a public benefit in encouraging greater competition and choice in sectors with substantial government participation (including education, health and disability care and support)?

Will more competition among providers serve the interests of consumers of health, education and other services? What issues arise when government agencies, private businesses and not-for-profit organisations simultaneously seek to provide human services? Can competition be increased in other markets currently served by government-operated providers? Is current policy conducive to competition with government-operated services?

The APHA is of the view that there is unrealised potential to encourage greater competition and choice within the health sector including in the provision of public patient services. For the purposes of this discussion, a public patient is a patient whose care is paid for through a jurisdictional health service budget and who elects on admission to be treated as a public patient. Such patients have no out of pocket charges, their care is jointly funded by State and Federal governments.

Hitherto, private entities have competed successfully in a variety of roles:

- design and construction of public hospital facilities
- management of public hospitals, estimated to contribute less than 10% of public sector capacity,
- provision of discrete services to public hospitals such as cleaning, and
- short-term contractual provision of care for public patients in privately owned and run facilities, currently accounting for only 3% of admitted public patient services.

However competition within the health sector is constrained by the limited extent to which jurisdictions have been willing to open up the provision to public services on a genuinely contestable basis. Contracts for the provision of patient care have often been short-term and for a limited range of services. Experience within the sector of the negotiation of major public-private partnerships is limited and success in such ventures has been variable.

Issues to be addressed include:

- competitive neutrality in the provision of services to private patients
- development of expertise in the design and management of public-private partnerships,
- development of coherent and consistent approaches to the tendering public hospital services,
- clarity regarding public policy objectives and community service obligations.

Competitive neutrality in the provision of services to private patients

As discussed on page 10, there is a lack of neutrality in competition between public and private hospital sector for private patients. This distortion also impacts on the contestability of public patient services. Faced with funding constraints and the introduction of activity based funding, public hospitals and, the health districts to which they are accountable, are increasingly responding

with a two-fold strategy of actively seeking to grow private patient revenue while at the same time contracting out public patient services and demanding a heavy discount on the National Efficient Price (the price determined by the Independent Hospital Pricing Authority). While in some circumstances such strategies might, in the short term, deliver an improved return on investment to State/Territory budgets, they are not sustainable and cannot deliver the major improvements in productivity that must be achieved if future health needs are to be met.

Development of expertise in the design and management of public-private partnerships

Effective and sustainable public-private partnerships call for a complex mix of skills on the part of those involved in the design and management of such partnerships. The skills required include both the ability to assess and manage commercial risk but also experience in planning, designing and managing the delivery of public hospital services. If such partnerships are to endure and to provide the sustainability, reliability and consistency expected of public services, the benefits and the risks must be proportionate for both parties. At the present time, such expertise is still relatively rare across the health sector as a whole. It is also essential that the learnings from partnerships that have not succeeded in the past by absorbed by both government and non-government stakeholders.

Development of coherent and consistent approaches to the tendering public hospital services

A lack of coherent and consistent approaches to tendering of public hospital services on a contestable basis has limited creation of an openly competitive market in the provision of public hospital services.

As discussed in Appendix C, The Productivity Commission suggested that private hospitals are at least 30% less costly than public hospitals per casemix-adjusted separation(6). However, rather than trying to reduce overall costs to the taxpayer by tendering for long-term contracts to provide core patient treatment services, tenders are often limited and short-term in nature. Such contracts are often let where the public sector has failed in service delivery and seeks assistance in dealing with waiting lists.

Short-term or ad-hoc contracting practices discourage private investment and may also result in in-efficient outcomes if for example a premium is paid for the delivery of services at short notice.

Public Policy Objectives

The Australian health system is premised on the principle of universal access. This means that all Australians eligible for Medicare services are entitled to care in a public hospital on the basis of clinical need. This policy foundation presents some particular challenges, however it is in no way antithetical to open competition between public and private providers in the provision of public patient services provided policy objectives are clearly identified. In negotiations deliverables need to be measurable, realistic and relevant.

Are the current competition laws working effectively to promote competitive markets, given increasing globalisation, changing market and social structures, and technological change?

Given structural changes in the economy over time, do the definitions of 'market' in the CCA operate effectively, and do they work to further the objectives of the CCA?

The private hospital sector is being impacted by a range of trends identified in the Issue Paper. These impacts and potential implications for competition policy are described below.

Globalisation

With respect to the private hospital sector globalisation has for a significant period of time meant that the industry is dependent on a globalised market for the supply of a wide range of consumables and equipment. Consequently, as already discussed, it is open to the impacts of competition in these supplier markets.

The private sector is also dependent on a globalised workforce recognising that health sector professionals are a mobile workforce moving both into and out of Australia. Australia continues to be an attractive destination for people seeking both training and qualifications and employment in the health sector. The Australian health sector is also reliant on a strong regulatory framework. While this framework is not a barrier to competition in itself, the cost and administrative burden involved in recruiting professionals from overseas and facilitating their accreditation are unnecessarily high.

These factors act to the detriment of Australian consumers at a time when the health sector is facing significant skills shortages in a number of key areas; shortages that cannot be met from within Australia by training and retention alone.

Medical Tourism

In recent years an international market in medical tourism has emerged with a growing number of Australians choosing to travel overseas to receive treatment. Often the treatment received is a surgical procedure. While medical tourism offers Australians access to cheaper treatment, the quality and safety of care may not always meet Australian standards and consumers may face significant difficulties if complications arise while they are overseas. As the international market for medical tourism continues to grow, it can be expected that the private hospital sector will be subject to increased competition in some areas.

Inbound medical tourism accounts for just 0.001% of the global market. A report by Deloitte Access Economics found however that the challenges faced by Australian providers could not be attributable to any market failures that would justify regulatory reform(13).

Telehealth

Technological change while a major feature of the health sector has not resulted in significant change to market structures. Over time however, the growing use of telehealth will increase the capacity of both public and private hospitals to treat patients over a wider geographical range. Such technologies will add to the capacity of hospitals in regional areas to offer a wider range of clinical services by engaging the expertise of clinicians in major metropolitan centres.

Tele-health technologies also provide access to global markets is some specific areas such as the use of 'night watch' radiology services where overseas Radiologists can provide reports remotely. Such services are sometimes used in major hospitals to increase capacity to provide a 24-hour service.

The use of tele-health services both domestically and internationally in the private hospital sector is constrained by rules attached to the Medicare Benefits Schedule. The MBS governs the payment of Medicare payments to clinicians, however, it serves as a strong break on the range of services that can be provided in the private hospital sector because Health Funds can only pay for services associated with a valid MBS item and delivered by a clinician with a valid MBS provider number. These constraints do not apply to the public hospitals sector.

Given structural changes in the economy over time, how should misuse of market power be dealt with under the CCA? Are existing unfair and unconscionable conduct provisions working effectively to support small and medium sized business participation in markets?

