3 Australia's private hospital sector

Key points

- Private hospitals differ greatly in size, function and management. Of the 556 private hospitals in Australia, there are large organisations operating many hospitals, as well as smaller bodies running single or only a few facilities. A substantial number of private hospitals are run as not-for-profit entities while others are operated on a for-profit basis.
- Around 80 per cent of patients in private hospitals are privately insured, and the majority of private hospital funding is received from private health insurers for treating their members. Indeed, patient revenue (including from self-funded patients) accounted for around 96 per cent of private acute and psychiatric hospital income in 2006-07.
- Private hospitals treated 40 per cent of all hospital inpatients and performed 64 per cent of elective surgeries in Australia in 2007-08. About 17 per cent of separations from private hospitals in 2007-08 were for chemotherapy, renal dialysis and same-day colonoscopies. Fewer than 10 per cent of private acute and psychiatric hospitals had emergency departments in 2006-07.
- Rights of private practice for medical specialists are an important feature of workforce arrangements in private hospitals, and there is evidence suggesting that medical specialists are generally able to earn higher incomes in private hospitals than in public hospitals. There is little publicly available data about the wages and conditions of nursing staff in the private hospital sector.
- Private hospitals have recently experienced significant increases in the number of separations and some changes to the composition of services provided. There also appears to be some increase in the extent of clinical teaching by private hospitals.

Private hospitals are privately owned and operated institutions, catering for patients who are treated by a doctor of their own choice.[1] Patients are charged fees for accommodation and other services provided by private hospitals and relevant medical and paramedical practitioners (AIHW 2009a). Private hospitals exist in response to patients' willingness-to-pay for a choice of doctor, private ward

[1] Some hospitals which deliver public hospital services are privately owned. Such hospitals are classified as public as they operate on behalf of, and are funded by, a government.

facilities and relatively faster access to hospital services. The Australian Private Hospitals Association (APHA, sub. 25, p. 2) commented that the private hospital sector exists in 'explicit recognition that individuals should be able to exercise choice in health care'.

Recent data show that there are 556 private hospitals in Australia, of which 285 are acute or psychiatric hospitals and 271 are freestanding day hospitals (DOHA 2009c). Acute hospitals provide at least some medical, surgical or obstetric care for admitted patients and provide round-the-clock comprehensive qualified nursing services, as well as other necessary professional services. Freestanding day hospital facilities provide investigation and treatment for acute conditions on a day-only basis (ABS 2008e).

This chapter profiles the structure and activity of Australia's private hospitals, including the types of services delivered, the characteristics of the patients treated, and the workforce. Recent developments in the public hospital sector are also examined. While focus is placed on the activity of acute and psychiatric hospitals, private freestanding day hospitals are separately profiled, given their role in the wider private hospital system.

3.1 Structure of private hospitals

Ownership and management

Of the 289 private acute and psychiatric hospitals in Australia in 2006-07, 165 were run on a for-profit basis and 124 were not-for-profit (table 3.1). Not-for-profit hospitals are those which qualify as a non-profit organisation with either the Australian Taxation Office or the Australian Securities and Investments Commission. These are further categorised as 'religious or charitable' and 'other' (ABS 2008e).

Both for-profit and not-for-profit entities are among the largest providers of private hospital services in Australia. The for-profit companies Ramsay Health Care and Healthscope are among the ten largest enterprises — by market capitalisation — in the Australian Securities Exchange's listed healthcare sector (ASX 2009). Ramsay Health Care operates over 65 hospitals and day surgery units across Australia, while Healthscope owns or manages 44 medical and surgical, rehabilitation and psychiatric hospitals (Ramsay Health Care Limited 2009a; Healthscope Limited, sub. 42). In the not-for-profit sector, Catholic services represent the largest grouping of health, community and aged care services in Australia, providing 9500 beds in 75

(private and public) healthcare facilities including seven teaching hospitals (CHA 2009b). In relation to the services provided by Catholic hospitals, Catholic Health Australia (CHA) noted that:

> Catholic hospitals also have a mission focus which is often reflected in providing a wider range of treatments, such as palliative care, than might be the case than if the hospital was purely focused on profit maximisation. It also means that some Catholic hospitals are located in geographic regions which might not necessarily be attractive to for-profit operators. (sub. 20, p. 2)

Table 3.1 **Number of private acute and psychiatric hospitals, 2006-07**

	For-profit	*Not-for-profit*		*All*
		Religious or charitable	*Other*[a]	
New South Wales	np	18	np	85
Victoria	50	18	14	82
Queensland	27	24	6	57
South Australia	6	7	17	30
Western Australia	np	10	np	23
Tas, NT and ACT[b]	np	6	np	12
Australia	**165**	**83**	**41**	**289**

[a] Comprises bush nursing, community and memorial hospitals. [b] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions. **np** Not published but included in totals where applicable, unless otherwise indicated.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

Funding arrangements

Private hospitals source their revenue largely from use of their operating theatres and bed facilities, and a number provide a broad range of services such as diagnostics, chemotherapy and sub-acute care that also generate revenue from patients. Private hospitals generally order and pay for prostheses and then recoup the cost from health insurance funds and, in some instances, patients. Medical fees are usually billed separately and direct to the patient from the medical provider, as opposed to being directed via hospital accounts.

Private hospitals operate under fee-for-service funding models that reward additional activity. Therefore, private hospitals generally have an incentive to maximise throughput. Private hospitals, particularly the for-profit sector, seek to maximise returns on their capital investment and labour force, for the benefit of owners/shareholders. While the revenue-generation motive is likely to be less strong for not-for-profit private hospitals, these hospitals also aim to avoid making losses.

Across most private hospital structures, patient revenue is the dominant source of hospital income. In 2006-07, this ranged from 95 per cent of hospital income for religious or charitable private acute and psychiatric hospitals to 98 per cent for for-profit providers (table 3.2). DOHA advised that:

> Revenue for private hospitals and day hospital facilities can come from a number of sources (e.g. Department of Veterans' Affairs, state/territory health authorities' contracts, self-funding by patients and compensable patients), but the majority of funding is received from private health insurers for treating their members. It is therefore in the interest of facilities to negotiate comprehensive contracts with individual insurers. (sub. 32, p. 6)

Table 3.2 **Income and expenditure of private hospitals, 2006-07**

	For-profit	*Not-for-profit*	
		Religious or charitable	*Other*[b]
	$'000	$'000	$'000
Income			
Patient revenue[c]	3 543 450	3 012 142	254 890
Recoveries[d]	53 238	74 009	6 650
Other[e]	39 336	92 335	6 427
Total income	3 636 025	3 178 486	267 967
Recurrent expenditure[f]			
Wages and salaries including on-costs	1 700 724	1 556 302	144 770
Drug, medical and surgical supplies[g]	873 026	810 497	68 778
Food supplies	45 478	47 084	4 951
Other domestic services	45 630	49 801	4 179
Administrative expenses	208 042	239 737	17 022
Repairs and maintenance	46 237	39 177	3 537
Other[h]	297 164	353 347	26 230
Total recurrent expenditure	3 216 301	3 095 945	269 464
Gross capital expenditure[i]	207 984	220 453	11 282

[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). [b] Comprises bush nursing, community and memorial hospitals. [c] Includes revenue received by, and due to, the hospital in respect of patient liability for accommodation and other fees. [d] Recoveries includes income received from items such as staff meals and accommodation, and facility fees paid by medical practitioners. [e] Includes investment income, income from charities, bequests and visitors' expenses. [f] Expenditure on goods and services which does not result in the creation or acquisition of fixed assets. [g] Includes surgically implanted prostheses and homograft items. [h] Includes interest, depreciation, contract services and transport. [i] Expenditure on the acquisition or enhancement of assets (excluding financial assets).