As commented before, the inappropriate use of market power by large health funds negotiating with small hospitals and day surgeries have been an issue of on-going concern to the APHA. In the APHA's submission the ACCC's first inquiry into anti-competitive and other practices by health funds and providers in relation to private health insurance, concern was expressed that hospitals and day surgeries feared commercial reprisals for making complaints.

While the ACCC has, on one occasion, upheld a complaint of unconscionable conduct resulting enforcement against a health fund for imposing a unilateral variation clause within a proposed Hospital Preferred Provider Agreement (HPPA)(14), most complaints by private hospitals have not resulted in action by the ACCC. As has been acknowledged by the ACCC itself,

> "Section 46, the misuse of market power provision, prohibits any business that has a substantial degree of power in a market from taking advantage of that power for the purpose of:
>
> - Eliminating or substantially damaging a competitor;
> - Deterring or preventing a person from engaging in competitive conduct in any market; or
> - Preventing the entry of a person into any market.
>
> While some conduct of health funds may have the **effect** of one of the above prohibitions, the Commission has found no evidence to date to support a claim that the conduct of the health funds is done for that **purpose.**"(11).

It is also important to note that the private health sector is peculiar in that it is heavily shaped by government policy. As the ACCC has observed,

> "The Health Legislation (Private Health Insurance Reform) Amendment Act 1995 encouraged the development of agreements between funds, hospitals and doctors. It fundamentally changed the role of the health funds from price takers to active purchasers of services."(11)

The impact of this legislation demonstrates the role of government policy in shaping market power. Arguably such power is not simply determined by size or market share, it is also determined by the

roles and options available to an entity and the extent to which these roles lead over time to practices (eg use of HPPAs) that become dominant within a market.

The experience of the private hospital sector has also raised issues that are not addressed under current provisions regarding unconscionable conduct. These issues raise questions pertaining to issues of effect and purpose. They also raise concerns pertaining to the impact of the conduct of negotiating parties on third parties. For example, might it be desirable for conduct be considered unconscionable if it impinges on the ability of a hospital to fulfil its legal, clinical and moral obligations to a patient, for example, a hospital's obligations with respect to the provision of informed financial consent? Might it be desirable for conduct to be considered unconscionable if a health fund imposes contractual terms on a hospital which impinge on the services that can be offered to a health fund member in ways that are not disclosed to that member?

How accessible is the collective bargaining process for small businesses, and can they use it without requiring substantial legal assistance or advice?

The ABS reports that in 2011-12 there were 281 private hospitals in Australia(3). The APHA estimates that of these, 60 are independent non-Catholic (and hence not participants in the Catholic Negotiating Alliance) private hospitals. These independent, non-Catholic private hospitals represent an estimated 10% of the overnight beds provided by the private hospital sector. Of the 311 free standing day surgeries reported by the ABS, APHA estimates that up to 80% are independent. The APHA estimates that independent, non-Catholic hospitals and day surgeries care for around 25% of all private sector hospital separations each year. While the private hospital sector is dominated by two major corporations, Ramsay Health Care and Healthscope, no other single for-profit or not-for-profit group would account for more than 10% of the market. Consequently while the private hospital sector has been subject of significant consolidation it remains characterised by a significant degree of fragmentation.

While there have been several occasions in which groups of hospitals have sought and been granted authorisations from the ACCC for the purposes of collective bargaining, these applications have been expensive and time consuming to seek and to exercise. Instances where authorisations have been granted include:

- Five Queensland private hospitals – granted with conditions in 1999(11)
- Eight small NSW hospitals (Alwyn Rehabilitation Hospital, Wolper Jewish Hospital, Hornsby Day Surgery Centre, Longueville Private Hospital, Poplars Private Hospital, May Private Hospital, Calvary Hospital in Wagga Wagga, Hunter Valley Private Hospital – granted in 2001 (15)
- St Vincent's Private Hospitals and Mater Misericordiae Hospital – granted in 2000 (16)
- Sisters of Charity Health Services, Mercy Health and Aged Care and Holy Spirit care Services – granted in 2004 (17)
- St Vincent's Health Australia Limited, The Congregation of Religious Sisters of Charity of Australia, The Holy Spirit Northside Private Hospital Limited and Trustees of Mary Aikenhead Ministries – granted in 2012 (18)
- The Catholic Negotiating Alliance representing a network of catholic health facilities was granted authority in 2009 for a period of five years, St Vincent's Health Australia is currently seeking re-authorisation on behalf of a network of Catholic hospitals and aged care facilities for a period of ten years(19, 20).

- In 2012 the Private Hospital Collective Bargaining Group[5] was granted conditional authorisation until 11 September 2017 to form a group of no more than 75 private hospitals in total, comprising:
    - up to 50 private hospitals with not more than 200 beds each (small private hospitals); and
    - up to 25 additional private hospitals with not more than 20 beds each (very small private hospitals);
    - consisting of no more than 20 private hospitals in any one Australian state or territory, comprising:
        - up to 10 small private hospitals; and
        - up to 10 additional very small private hospitals(21).

Furthermore such authorisations have only been granted where the ACCC has been satisfied that competition will not be materially impaired(22). This usually means that hospitals wishing to seek an authorisation need to be operating if different locations, a factor that further adds to the cost and difficulty of forming such a group.

Is the code framework leading to a better marketplace, having regard both to the aims of the rules and the regulatory burden they could create? What has been the experience of businesses in the use and implementation of codes of conduct?

In the environment within which private hospitals operate many aspects of clinical practice and service to consumers are governed by regulation consequently there is little reliance on voluntary codes of conduct.

One area where voluntary codes of conduct have been attempted is in relation to dealings between private hospitals and health funds. The APHA was party to extensive discussions with the Australian Health Insurance Association (now known as Private Healthcare Australia) to establish A Voluntary Code of Practice for Hospital Purchaser/Provider agreement Negotiations Between Private Hospitals and Private Health Insurers. The code lapsed within 18 months of inception due to failure of the Australian Health Insurers Association (AHIA) to engage in the inbuilt review process. The code also failed to secure several significant private hospital providers as signatories even though these non-signatories professed support. The code provided no meaningful sanctions and failed to address a number of issues of concern to hospital sector representatives. Following the collapse of attempts to implement a voluntary code, APHA proposed that a mandatory code of conduct should be instituted but this was not supported by other stakeholders.

The failure of the voluntary code of conduct is a source of ongoing frustration on the part of APHA members. As a result the industry remains heavily reliant on recourse to default provisions under the Health Insurance Act including the default payment and Second Tier benefits schedules. These legislated provisions remain intrinsic to the protection of consumers from the consequences of disputes between hospitals and health funds. They are also vital in preserving competition with in the private hospital sector by removing a significant barrier to entry frequently faced by day surgeries and small hospitals, ie failure to obtain contracts from health funds. Reliance on these measures is not reflected in Department of Health statistics because they do not adequately capture the extent to which such schedules are relied upon. The importance of Second Tier provisions is however reflected in the strong interest maintained by private hospitals and day surgeries in

[5] At the time this authority was granted the PHCBG had no members and it is not known if the Group has succeeded in becoming operative.

applying for and maintaining eligibility notwithstanding the additional regulatory requirements and cost involved.

Frequent recourse is also taken on the part of private hospitals and consumers to the Private Health Insurance Ombudsman and the Department of Health when issues arise which impact directly on the ability of private hospitals to provide services to health fund members.

As contractual arrangements and private health insurance products evolve, new issues continue to arise. For example, as was noted in Senate Estimates, there has been a recent increase in complaints to the Private Health Insurance Ombudsman following the unilateral decision by a major health funds to cease paying costs on an 'ex gratia' basis.

> **Senator McLUCAS:** Can you take on notice a breakdown of the types of complaints and the proportion of the total that they represent?
> **Ms Gavel:** Just on those where we are getting high numbers?
> **Senator McLUCAS:** If you can break it down to everything, and then 'other', that would be helpful. Is that level of complaint static?
> **Ms Gavel:** It is similar to what we were seeing last year. I would expect that by the end of year there will be an increase in the number of complaints. One reason for that is that one of the larger insurers made some changes to its ex-gratia benefits policies and that has increased complaints to us significantly(23).

Are the enforcement powers, penalties and remedies, including for private enforcement, effective in furthering the objectives of the CCA?

The Issues Paper published by the Review raises the question as to whether remedies and powers used in overseas jurisdictions are applicable to the Australian context.

The Issues Paper notes work done by United Kingdom Competition Commission including a recent review of private health care which, while allowing for detailed consideration of a wide range of competition issues within the sector, took two years before the final report was complete. Consultations are still ongoing before the final remedies are enforced on 1 October 2014, two years and seven months after the review's inception(24).

In Australia, major players, both private hospital groups and private health insurers typically operate in multiple geographic markets. The size, complexity and diversity of the private health sector in Australia would make such a review of the type undertaken in the United Kingdom a much more complex task.

Hitherto, Australia, recognising that the health sector merits particular attention because of the risks involved for consumers, has taken a different approach:

- mergers and acquisitions have been assessed on a case by case basis as they have been proposed. This assessment includes close analysis of specific markets for discrete services (eg hospital services for rehabilitation patients)(25).
- the ACCC has invited complaints regarding anti-competitive behaviour and investigated those complaints found to fall within the legislation and to be of sufficient significance to merit the resources involved, and
- since 1999, the ACCC has been also been charged with conducting a regular review of anti-competitive practices by health funds and providers in relation to private health insurance(11).

This approach has had both strengths and limitations. Enforceable determinations are made prospectively rather than retrospectively. Applications for exemption are dealt within a relatively timely manner. Limitations arise however with matters arise which are outside the scope of the powers granted to the ACCC or when problems raised by stakeholders require intervention by government. Interventions by government have included establishment of independent complaint and mediation processes (outside the ACCC) through to policy change and legislation.

While in the early years, the ACCC reports to the Senate were instructive in identifying issues of concern to consumers and industry stakeholders and in guiding the ACCC in its educative role, the constraints within which the ACCC has been required to operate meant that substantive issues of concern to the private hospital sector could not be addressed by the ACCC.

Over time several of these issues have been addressed through legislative change and government led initiatives. It is only through government intervention that it has been possible to address issues of significant concern to consumers including:

- provision of clear and consistent information regarding health insurance policies
- portability arrangements for consumers switching between health funds
- affordable access to prostheses, and
- access to choice of doctor and hospital irrespective of health fund contracting arrangements (ie provision enabled through the Second Tier Benefits Schedule).

This 14 year history demonstrates the difficulty of implementing competition reform in a context where consumers face significant information asymmetry and where they are reliant on the collaboration of multiple stakeholders – health funds, private hospitals, health professionals and, manufacturers and medical devises and pharmaceuticals – who must negotiate with each other and who also have their own commercial interests to protect. This problem has been clearly apparent in relation to the provision of information to consumers, informed financial consent and access to prostheses.

What are the experiences of small businesses in dealing with the ACCC? Are there any factors that make it difficult for small businesses to enforce their rights or otherwise take action in relation to competition issues?

As previously discussed, the ACCC has produced regular reports on anti-competitive and other practices by health funds and providers in relation to private health insurance. These reports have been produced in response to an order agreed by the Australian Senate on 25 March 1999 and amended on 18 September 2002. Reports produced up until the 2012 show a consistent concern regarding the difficult negotiating environment within which private hospitals operate but equally they point to limitations in the ability of the ACCC to resolve these concerns.

These reports show that although the ACCC was consistently welcoming of complaints from the private hospital sector, the occasions on which the ACCC intervened have been rare. Sometimes formal intervention has been unnecessary because the party against whom a complaint has been made has changed their behaviour. More often the ACCC has found that upon investigation the matter raised did not constitute a breach of the Act. On other occasions action has not been possible because of insufficient evidence. The reduction in complaints over time may be attributable to multiple factors including:

- an increased understanding of the scope of the ACCC powers and
- an increase understanding by health sector stakeholders of their legal obligations, and
- the expansion of the powers of the Private Health Insurance Ombudsman to include the power to compel an insurer and health care provider to attend mediation to result contractual disputes that may adversely affect consumer entitlements.

Notwithstanding positive changes over the 14 year period, the APHA retains the view that the contracting environment between private hospitals and health funds remains difficult. Fear of commercial reprisal and scepticism that a complaint will result in a resolution cannot be discounted as contributing factors to the low level of complaints.

Are there issues in key markets that raise competition concerns not addressed by existing anti-competitive conduct laws? If so, in which ways might they be addressed through competition-related policies?

The issues of concern to the private hospital sector have already been raised throughout this submission. The APHA reserves comment as to the way in which they might be addressed through competition related policies.

The experience of the private hospital sector suggests that it is unlikely that issues of concern to consumers – availability of clear and reliable information, availability of services that are fit for purpose, assurance of safety and quality, the passing on to consumers of the benefits of efficiency gains - can been addressed through competition policy alone.

Are competition-related institutions functioning effectively and promoting efficient outcomes for consumers and the maximum scope for industry participation?

For the most part consumers and participants in the hospital sector have been primarily reliant on institutions whose scope and purpose relates more specifically to the health sector and the private health insurance sector in particular.

What institutional arrangements would best support a self-sustaining process for continual competition policy reform and review?

From time to time individual hospital operators have had dealings with the ACCC and jurisdictional bodies, however as the APHA has not been a party to these dealings, no comment is offered in this submission regarding the manner in which these matters pertaining to individual companies are addressed.

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Appendix A: APHA's response to the paper Competition in the Australian Private Health Insurance Market

Australian
Private Hospitals
Association

Competition in the Australian Private Health Insurance Market

Executive Summary

The APHA believes that it is important that discussion of competition within the Australian Private Health Insurance (PHI) market should take account of both the benefits to consumers and the broader public good delivered by investment in PHI.