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

Wages and salaries, and drug, medical and surgical supplies are the biggest recurrent expenditure items for private acute and psychiatric hospitals. Together these represented 78 per cent of total recurrent expenditure in 2006-07 (ABS 2008e). Wages and salaries (including on-costs) constituted around or just

above 50 per cent of total recurrent expenditure for both for-profit and not-for-profit private hospitals (ABS 2008e). These expenditure figures do not include the costs of non-salaried medical staff (such as independent practitioners).

Capital expenditure varies year-to-year in the private health sector due to the irregular nature of such expenditure. Significant purchases or construction undertaken in a given year are unlikely to be repeated for some time (ABS 2008e).

Service costs

The cost structures for services in the private hospital sector are very different than those in the public sector. The SA Department of Health commented that:

> Medical services in private hospitals are provided on a fee-for-service basis rather than by the hospital. One result is that it is in the doctors' best interests to ensure as many theatre cases as possible are done in each set of booked theatre time. (sub. 4, p. 4)

Medical costs for the private sector are difficult to ascertain, as doctors usually bill patients directly. Private hospitals are not made aware of, and so do not record, these costs (APHA, sub. DR65). The Australian Health Service Alliance noted that:

> Doctor costs in the private sector are in general a matter between the patient and the doctors involved in the care. This applies to doctors involved in such care whether they are the primary treating physician or surgeon, or other medical practitioners involved in care such as anaesthetists, pathologists and radiologists … Prostheses costs have a different basis in the public and private sector. In the public sector they are included in hospital funding. In the private sector they are in effect negotiated separately at the industry level and the hospital is simply the conduit by which prostheses are supplied to patients by their treating doctor. (sub. 1, pp. 4–5)

Tax regimes differ between for-profit and not-for-profit hospitals. Fringe benefits of up to $17 000 per employee are exempt from fringe-benefits tax for not-for-profit hospitals (and public hospitals). Not-for-profit private hospitals (and public hospitals) are also exempt from payroll tax. The tax arrangements for private and public hospitals are discussed further in chapter 5 and appendix D.

The average cost per patient day tends to increase as hospital size increases, which the ABS noted 'is a reflection of the greater complexity of procedures undertaken at the larger hospitals' (ABS 2008e, p. 18).[2] More complex procedures necessitate greater use of highly trained staff, expensive equipment, drugs and medical supplies. It is also noted that religious and charitable hospitals have relatively higher

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[2] Patient days are the aggregate number of days of stay for all overnight-stay patients who were separated from hospital during the year. Same-day patients are each counted as having a stay of one day (ABS 2008e).

average costs per patient day than for-profit and other not-for-profit hospitals. (ABS 2008e). The fact that religious and charitable hospitals constitute over half of the largest sized private acute and psychiatric hospitals (more than 200 beds) — while comprising less than 30 per cent of all private acute and psychiatric hospitals — may help to explain the higher average costs of larger-sized hospitals.

Licensing

State and territory health authorities are responsible for licensing private hospitals and private day hospitals, and mandate a range of operational and quality requirements. Licensing requires these facilities to meet a range of criteria, such as building regulations, provision of speciality services, as well as safety and quality. Licensing requirements vary from one jurisdiction to another and, in some jurisdictions, differ for private hospitals and day hospital facilities.

New South Wales currently has separate regulations for private hospitals and private day hospitals. The regulations for private hospitals are somewhat more prescriptive around furnishings, staffing and quality assurance processes than for private day hospitals. New South Wales' proposed Private Health Facilities Regulation 2009 will remove the distinction between private hospitals and private day hospitals and impose compliance burdens based on services offered, rather than facility type, size or location.

In Victoria, private hospitals and private day hospitals are subject to the same regulatory requirements (Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002). These regulations contain minimum nursing staff-to-patient ratios and the mix of nursing staff. These staffing requirements are more specific than for other jurisdictions.

Among the jurisdictions, South Australia, Tasmania and the Northern Territory do not have specific licensing criteria for day hospital facilities but inspect new facilities and provide assurances that the facilities are suitable for Australian Government declaration as private hospitals. The Australian Department of Health and Ageing (DOHA) noted that the Commonwealth Minister for Health and Ageing has the power to declare private hospitals for health insurance purposes, Medicare benefits and the Pharmaceutical Benefits Scheme (DOHA, sub. 32).

3.2 Characteristics of private hospitals

Private hospitals exhibit great diversity in the choice of where, how and what services they offer, and may specialise in particular procedures or types of patients. For example, some private hospitals are women's or children's hospitals, or have units or departments specialising in women's and/or children's health. Examples include the Mater Children's Private Hospital and the Mater Mothers' Private Hospital (Queensland), Woodvale Private Hospital for Women (Western Australia), and the Allowah Presbyterian Children's Hospital (New South Wales).

Number and activity of private hospitals

The majority of private acute and psychiatric hospitals are located in New South Wales and Victoria (table 3.3). New South Wales had a lower number of private acute and psychiatric hospital patient separations per 1000 residents than the national average in 2007-08, while Queensland's number was comparatively higher. On average, 57 per cent of separations in private acute and psychiatric hospitals were same-day admissions.

Table 3.3 **Number and activity of private hospitals, 2007-08[a]**

	Number of hospitals	*Number of separations*	*Number of separations per 1000 residents*	*Proportion same-day separations*[b]
New South Wales	84	662 743	90.8	59.7
Victoria	75	663 465	114.9	55.6
Queensland	55	596 730	138.8	56.9
South Australia	31	196 865	112.0	53.1
Western Australia	24	259 807	120.5	55.9
Tas, NT and ACT[c]	11	np	np	np
Australia	**280**	**2 461 852**	**115.1**	**56.8**

[a] Acute and psychiatric hospitals (excludes freestanding day hospitals).

Source: AIHW (2009a).

Size of private hospitals

A significant proportion of private acute and psychiatric hospitals are relatively small: 43 per cent have fewer than 50 beds, while less than 10 per cent have more than 200 beds (table 3.4).