In a market characterised by long tenure, and a small number of large national providers combined with a large number of small niche providers, it is important that the regulatory framework be carefully targeted to protect both individual consumers and the benefits delivered to Australian taxpayers in return for the investment make by both individuals and government.

APHA is concerned that discussion of the impact of economies of scale needs to be coupled with discussion of the impact of consolidation. Secondly the impacts of these factors within PHI need to be considered not only with respect to their impact on the PHI industry but also with respect to their impact on the complete value chain of health care delivery.

APHA strongly supports the needs highlighted in the Discussion Paper for more detailed investigation and understanding of important trends including:

- The growth in policies with exclusions and limitations, and
- The growth in 'general cover only' policies.

In addition it is important to understand the effectiveness of current portability arrangements and to remove/reduce barriers to portability.

APHA is of the view that public good and the sustainability of affordable and accessible health services requires a relatively high level of regulation including community rating and regulation of policy coverage. Nevertheless, there remains further scope for innovation, eg greater use of loyalty rewards and no-claim bonuses, within the existing regulatory environment.

Scope of the Discussion

The APHA believes that it is essential that discussion of competition within the Australian Private Health Insurance market should take account of social and economic impacts including broader policy objectives of:

- increasing coverage, access and affordability to enhance consumer choice and expand consumer contributions to the costs of healthcare

- sharing the casemix and case load across public and private hospitals, and
- ensuring that private health insurance plays a supplementary and positive role in the financing of healthcare.

These objectives are essential to ensuring that the government, and the Australian public, as both consumers of PHI and as taxpayers, receive an optimal return on their investment in PHI. They are integral to ensuring that policy and regulatory frameworks are not excessive and are appropriately targeted.

For example, the growth of exclusionary products impacts not only on the level of price competition but also on the level of service. This in turn influences consumer perceptions and the value proposition of private health insurance as a whole underpinned as it is by community rating.

Exclusions and Limitations (Question 6)

APHA strongly supports more detailed research and discussion on the issue of exclusions and limitations. Policies including exclusions have grown six fold since 2005 and now constitute 25% of all hospital care policies held in Australia. Such a significant trend requires more understanding particularly when it is known that there is considerable variation in the nature and extent of exclusions made.

The Paper observes that growth in such policies has accelerated in the last five years but offers no explanation for this trend.

It is of concern that the Discussion Paper does not reference evidence to support some of the statements made:

> "exclusions products are chosen, but not valued, by price sensitive consumers" (page 29)

This statement appears at odds with data that shows that complaints concerning exclusionary projects are the second highest category of complaint received by the Private Health Insurance Ombudsman (PHIO, 2012, page 9). This trend would appear to indicate that holders of exclusionary products seek to make claims against them – ie they do not see them merely as a tax product.

The Discussion Paper observes that:

> "The proportion of dissatisfied customers that drop or downgrade their private health insurance, or move between funds, is very low." (page 56)

However, the APHA would caution that this statement needs to be set against the pronounced growth in policies containing exclusions both in absolute numbers and as a proportion of policies held.

It should be noted that exclusionary/restricted benefit products result in an increased administrative burden for hospitals as they introduce added complexity to claiming, billing and payment collection processes. Hospitals are also exposed to additional financial risk particularly if it cannot be foreseen and confirmed prior to admission whether a patient's policy will provide adequate cover (1).

General Treatment Cover (Question 7)

Two million people (15% of the market) hold general treatment cover policies only and this segment is growing. The Discussion Paper observes that contributing factors may include regional effects (lack of access to private hospitals), disincentives created by the LHC and perceived risk. However the trends observed are small and the diversity of contributory factors make it difficult to determine whether competition is contributing to the growth in general treatment cover.

Community Rating (Question 8)

The benefits of community rating outweigh any potential barriers to innovation because it ensures that the elderly and the sick are not priced out of the market. Without this protection the public good provided by PHI would be eroded.

While community rating precludes pricing on the basis of age and individual risk profile, it does not preclude other forms of innovation such as loyalty based discounting or no-claim bonuses.

Regulation of product content and pricing oversight (Question 9)

Regulation of product content and pricing oversight is essential to consumer protection for vulnerable consumers (the mentally ill, the infirm and the dying). Such regulations also protect the public good by limiting the scope of PHI to compete against Medicare and shift risk to the public sector.

Risk Equalisation (Questions 10 and 11)

The APHA does not offer any comment in regard to the impact of risk equalisation on competition or the efficiency of the current model other than to observe that care should be taken to ensure that any changes to risk equalisation should not increase barriers to membership portability. As is observed in the Discussion Paper on page 55, there is no means of evaluating "the extent to which portability requirements fail to act as it is intended by the legislation". A central repository for transfer requests and process for enforcing legislated requirements should be established as a matter of priority.

Premium Approval, Incentives and Regulation (Question 12)

APHA makes no comment with regard to the impact of current arrangements for premium approval, take-up incentives and regulation on competition with in the PHI sector other than to observe that evaluation of current arrangements is now even more difficult in the absence of any clear understanding as to the impact of recent changes to the PHI Rebate.

Impact of Regulation of Market Conditions (Questions 17, 23 and 24)

APHA is concerned that discussion of the impact of economies of scale needs to be coupled with discussion of the impact of consolidation. Secondly the impacts of these factors need to be considered not only with respect to the PHI industry but also with respect to the impact on the complete value chain of health care delivery.

Second Tier Default Benefit Arrangements

The Discussion Paper is deficient in its consideration of the impact of Second Tier Default Benefit Arrangements and statements included reflect a misunderstanding of the nature and purpose of these arrangements. The Discussion Paper states:

> "regulatory safety nets, such as tier two hospital contracts, which stipulate a floor to contract prices" (Page 59.)

First it must be understood that there is no such thing as a 'tier two hospital contract' rather hospitals must meet a range of strict eligibility criteria in order to be assessed by the Second Tier Advisory Committee as eligible for Second Tier Default Benefits. Compliance must be assessed annually. In the last six months, 24% of applicants were denied eligibility as they were unable to demonstrate compliance with these criteria.

Second, the Second Tier Default rate does not act as a floor price for the market rather it is a benefit level offered to qualifying hospitals for the period 1 September to 31 August. This 'minimum benefit' is set at not less than 85% of the average charge for the equivalent episode of hospital treatment under that health insurer's negotiated agreements in force on 1 August. Consequently the benefit paid to Second Tier hospitals is usually set relative to the average contract rates for equivalent episodes negotiated by that particular insurer with comparable hospitals within a particular State(2).

The purpose of Second Tier Arrangements is to provide protection for private hospitals in the face of selective contracting by health funds. Given that there has been significant consolidation in the health fund market since 1997 when these arrangements were first introduced, they are arguably of even greater relevance now.

Similarly the statement on page 60 of the Discussion Paper that:

> "Smaller private hospitals are not able to rely on tier two rates, but nor can they sustainably attract co-payments from patients"

reflects an inadequate understanding of the interaction between the regulatory limits and supports within which both health funds and hospitals have been obliged to operate in the interests of maximising the affordability of private health care.

Control of Inputs

APHA takes issue with the statement in the Discussion Paper that insurers have no influence or control over some inputs "such as medical devices and specialist fees". While insurers do not control all inputs, they do have a voice in formal arrangements with Government to influence the regulations which in turn determine their obligations with respect to medical devices (though the Prostheses List) and specialist fees (through the MBS). These arrangements provide opportunity to all stakeholders to provide advice to Government and provide both protection from excessive price inflation and certainty as to the obligations to be borne by insurers.

Geographic Variations

As is observed in the Discussion Paper, there are marked differences between States/ Territories in the size and composition of the PHI market. Historical factors play a significant part in the way in

which these markets have developed. Just as a single fund may hold significant power in one State but less power in another, so too a hospital group may be a price maker in one jurisdiction but a price taker in another. Moreover there are significant differences between States/ Territories in the degree of consolidation not only within PHI but also within the private hospital sector and the day surgery sector is even more diverse.

Consumer Behaviour (Questions 18 and 19)

As already observed above, evaluation of the market is difficult in the absence of any clear understanding as to the impact of recent changes to the PHI Rebate. Likewise it has become much more difficult to interpret consumer behaviour. The lack of adequate data in respect of policy switching and uptake of exclusionary policies further compounds this problem.

(1) The Private Health Insurance Ombudsman, *Annual Report 2011-12*, page 31, Canberra, 2012 .

(2) *Private Health Insurance (Benefit Requirements) Rules 2011* as amended taking into account amendments up to the *Private Health Insurance (Benefit Requirements) Amendment Rules 2012 (no8)*, Department of Health and Ageing, Canberra, 29 November 2012.

21 January 2013

Appendix B: Correspondence to the Minister for Health regarding "Area of Need" Placements

Australian
Private Hospitals
Association

The Hon Peter Dutton MP
Minister for Health
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear Minister

Area of Need and Area of Speciality Appointments for Overseas Trained Specialists

As you may be aware, medical specialists trained overseas can be appointed to designated 'Area of Need'(AON) and 'Area of Specialty'(AOS) positions. These appointments are approved by the State within which the appointment is made, however, applications for approval must be supported by the relevant specialist medical college. The Australian Private Hospitals Association notes that in some instances in recent years, approval appears to have been withheld because the appointment sought is to a position within a private hospital.

The Royal Australasian College of Physicians (RACP) has a stated policy of requiring that all 'area of need appointments' be joint appointments between public and private sectors on a 50:50 basis. While other colleges have not gone as far as to formally adopt this position in writing, APHA is concerned that adoption of such a policy in practice significantly impacts on access to specialist medical services, particularly in regional areas. It should be noted that this is an arbitrary policy position adopted by the College with no supporting evidence base and not a regulatory requirement of either the Commonwealth or State Governments.

This quasi-regulatory requirement for 50:50 public/private appointments creates difficulties when a private hospital seeking to address its service requirements through an 'area of need' appointment is unable to secure commitment from a public hospital to provide a parallel appointment. The problem is particularly acute in those regions where private hospitals are the principal, or even the only, provider of specific services such as cancer care, dialysis and rehabilitation.

The RACP has stated that the justification for its position is: 'to ensure peer review is independent, includes exposure to a broad Casemix, and to minimise potential conflicts of interest'. The implications of the College's position are inappropriate, inequitable and reflective of an inadequate or outdated understanding of the scope and complexity of services provided by the private hospital sector. The College imposes no similar requirement upon public hospitals.

The APHA would prefer that each 'Area of Need' or 'Area of Specialty' application is assessed on its own merits recognising that private hospitals play a significant role in providing services to regional communities.

Both APHA and the Private Hospitals Association of Queensland have recently written to the RACP in relation to this issue and I have attached copies of this correspondence for your information.

It would be greatly appreciated if you could raise this matter with your State/Territory Ministerial colleagues so as to ensure that the needs of regional communities can be met.

Yours sincerely

Michael Roff
Chief Executive Officer
The Australian Private Hospitals Association
8 January 2014

Australian
Private Hospitals
Association

Associate Professor Leslie E Bolitho AM
President
Royal Australasian College of Physicians
145 Macquarie Street
SYDNEY NSW 2000

Dear Associate Professor Bolitho

Area of Need and Area of Speciality Appointments for Overseas Trained Specialists

I write in support of representations made to you last November by the Private Hospitals Association Queensland in relation to problems experienced by private hospitals seeking approval of 'Area of Need'(AON) and 'Area of Specialty'(AOS) Positions. These appointments are approved by the State within which the appointment is made, however, applications for approval must be supported by the relevant specialist medical college. The Australian Private Hospitals Association notes that in some instances in recent years, support appears to have been withheld by your College because the appointment sought is to a position within a private hospital.

We note that the Royal Australasian College of Physicians has a stated policy of requiring that all 'area of need appointments' be joint appointments between public and private sectors on a 50:50 basis. The APHA is concerned that adoption of such a policy significantly impacts on access to specialist medical services, particularly in those regional areas where private hospitals are the principal, or even the only, provider of specific services. As you may be aware, for example, the private hospital sector plays an essential role in Queensland particularly in the provision of services in cancer care, dialysis and rehabilitation.

The requirement for 50:50 public/private appointments creates difficulties when a private hospital seeking to address its service requirements through an 'area of need' appointment is unable to secure commitment from a public hospital to provide a parallel appointment. As public hospitals are forced to rationalise services, it is often left to private hospitals to meet the service gap. Furthermore as you will be aware, the case-mix and loads treated by the private hospital sector differ significantly from those treated in the public sector and in consequence it cannot be expected that the two sectors will have identical resource requirements.

The RACP has stated that the justification for its position is: 'to ensure peer review is independent, includes exposure to a broad Casemix, and to minimise potential conflicts of interest'. In our view, the College's position is inappropriate, inequitable and reflective of an inadequate or outdated understanding of the scope and complexity of services provided by the private hospital sector. Independence of peer review and minimisation of conflict of interest are important considerations which need to be taken into account in relation to any

appointment, irrespective of whether it is an appointment to a public, private or cross-sector position.

The APHA would prefer that each 'Area of Need' or 'Area of Specialty' application is assessed on its own merits recognising that private hospitals play a significant role in providing services to regional communities.

I look forward to your response and would welcome the opportunity to discuss this matter further.

Yours sincerely

Michael Roff
Chief Executive Officer
The Australian Private Hospitals Association
8 January 2014

Appendix C: Productivity Commission Report on Public and Private Hospitals - APHA Analysis

Australian
Private Hospitals
Association

APHA Information Paper Series

Productivity Commission report on Public and Private Hospitals APHA Analysis

This document provides an analysis of the data presented in the Productivity Commission report ' Public and Private Hospitals'

Australian Private Hospitals Association ABN 82 008 623 809

February 2010

Productivity Commission – Public and Private Hospitals

1 Executive summary

- The Commission has found that on average treatment in Private Hospitals costs $130 less than in Public Hospitals.
- The Commission's data shows that when looking at the costs that private hospitals can control they cost 32% or $1,089 less than public hospitals.
- According to the report private hospitals have a more complex casemix than public hospitals.
- Where comparable safety and quality data exists in the report private hospitals are shown to be safer than public hospitals.
- Private hospitals offer more timely access to elective surgery, and analysis by the Commission shows that private hospitals carry out more elective surgery with patients from disadvantaged socioeconomic backgrounds than public hospitals.