Table 3.4 **Number of private hospitals by size, 2006-07[a]**

	0–50 beds[b]	51–100 beds	101–200 beds	Over 200 beds	Total
New South Wales	35	32	15	3	85
Victoria	37	24	16	5	82
Queensland	22	16	12	7	57
South Australia	8	7	np	np	30
Western Australia	10	3	6	4	23
Tas, NT and ACT[c]	3	5	np	np	12
Australia	**125**	**87**	**55**	**22**	**289**

[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). Data refers to different time period to previous table due to differences in data availability. [b] Number refers to hospitals with 26 to 50 beds for South Australia, Tasmania, the Northern Territory and the ACT. The number of hospitals with fewer than 26 beds is not published for these states and territories. [c] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions **np** Not published but included in totals where applicable.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

In terms of the number of beds, acute and psychiatric hospitals operated by religious and charitable institutions were generally larger than other private hospitals. They accounted for around 20 per cent of the smallest private hospitals (up to 50 beds), but for 40 per cent of hospitals with 101 to 200 beds, and around 60 per cent of those with more than 200 beds (ABS 2008e).

Location of private hospitals

About 75 per cent of all available private acute and psychiatric hospital beds in 2006-07 were located in capital cities, even though only 64 per cent of Australia's population lived in these areas (ABS 2008e). There are more private acute and psychiatric hospitals in metropolitan than regional areas nationally (table 3.5). The one exception at a state level is Queensland, which has 63 per cent of its private acute and psychiatric hospitals, and 50 per cent of its private acute and psychiatric hospital beds, outside of Brisbane. For other jurisdictions (where data are available), at least 70 per cent of all beds are located within capital cities. There are relatively fewer private hospital beds outside of capital cities than there are private hospitals, suggesting that private hospitals outside of capital cities are, on average, smaller than their capital city counterparts.

Acute and psychiatric hospitals operated by religious and charitable institutions provided 10 246 beds during 2006-07, equivalent to 42 per cent of the total number of available beds in all private acute and psychiatric hospitals. Around 75 per cent of these beds were located in capital cities while the remaining share were outside capital cities (ABS 2008e).

Table 3.5 **Number of private hospitals and beds by location, 2006-07[a]**

	Number of hospitals[b]			*Number of beds*		
	Capital city	*Rest of state/territory*	*Total*	*Capital city*	*Rest of state/territory*	*Total*
New South Wales	57	28	85	4 573	1 823	6 396
Victoria	61	21	82	5 605	1 005	6 610
Queensland	21	36	57	2 863	2 824	5 687
South Australia	21	9	30	1 748	130	1 878
Western Australia	17	6	23	np	np	2 795
Tas, NT and ACT[c]	8	4	12	np	np	1 061
Australia	**185**	**104**	**289**	**18 095**	**6 332**	**24 427**

[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). [b] These data relate to a different reporting period (July 2006 to June 2007) than the DOHA figures cited earlier (September 2009). [c] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions. **np** Not published but included in totals where applicable.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

Patients in private hospitals

In 2007-08, private hospitals administered 3.1 million separations, of which nearly 2.5 million took place in acute and psychiatric hospitals. Female patients accounted for around 55 per cent of all private hospital separations, while patients aged 35 to 64 accounted for around 45 per cent of all private hospital separations. Of note is the lower incidence of private hospital separations for females aged 65 and over in Western Australia (table 3.6).

Table 3.6 **Share of private hospital separations by patient profile, 2007-08[a]**

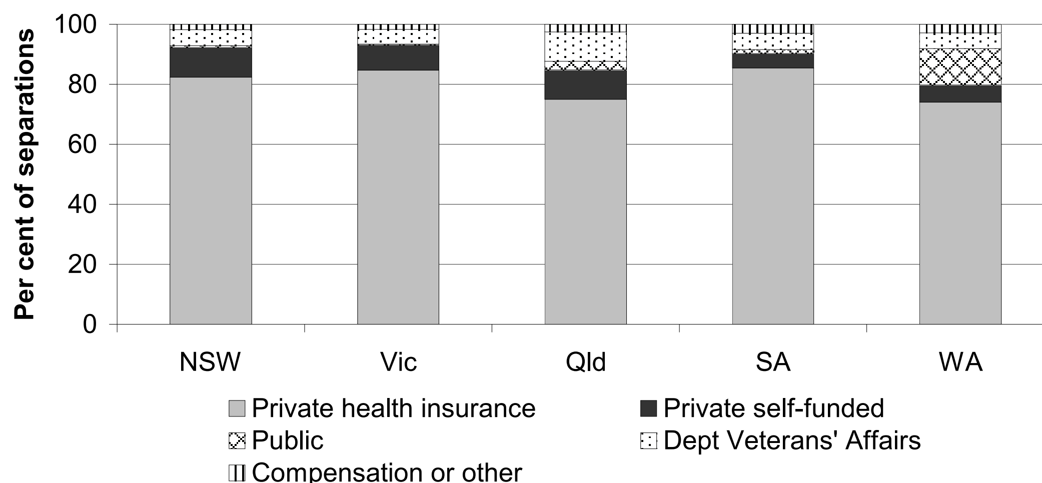
	Males				*Females*			
	0–14	*15–34*	*35–64*	*65 & over*	*0–14*	*15–34*	*35–64*	*65 & over*
New South Wales	2.3	4.6	19.5	18.4	1.7	9.7	25.1	18.5
Victoria	1.7	4.4	18.7	18.7	1.3	10.5	26.6	18.1
Queensland	1.9	3.9	20.1	20.2	1.4	9.7	24.4	18.4
South Australia	2.0	4.5	19.3	20.5	1.4	7.8	24.9	19.5
Western Australia	2.6	5.4	21.4	17.0	1.9	11.1	26.5	13.9
Tas, NT and ACT[b]	2.3	5.1	19.9	16.8	1.7	11.5	26.6	15.7
Australia	**2.1**	**4.5**	**19.7**	**18.9**	**1.5**	**10.0**	**25.5**	**17.9**

[a] All private hospitals. Per cent of total separations in each state or territory, according to patient's sex and age group. Each row sums to 100 per cent. [b] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions.

Source: AIHW (2009a).

The majority of patients in private hospitals are funded by private health insurance or self-funded. Nationally, the proportion of private hospital separations covered by private hospital insurance was 80 per cent in 2007-08 (figure 3.1). For Queensland, a larger proportion of private hospital patients are self-funded or funded by the Department of Veterans' Affairs than is the case for other jurisdictions.