2 Introduction

In May 2009, the Federal Government asked the Productivity Commission to carry out a research study into public and private hospitals. The final report produced by the Commission offers an overview of the two sectors, showing their differences, similarities, areas where they compete against each other, and areas where they complement each other. The most publicised part of the report has been the Commission's attempts to compare the two sectors on the basis of cost, but some attention has focussed on the safety and quality section.

There is inconsistency between the commentary and quantitative data in the report. In an apparent attempt to provide 'balanced' commentary the Commission has unfortunately failed to draw sufficient attention to many of the key points revealed by the data.

APHA has therefore analysed the data the Commission's report presents. This document provides a brief overview of the cost and safety and quality findings in that data.

3 Data collections

Despite all the data that private hospitals submit at their own expense to the various state and territory data collections, the Productivity Commission found that there was no straight forward way to compare

hospital and medical costs and health and safety indicators. The Commission has found that existing data collections are limited by inconsistent collection methods and missing information. For this reason, the Commission has stated that the cost data it presents is experimental. It has tried to identify shortcomings in the data and account for these in its calculations.

The difficulties the Commission faced in accessing and analysing the data strengthens APHA's call for a rationalisation of data collection. It is absurd that with all the health data that is currently being collected that simple inter-state comparisons cannot be made because each of the states collects data in different ways. This is a waste of taxpayer money and prevents analysis that could drive health outcome improvements. **A straightforward cost-saving measure that will improve health outcomes would be for one national agency to be responsible for all health data collection in Australia**. There should be a single national data collection to which all public and private hospitals provide consistent information.

4 The Commission's cost data findings

The data that the Commission used to produce its cost comparisons were drawn from the National Hospital Costs Data Collection (NHCDC) for hospital expenditure, and from the Hospital Casemix Protocol for medical and diagnosis costs. **The Commission found that public hospitals are underreporting the cost of treatment by excluding administrative and head-office costs from their NHCDC submissions**. For example, asset depreciation is not reported for Victorian public hospitals, building depreciation is not reported for public hospitals in Queensland. The costs associated with financial, payroll and human resource management services are also not included in public hospital costs in Queensland. Head office costs are excluded in public hospital costs from New South Wales, Victoria, South Australia, Western Australia and the ACT. The extent to which head office and administrative costs are reported in Tasmania has also started to be reduced. As a result of excluding these costs the reported public hospital costs will appear lower than the actual costs incurred, thereby making public hospitals appear more efficient and cost-effective than they actually are.

It is therefore likely that these data collections under report the cost of treatment within public hospitals in some states.

The Commission used this data to estimate the cost per casemix-adjusted separation for public and private hospitals in each state and for Australia as a whole. The cost per casemix-adjusted separation is the average cost of treating a range of different diagnoses, after controlling for differences in the complexity of required treatments (casemix adjustment).

Casemix adjusted separations were calculated by weighting the number of separations for groups of cases which had similar conditions and which used similar hospital services (known as the Diagnosis Related Group or DRG) by its relative complexity. The relative complexity of each DRG was measured by its costs – the average cost of the DRG across all relevant hospitals divided by the average cost for all DRGs.

The results of the calculations can be seen below in Table 1

	NSW		Vic		Qld		SA	
Cost component	Public	Private	Public	Private	Public	Private	Public	Private
General hospital	2511	1944	2106	2004	2683	1948	2800	1803
Pharmacy	164	42	235	87	174	45	146	53
Emergency	205	16	251	50	211	40	135	61
Medical and diagnostic	733	1497	900	1226	794	1404	621	1214
Prostheses	137	620	108	527	121	491	140	495
Capital	439	210	359	240	560	223	381	158
Total	4189	4330	3960	4133	4543	4151	4223	3783
Total excluding costs not controlled by private hospitals[1]	3319	2213	2952	2380	3628	2256	3462	2074

	WA		Tas, NT & ACT		Australia	
Cost component	Public	Private	Public	Private	Public	Private
General hospital	3094	1845	3243	2236	2552	1953
Pharmacy	202	144	186	55	187	68
Emergency	147	11	238	21	208	34
Medical and diagnostic	1048	1275	725	1391	798	1346
Prostheses	155	555	141	540	131	542
Capital	359	281	447	345	426	230
Total	5006	4111	4980	4586	4302	4172
Total excluding costs not controlled by private hospitals[1]	3803	2281	4114	2655	3373	2284

Table 1 Cost per casemix-adjusted separation by jurisdiction and sector, 2007-08

The cost data shows that private hospitals control their costs far better than public hospitals.

The cost data shows that on average treatment in private hospitals costs $130 less than treatment in public hospitals per casemix-adjusted separation.

5 Private hospital costs

The Productivity Commission allocated hospital costs into six different areas. These are: general hospital, pharmacy, emergency, medical and diagnostic, prostheses and capital costs. The combined total of each of these areas is the basis of the reported cost data in the report. However due to government control on prostheses pricing, and the fact that that medical and diagnostic costs relate to fees charged by doctors, not hospitals, private hospitals only have control over the costs in four of these six cost areas.

[1] This total shows the cost of treatment per casemix-adjusted separation only for the cost components that private hospitals are responsible for. It therefore excludes prostheses and medical costs. Private hospitals do not control prostheses and medical costs. Prostheses costs are set by the Prostheses and Devices Committee. Medical costs are a matter for the patient and treating doctor to determine.

Prostheses costs

The Commission found that the lower prostheses costs in public hospitals were a result of bulk purchasing agreements by hospitals. Private hospitals have no control over the cost of prostheses used in their hospitals and are unable to enter into such bulk purchasing agreements. The prices are fixed by a government committee and the prostheses used in an operation are chosen by the treating doctor. In addition to being unable to take advantage of bulk purchasing agreements, the Commission notes that the higher cost of prostheses in the private sector is a result of a wider range of prostheses being available to patients.

Medical and diagnostic costs

Medical and diagnostic costs are incurred differently in the public and private hospitals systems. The Commission notes that in public hospitals these costs generally relate to the wages and salaries of doctors and specialists. Public hospitals are responsible for negotiating and managing these salaries. However in private hospitals, medical and diagnostic costs consist of fees charged directly to patients by doctors and those fees are outside the control of the hospital in which treatment is performed.

6 The real difference in hospital costs

APHA has determined that when looking at those costs for which private hospitals are responsible the data shows that private hospitals cost $1,089 or 32% less than public hospitals per casemix-adjusted separation.