Figure 3.1 **Share of private hospital separations by patient funding source, 2007-08**[a]

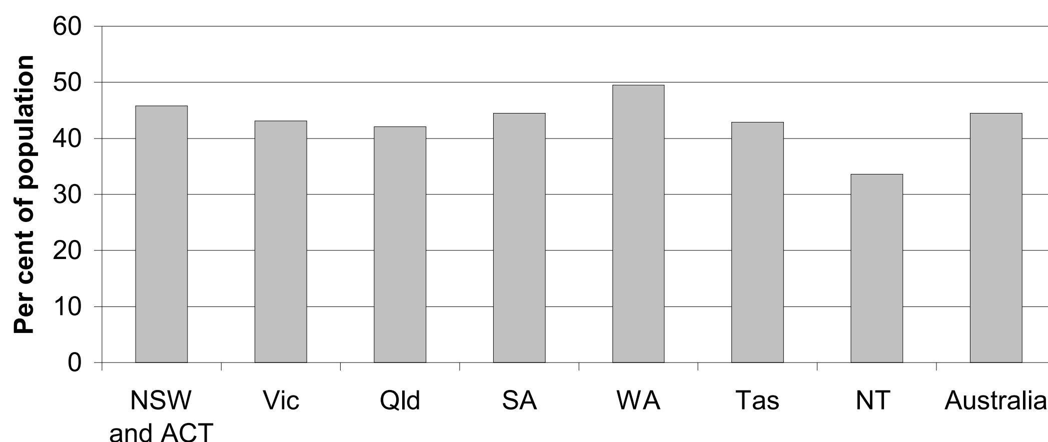


[a] The share of self-funded patients may be underestimated as some are unable to be identified. Data exclude patients whose funding source is not reported. Compensation or other includes workers compensation, other compensation, motor vehicle third party personal claim, other public authorities, and other funding sources. Data for Tasmania, the Northern Territory and the ACT are not published.

Source: AIHW (2009a).

These rates of private hospital usage do not appear to be fully explained by private health insurance participation rates of the states and territories (figure 3.2). Among the jurisdictions, Western Australia and the grouping of New South Wales and the ACT have the highest rates of private health insurance, while the Northern Territory and Queensland have the lowest.

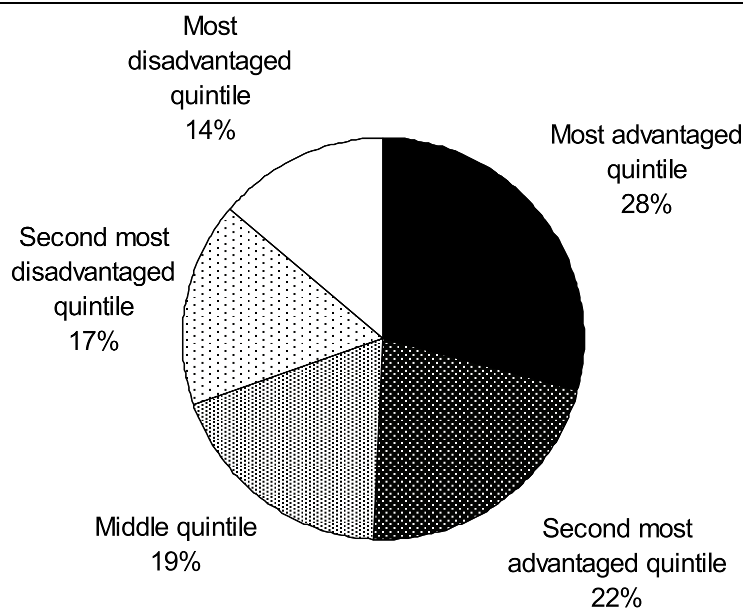
Figure 3.2 **Share of population with private health insurance, 2008**



Source: PHIAC (2009c).

The share of private hospital separations according to patients' socioeconomic status is presented in figure 3.3. In 2007-08, nearly 30 per cent of patients in private hospitals were from areas of the highest quintile of socioeconomic advantage. The top two quintiles of socioeconomic advantage accounted for around 50 per cent of all private hospital separations. Comparatively, 14 per cent of patients in private hospitals were from the lowest quintile.

Figure 3.3 **Share of private hospital separations by socioeconomic status of patients, 2007-08[a]**



[a] Quintile of socioeconomic status based on ABS (2008f) Index of Relative Socioeconomic Advantage/Disadvantage score based on the patient's area of usual residence.

Source: AIHW (2009a).

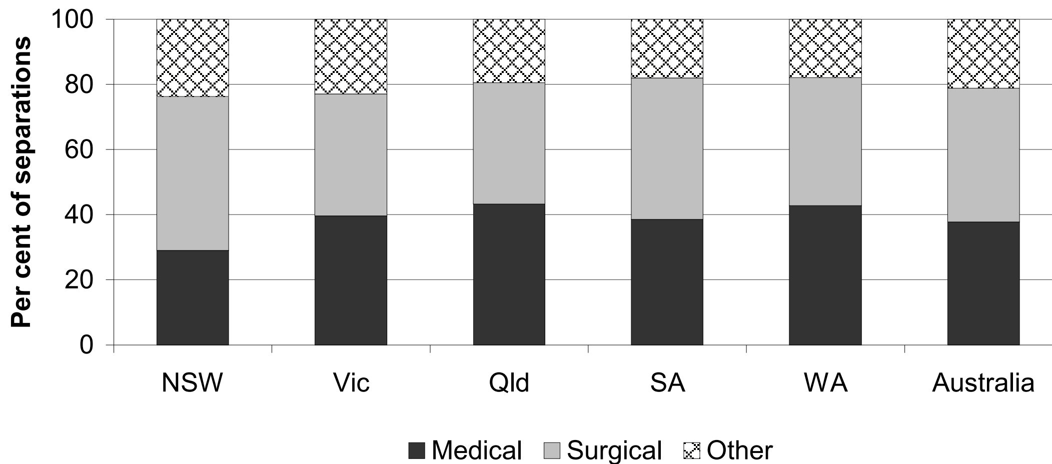
3.3 Services provided by private hospitals

Private hospitals often specialise in a limited range of surgical procedures, although there are also a number of full-service private hospitals that offer a comparable range of services to those provided by the large public teaching hospitals. Private hospitals tend to provide more elective procedures than public hospitals, accounting for approximately 64 per cent of all elective surgery separations in Australia in 2007-08 (AIHW 2009a).

Patient services

Nationally, 41 per cent of separations from private hospitals were classified as surgical in 2007-08. A further 38 per cent of private hospital separations were classified as medical (figure 3.4).

Figure 3.4 **Share of private hospital separations by AR-DRG partition, 2007-08[a]**

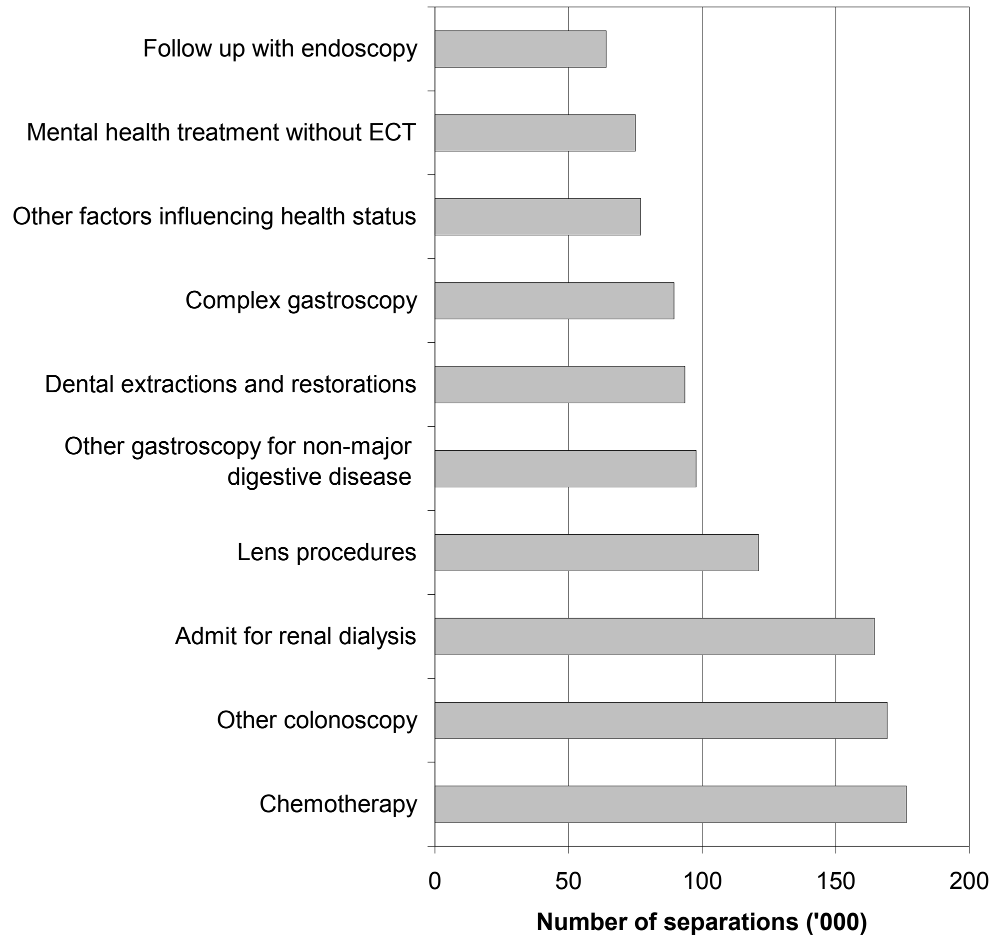


[a] As defined in AR-DRG version 5.1 (see box 2.2). Data for Tasmania, the Northern Territory and the ACT are not published, but are included in totals.

Source: AIHW (2009a).

The most frequent private hospital same-day and overnight separations in 2007-08 are listed in figures 3.5 and 3.6. The ten most frequent same-day separations made up around 37 per cent of all private hospital separations.

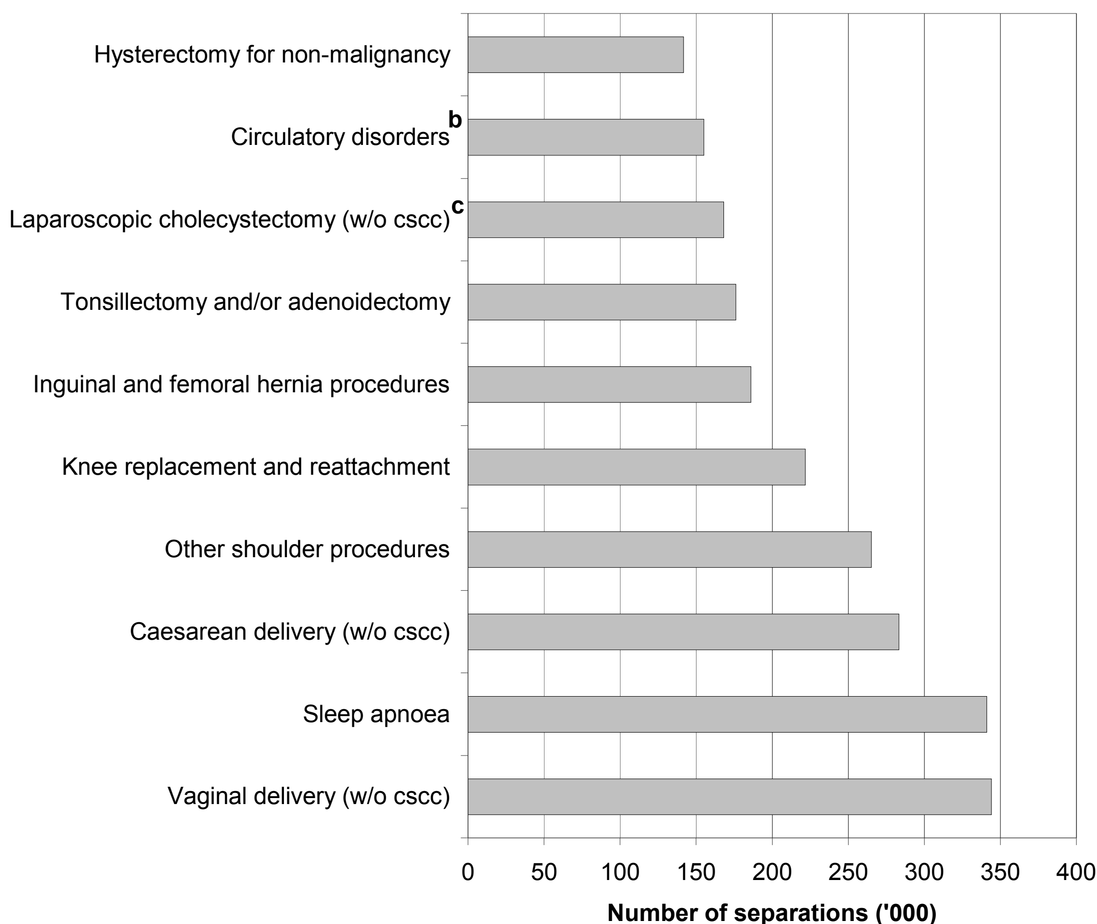
Figure 3.5 **Most frequent same-day private hospital separations by AR-DRG, 2007-08[a]**



[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). Ten most frequent same-day separations, as defined in AR-DRG version 5.1 (box 2.2). ECT: electroconvulsive therapy.

Source: AIHW (2009a).

Figure 3.6 **Most frequent overnight private hospital separations by AR-DRG, 2007-08[a]**



[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). Ten most frequent overnight separations, as defined in AR-DRG version 5.1 (box 2.2). [b] Without acute myocardial infarction; with invasive cardiac investigation procedure; without complex diagnosis or procedure. [c] Without common bile duct exploration. w/o: without. cc: complications and comorbidities. cs: catastrophic or severe.