This is a much fairer comparison as it excludes medical and prostheses costs which are beyond the control of private hospitals. Public hospitals have lower costs as they are able to negotiate directly with manufactures of devices and do not provide patients with a choice of prostheses. Prostheses costs in private hospitals are determined by the Prostheses and Devices Committee (PDC). Private hospitals do not profit from the provision of prostheses to patients and must supply them at the cost the PDC determines. One of reasons medical costs are lower in public hospitals is because they are indirectly subsidised by the work doctors carry out in the private hospitals[2].

Individual DRG costs

In addition to examining the cost per casemix-adjusted study, the Commission has also analysed the cost per separation for individual DRGs. This is another area in the report where the commentary offered does not match the data produced. The Commission concludes that most DRGs had broadly similar costs in public and private hospitals. The Commission's analysis was based on allowing public hospitals a very generous 10% leeway when comparing the costs. This has meant that the Commission has

[2] Productivity Commission (2009) Public and Private Hospitals. Page 105 citing Australian Health Service Alliance and Australian Medical Association.

allowed the cost of the individual DRGs in a public hospital to be categorised as 'the same' as in private hospitals so long as they are within 90 to 110 per cent of the private hospital cost.

It is under this conservative analysis that **50% of DRGs were estimated to cost less in private than public hospitals**, and 18% of DRGs less in public hospitals than private hospitals. The remainder of the DRGs (32%) were said to cost the same in both sectors. Therefore, even by its own conservative analysis the Commission is incorrect to conclude that for most DRGs, costs were similar in public and private hospitals. Only 32% of DRGs had similar costs (i.e. within 10% of each other). The majority (50%) of DRGs cost less in private hospitals (see Figure 1).

APHA has analysed the Commission's data and when the 10% buffer that was afforded to public hospitals is removed, **66% of DRGs cost less in private than public hospitals**, and 34% of DRGs cost less in public than private hospitals (see Figure 2).

However when looking at the cost of individual DRGs for the components for which private hospitals control (and so removing prostheses and medical costs), **APHA have calculated from the Productivity Commission data that 90% of DRGs cost less in private hospitals than public hospitals** (see Figure 3).

The cost results from the Productivity Commission and the subsequent analysis by APHA clearly show that private hospital costs are lower than public hospital costs.

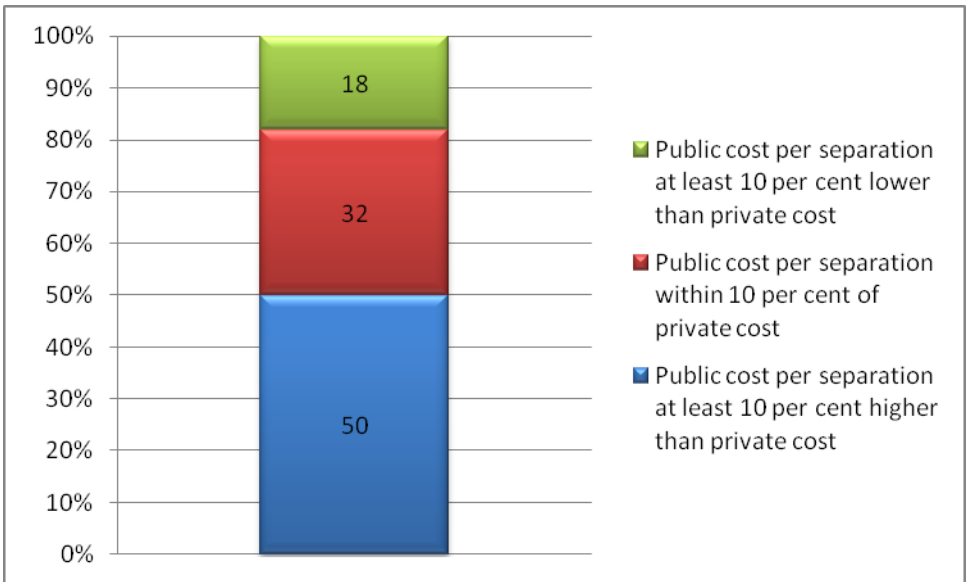

Figure 1 Percentage of DRGs lower/higher than in the private sector

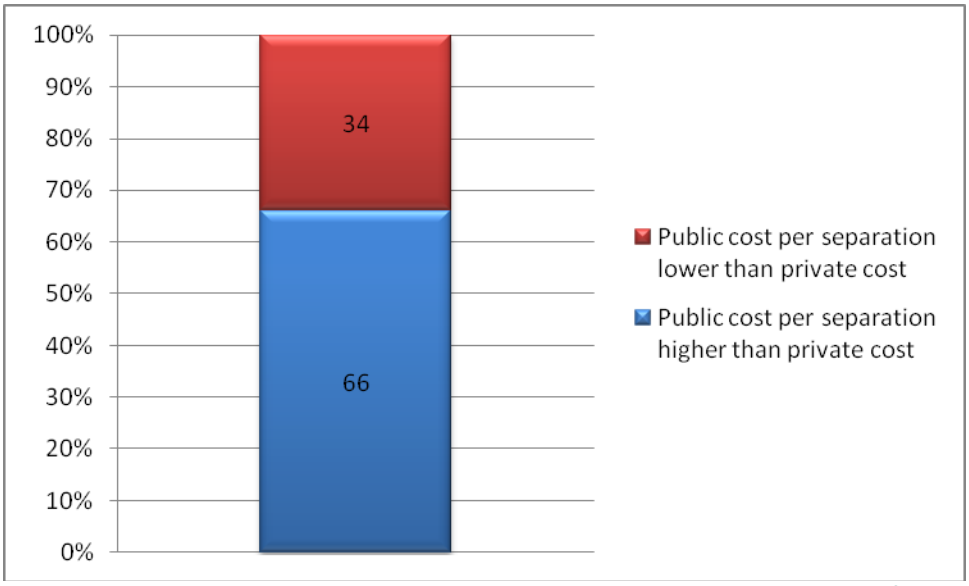

Figure 2 APHA analysis of Productivity Commission estimates - Percentage of DRGs lower/higher than in the private sector