Source: AIHW (2009a).

The type of care offered by private hospitals differed across jurisdictions (table 3.7). There are a comparatively high number of private geriatric separations in Victoria, a low number of private newborn separations in South Australia, a high number of private maintenance care separations in Queensland, and a high number of private rehabilitation separations in New South Wales.

Table 3.7 **Number of private hospital separations by care type, 2007-08[a]**

	Acute care	*Rehabilitation*	*Newborn*	*Geriatric[b]*	*Palliative care*	*Maintenance care[c]*
New South Wales	783 374	68 039	22 917	..	441	105
Victoria	777 176	13 717	4 057[d]	6 778	511	63
Queensland	748 685	25 036	18 716	66	2 433	1 208
South Australia	235 971	6 511	920	35	199	10
Western Australia	319 665	1 159	10 177	64	2 098	258
Tas, NT and ACT[e]	118 464	1 197	4 640	1	84	55
Australia	**2 983 335**	**115 659**	**61 427**	**6 944**	**5 766**	**1 699**

[a] Acute, psychiatric and freestanding day hospitals. Excludes other and not reported care types. [b] Includes geriatric evaluation and management, and psychogeriatric care. [c] Maintenance care refers to the provision of accommodation and nursing care as a service itself. This can include respite care, care to patients awaiting placement, and care to inpatients designated as nursing home type, but excludes residential aged care. [d] The reporting of newborns with unqualified days only is not compulsory for the Victorian private sector, resulting in a low number of separations in this category. [e] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions. **..** Not applicable.

Source: AIHW (2009a).

Research and training

Research and training are important and growing activities of private hospitals. Historically, these services have been more typically provided by the public sector. However, 47 private hospitals provided teaching to medical staff and undergraduates in 2006-07 (ABS 2008e).

The interim results of a recent CHA clinical placements survey suggest that midwifery, nursing and medical placements are the most common clinical placements in CHA facilities (both public and private) (CHA 2009a).[3] In its submission to this study, CHA (sub. 20) noted the significant clinical teaching and research that is undertaken by Catholic private hospitals. For-profit private hospital operators also offer clinical training opportunities for health care students. For example, Ramsay Health Care provided over 2 million clinical placement hours to undergraduate nursing and medical students in 2007-08 (Ramsay Health Care Limited 2009c). Further, APHA advised that:

> Australia's private hospitals invest $35 000 000 a year in the education and training of surgeons, doctors, nurses and other healthcare professionals. (sub. 25, p. 5)

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[3] The CHA clinical placements survey reported 40 responses received from CHA facilities, and includes aged care facilities as well as public and private hospitals (CHA 2009a).

There are a number of government programs facilitating greater training in private hospitals. For example, under the Expanded Specialist Training Program, medical registrars on training programs undertake rotations through a range of settings, including: private hospitals; specialists' rooms; clinics; day surgeries; and Aboriginal medical services (DOHA 2009g). The private hospital sector's increasing role in training is discussed further in section 3.6.

Emergency care in private hospitals

Comparatively few private hospitals provide emergency department services. APHA noted that:

> Some of the large acute medical/surgical private hospitals provide similar services to their public sector counterparts, including accident and emergency services. However, this applies largely in the densely-populated metropolitan areas. (sub. 25, p. 3)

In 2006-07, 24 private hospitals had emergency departments and 47 private hospitals treated accident and emergency cases. Among the states, Victoria had the largest number of private hospitals with accident and emergency services (15), followed by Queensland (13) (table 3.8).

Table 3.8 **Accident and emergency treatment in private hospitals, 2006-07[a]**

	Number of hospitals treating accident and emergency cases	*Number of hospitals with an emergency department*	*Number of accident and emergency patients treated*
New South Wales	5	4	54 829
Victoria	15	4	106 095
Queensland	13	9	162 758
South Australia	8	np	35 345
Western Australia	np	3	np
Tas, NT and ACT[b]	np	np	np
Australia	**47**	**24**	**453 572**

a Acute and psychiatric hospitals (excludes freestanding day hospitals). **b** Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions. **np** Not published but included in totals where applicable.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

Without an emergency department, private hospitals arguably have more predictable workflows and uninterrupted throughput of patients. However, the NSW Health Surgical Services Taskforce (sub. DR43) observed that disruptions to elective surgical services can be minimised through effective management of emergency surgical admissions.

The Australasian College for Emergency Medicine noted that some private hospitals have established emergency departments for a number of reasons:

> a. Emergency departments are the safest and most efficient way to provide acute, unscheduled care whether in public or private hospitals.
>
> b. As private hospitals began to expand their range and complexity of services, a mechanism was needed to provide acute care whether to new patients or to patients post-discharge.
>
> c. Private hospitals needed to respond to the expectation from insured patients that they should be able to choose private hospital care in the event of an emergency and not have to attend a public hospital. Some private hospitals, in particular the church and charitable organisations, felt they had an obligation to their communities to provide an alternative to public hospital emergency departments, albeit at a cost to the patient.
>
> d. An emergency department gave the hospital a source of patients that was independent of their attending specialists. It also attracted patients at times and on days when elective admissions were less frequent such as weekends thereby increasing the productivity of hospital facilities.
>
> e. In general, health insurance rates were declining during the 1990s. Therefore, ensuring 24-hour availability and expanding services beyond elective or scheduled care gave private hospitals with an emergency department a competitive edge.
>
> f. Patients who were admitted via an emergency department represent a casemix and complexity that helps attract new specialists to a private hospital.
>
> g. For some private hospitals, an emergency department was the only way they could fund a medical staff presence on the campus 24 hours a day. (sub. 14, p. 2)

3.4 Workforce characteristics

There were 46 718 salaried staff in private acute and psychiatric hospitals in 2006-07 (table 3.9), although this figure does not include medical practitioners with rights of private practice. In these hospitals, nursing staff accounted for 60 per cent of total salaried staff, and there were an average of 1.4 nurses per occupied bed. Salaried medical officers and other diagnostic professionals accounted for close to 7 per cent of total salaried staff in these hospitals, and administrative and clerical staff accounted for 16 per cent (ABS 2008e). Within the category of administrative and clerical staff are occupations including: accounting; engineering; information technology; and communications. The number of hospital managers and their roles are difficult to discern from the data, as hospital managers may or may not also be clinicians (Centre for Health Economics, Monash University, sub. 7).