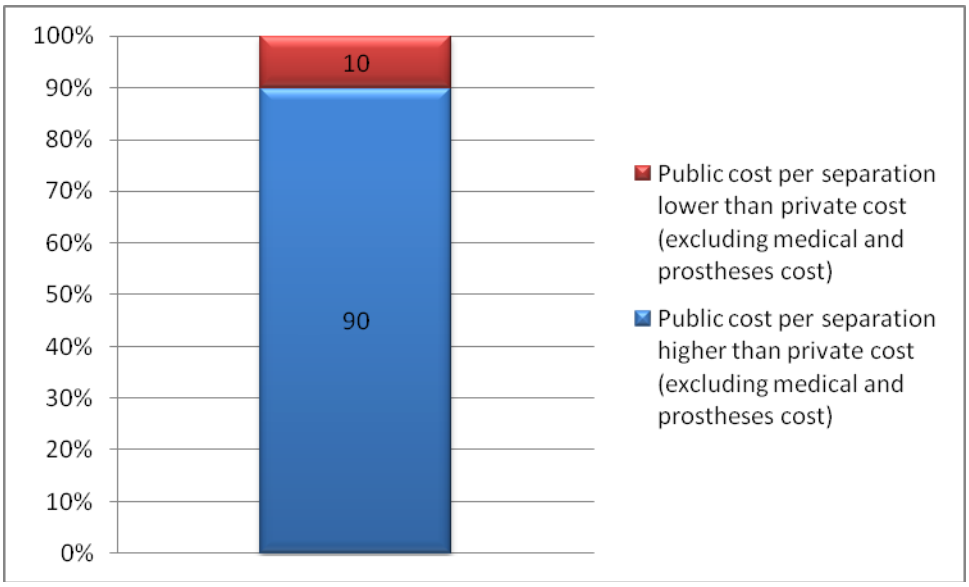

Figure 3 APHA analysis of Productivity Commission estimates - Percentage of DRGs lower/higher than in the private sector

7 Complexity

The lower costs incurred by private hospitals were, according to three state public health departments, the result of private hospitals 'specialising in relatively routine procedures, whereas public hospitals have to provide a broader range of services...'[3] However the Commission's own report disproves this theory. The Commission carried out analysis using cost-weights to determine whether public hospitals have a more complex casemix than private hospitals. According to the Commission cost-weights are commonly used as an indicator of the relative complexity of a DRG. The average for all separations is 1.00. If a

[3] Productivity Commission (2009) Public and Private Hospitals. Page 115 citing Queensland Health, SA Department of Health, Tasmanian Department of Health and Human Services

hospital has a cost-weight above 1.00 its casemix is more complex than average, and if it is below 1.00 its casemix is less complex than average.

The average cost weight for DRGs in public hospitals was 0.96, and in private hospitals it was 1.09. This led the Commission to conclude that '...**the overall casemix of public hospitals is slightly less complex than that of private hospitals**.'[4]

The Commission's analysis demonstrates that **costs per casemix-adjusted DRG and costs per individual DRGs are lower in private hospitals,** and that private hospitals have a more complex casemix than public hospitals**.**

8 Safety and quality

The Commission experienced many difficulties when examining the existing data sets that relate to safety and quality within hospitals. In many cases data is either incomplete or collected in different ways in different states. Where the available data allowed analyses and comparisons between sectors private hospitals consistently outperformed public hospitals.

The Australian Council of Healthcare Standards manages the Clinical Indicator Program (CIP). The CIP contains 47 clinical indicators that measure healthcare-associated infections linked to specific procedures. Of the 47 CIP indicators of healthcare-associated infections **four were found to be significantly lower in private hospitals than public hospitals**. No indicators were found to be lower in public hospitals.

		Infection rate		No. of reporting hospitals	
Indicator	Units	Public	Private	Public	Private
Deep incisional SSI in hip prosthesis procedures	Per 100 procedures	0.99	0.63	38	96
Superficial incisional SSI in abdominal hysterectomy	Per 100 procedures	2.02	0.94	16	37
ICU-associated new MRSA healthcare-associated infections in a nonsterile site	Per 10,000 ICU overnight occupied bed days	16.70	7.18	25	23
Non ICU-assocaited new MRSA inpatient healthcare associated infections in a nonsterile site	Per 10,000 ICU overnight occupied bed days	2.77	1.11	68	59

Table 2 Clinical Indicator Program indicators where private hospitals outperformed public hospitals[5]

The Commission has analysed hospital mortality data to produce 'risk adjusted mortality rates' (RAMRs) for public and private hospitals. These mortality rates show a hospital's actual mortality rate compared to its expected mortality rate. This means that these mortality rates take into account patient risk characteristics. RAMRs less than 1.00 show that the hospital has a lower risk adjusted mortality rate than is expected.

[4] Productivity Commission (2009) Public and Private Hospitals. Page 116-117
[5] Productivity Commission (2009) Public and Private Hospitals. Page 134

The results show that private hospitals risk adjusted mortality rates are less than half of those in public hospitals.

Public hospitals	Public contract hospitals[6]	Private hospitals	All hospitals
0.632	0.540	0.305	0.550

Table 3 Risk adjusted mortality rates[7]

In the analysis of the data on safety and quality the Commission makes reference to private hospitals being more likely to treat patients that are less likely to acquire hospital-acquired infections. This supposition was based on a statement made in a submission to the Commission for which no supporting evidence was provided. There is no actual evidence to substantiate this claim. APHA brought this to the attention of the Commission after the publication of the draft report. The Commission subsequently removed this in the private hospital overview section of the report, but left this unfounded claim in the main findings of the report and within the chapter on hospital acquired infections. Unfortunately the Commission also provides no reference to any evidence that shows that private hospital patients are less susceptible to hospital-acquired infections.

9 Access to services for the socioeconomically disadvantaged

The Commission's commentary states that "elective surgery in public hospitals is more accessible for disadvantaged socioeconomic groups, but tends to be less timely than in the private sector"[8].

Private hospitals do offer more timely access to elective surgery than public hospitals. However, the conclusion in regards to access for disadvantaged groups does not match the actual data presented in the report (see Table 4 and page 165 of the final report).

The data in the Commission's report show private hospitals carry out more elective surgery for patients from disadvantaged socioeconomic backgrounds. This disproves the commonly held misconception that public hospitals treat a 'sicker' group of patients by virtue of the socio-economic status of those patients.

[6] Public contract hospitals are public hospitals which are operated by a private company.
[7] Productivity Commission (2009) Public and Private Hospitals. Page 365
[8] Productivity Commission (2009) Public and Private Hospitals. Page 30

	Public elective surgical separations	Private elective surgical separations	All elective surgical separations
Most disadvantaged	37.9	37.9	75.7
Second most disadvantaged	34.0	45.0	79.0
Middle quintile	30.6	51.0	81.6
Second most advantaged	24.9	55.7	80.6
Most advantaged	16.9	69.1	86.0
All patients	29.0	52.0	81.0

Table 4 Elective surgical separations per 1000 people[9]

10 Conclusion

The Commission's data shows that private hospitals:

- **Cost less than public hospitals per casemix-adjusted separation**
- **Have lower infection rates than public hospitals**
- **Have lower risk adjusted mortality rates than public hospitals**
- **Have a more complex case-mix than public hospitals**

The Commission's own findings show that private hospitals have a more complex case-mix, treat a greater proportion of older patients, and now carry out a greater number of surgical separations with socioeconomically disadvantaged persons than public hospitals.

Despite this private hospitals are able to offer safer and a higher quality of service than public hospitals. Both infection rates and risk-adjusted mortality rates are lower in private hospitals than public hospitals. High quality treatment though does not mean high cost. Private hospitals have been shown by the Commission to provide lower cost treatment, and to manage their own costs far better than public hospitals.

[9] Productivity Commission (2009) Public and Private Hospitals. Page 165