Table 3.9 **Number of staff in private hospitals, 2006-07[a]**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas, NT and ACT*[b]	*Australia*
All salaried staff	12 066	12 152	10 882	3 672	6 093	1 854	46 718
Salaried medical officers and other diagnostic health professionals	881	988	589	129	419	100	3 106
Nursing	7 244	7 247	6 454	2 244	3 398	1 214	27 801
Administrative and clerical	1 815	1 885	2 099	589	959	297	7 645
Domestic and other	2 126	2 031	1 740	710	1 317	242	8 166
Staff per bed[c]	2.5	2.4	2.3	2.4	2.7	2.3	2.4
Nursing staff	1.5	1.4	1.4	1.5	1.5	1.5	1.4
Other[d]	1.0	1.0	0.9	0.9	1.2	0.8	1.0

[a] Full-time equivalent staff in acute and psychiatric hospitals (excludes freestanding day hospitals). [b] Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in these states/territories. [c] Average number of staff per occupied bed. [d] Includes salaried medical officers and other diagnostic health professionals, administrative, domestic and other staff.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

In the case of nursing staff, agreements at the enterprise or jurisdiction level between employers and employee unions are common means of setting wages. Available data suggest that pay rates for nurses in the private hospital sector are close to those in the public hospital sector (NSW Nurses' Association 2009). In Victoria, by 31 January 2010, the most experienced Grade 2 registered nurse will be paid $1201.40 per week in public and Healthscope hospitals and $1207.83 per week at the Epworth hospitals (Workplace Authority 2008a, 2008b; Department of Health Victoria 2009). In occupations such as nursing, employment conditions (for example, the length of breaks between shifts) are also a key focus in collective agreement negotiations.

Rights of private practice

In the hospital system, many medical specialists have rights of private practice as well as having an established relationship with one or more private and/or public hospitals. As CHA noted:

> Many private hospitals are co-located with a public hospital. Many doctors work in both sectors — as a salaried or sessional medical officer in the public sector and as an independent practitioner in the private sector. Many doctors view their work time spent across both types of hospitals as complementary and contributing to their overall work and remuneration package. Remuneration rates are lower in the public system compared with the private sector and many doctors who work in the private sector see it as part of their professional duties to work for part of a week in a public hospital — including undertaking teaching responsibilities. (sub. 20, p. 7)

Furthermore, CHA noted that it is not only doctors who move across both sectors — nurses, allied health professionals and medical students are among those who may also have this mobility.

In the private sector, medical specialists are in non-salaried positions and work independently of the hospital. Indicative requirements for such positions include: fellowship from an Australian specialty college or recognised equivalent; eligibility to be registered as a specialist with the relevant Australian medical board; and appropriate indemnity insurance (Healthscope Limited 2009b; Ramsay Health Care Limited 2009b).

Consultation with a number of study participants has suggested that there are no data collections to indicate the number of specialists who have the right to admit patients to private hospitals, the specific nature of these arrangements, or whether there are specialties for which such arrangements are more common. One possible reason may be that granting admission rights to medical practitioners is a decision for individual hospitals.

3.5 Private freestanding day hospitals

Private freestanding day hospitals make up around half of all private hospitals. The number of private freestanding day hospitals has been increasing over time, since many procedures which used to require overnight hospital stay can now be performed on a day-only basis due to advances in technology and treatment methods.

Private freestanding day hospitals are fundamentally different to private acute and psychiatric hospitals and public hospitals, making comparison with these entities difficult. Private freestanding day hospitals often focus on a small number of procedures at the exclusion of many other activities undertaken by larger acute hospitals. This is a key reason why these facilities have been excluded from the later comparative analysis. While not part of this study's direct comparison of public and private hospitals, these facilities are important for understanding the hospital sector overall and the sector's development over time.

Most private freestanding day hospitals are in metropolitan areas, and there are more in New South Wales than in any other state or territory (table 3.10). Private freestanding day hospital facilities accounted for almost 670 000 or around 20 per cent of total private sector separations in 2007-08 (AIHW 2009a). New South Wales has a lower ratio of separations to beds than Queensland and Victoria.

This may, in part, reflect differences in the activities undertaken by private freestanding day hospitals among the jurisdictions (table 3.10).

Table 3.10 **Private freestanding day hospital facilities, 2007-08**

	Number of facilities	*Number of beds*	*Number of separations*	*Separations per 1000 residents*
New South Wales	88	722	195 177	27
Victoria	73	558	168 826	31
Queensland	51	340	183 569	43
South Australia	24	130	46 732	26
Western Australia	28	352	65 611	30
Tasmania	2	9	np	np
Northern Territory	–	–	np	np
ACT	6	40	np	np
Australia	**272**	**2 151**	**668 033**	**32**

np Not published but included in totals where applicable. – Nil.

Source: AIHW (2009a).

The output of private freestanding day hospitals is mainly surgical. Of the 30 AR-DRGs with the largest number of separations from private freestanding day hospitals in 2007-08, 16 were classified as surgical, seven were medical and seven were classified as 'other' (AIHW 2009a). In 2006-07, specialist endoscopy, ophthalmic, plastic/cosmetic and general surgery facilities accounted for around 65 per cent of private freestanding day hospitals (table 3.11). In 2006-07, New South Wales accounted for 53 per cent of general surgery day facilities and around 44 per cent of ophthalmic day facilities in Australia.

Table 3.11 **Number of private freestanding day hospital facilities by type of centre, 2006-07**

	General surgery	*Specialist endoscopy*	*Ophthalmic*	*Plastic/ cosmetic*	*Other*[a]	*Total*[b]
NSW	8	21	25	7	29	90
Vic	np	31	9	np	23	73
Qld	4	15	14	3	16	52
SA	..	4	3	9	8	24
WA	..	np	np	..	12	17
Tas, NT and ACT[c]	np	np	np	np	4	12
Australia	**15**	**76**	**57**	**28**	**92**	**268**

[a] Includes fertility and sleep disorders clinics. [b] These data (2006-2007) are for a different reporting period than the AIHW data in table 3.10 (2007-08). The total number of hospitals changed between reporting periods. [c] Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions. **np** Not published but included in totals where applicable. **..** Not applicable.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

Nursing staff accounted for around 58 per cent of total staff in private freestanding day hospitals in 2006-07 (table 3.12). This is a similar proportion to nursing staff in private acute and psychiatric hospitals. Administrative and clerical staff accounted for about 32 per cent of staffing in private freestanding day hospitals, which is around double the proportion of these staff in private acute and psychiatric hospitals. This may reflect an increased administrative burden from higher patient turnover in these facilities.

Table 3.12 **Number of staff in private freestanding day hospitals, 2006-07**

	General surgery	*Specialist endoscopy*	*Ophthalmic*	*Plastic/ cosmetic*	*Other*[a]	*Total*[b]
Nursing staff	122	344	330	101	477	1 373
Administrative and clerical	33	240	173	52	263	761
Other[c]	14	51	74	8	105	251
Total staff	169	634	577	160	845	2 385

[a] Including fertility and sleep disorders clinics. [b] Full-time equivalent staff. [c] Includes salaried medical officers and other diagnostic health professionals, administrative, domestic and other staff.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

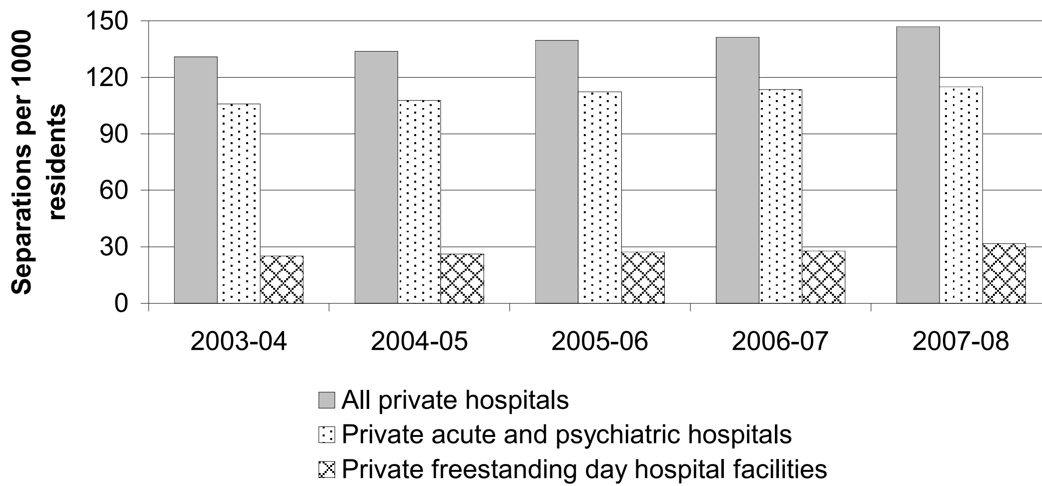
3.6 Recent developments in private hospitals

Increasing numbers of patient separations

Total private hospital separations per 1000 residents have increased by more than 12 per cent since 2003-04. Within this, separations from private acute and psychiatric hospitals have risen by close to 9 per cent over the same period (figure 3.7). This highlights the rapid growth of private freestanding day hospitals (close to 27 per cent over the period), albeit from a lower base. There was also an increase in the average number of beds in private acute and psychiatric hospitals in the capital cities by 410 beds, and a decrease in the average number of beds in regional Australia by 96 beds, between 2005-06 and 2006-07 (ABS 2008e).

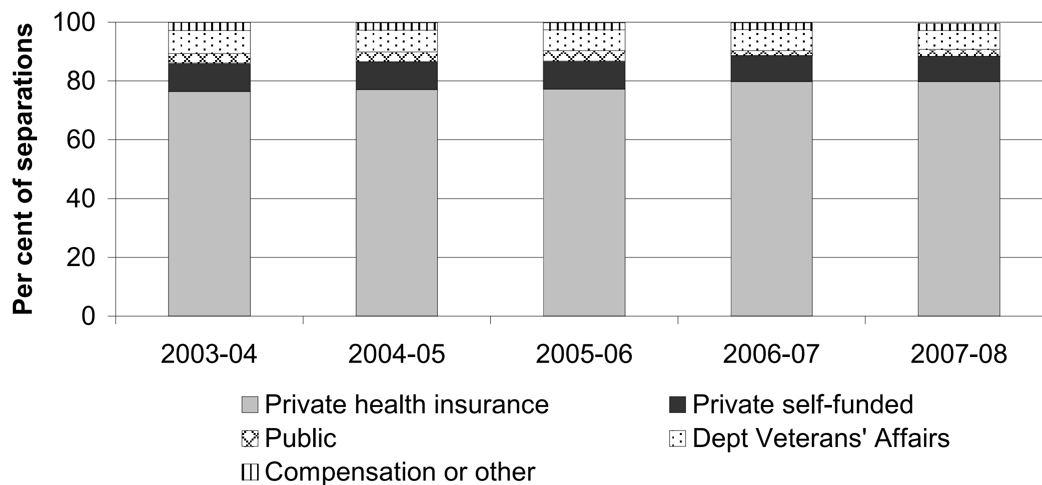
The proportion of private hospital separations funded by private hospital insurance increased slightly between 2003-04 and 2007-08, from around 76 per cent to 80 per cent (figure 3.8). The proportions of private hospital patient separations accounted for by public, Department of Veterans' Affairs and self-funded patients each declined by around 1 per cent over the period.

Figure 3.7 **Private hospital separations per 1000 residents, 2003-04 to 2007-08**



Source: AIHW (2009a).

Figure 3.8 **Private hospital patient separations by funding source, 2003-04 to 2007-08[a]**



[a] Data exclude patients whose funding source is not reported.

Source: AIHW (2009a).

Changing private hospital services

The most common AR-DRGs among private hospital patients have changed little in recent years. Of the 30 most common private hospital AR-DRGs in 2007-08,

28 were among the 30 most common in 2003-04.[4] However, there have been significant increases in the number of private hospital separations for the most common AR-DRGs. Table 3.13 sets out recent changes in the number of separations for the 15 most common private hospital AR-DRGs in 2007-08. All but two reported an increased number of separations between 2003-04 and 2007-08.

Table 3.13 **Number of separations for the most common private hospital AR-DRGs, 2003-04 to 2007-08[a]**

AR-DRG	*Description*	*2007-08*	*Change from 2003-04*
R63Z	Chemotherapy	176 372	32 228
G44C	Other colonoscopy, same-day	169 234	29 529
L61Z	Admit for renal dialysis	164 480	30 862
C16B	Lens procedures, same-day	121 181	23 934
G45B	Other gastroscopy for non-major digestive disease, same-day	97 758	- 5 061
D40Z	Dental extractions and restorations	93 575	14 826
G46C	Complex gastroscopy, same-day	89 533	28 689
Z64B	Other factors influencing health status, same-day	77 046	34 772
U60Z	Mental health treatment, same-day, without electroconvulsive therapy	75 018	9 624
Z40Z	Follow up with endoscopy	64 058	8 901
I18Z	Other knee procedures	64 026	8 477
J11Z	Other skin, subcutaneous tissue and breast procedures	53 625	3 280
O05Z	Abortion with operating room procedure	51 114	4 305
N07Z	Other uterine and adnexa procedures for non-malignancy	49 167	11 483
O60B	Vaginal delivery without catastrophic or severe complications or comorbidities	34 498	- 675

a Data for 2003-04 are defined according to AR-DRG version 5.0. Data for 2007-08 are defined according to AR-DRG version 5.1 (see box 2.2). Data classifications are subject to minor revision between years.

Source: AIHW (2009a).

Some study participants noted recent changes in the breadth and composition of private hospital services. CHA observed:

> The private hospital sector is providing an increasing proportion of total hospital services in many different specialty groups, particularly in the areas of cardiac medical, cardiac interventional, oncology, obstetrics, orthopaedics and gastroenterology. (sub. 20, p. 2)

APHA (sub. 25) commented that a number of complex procedures and treatments traditionally associated with public hospitals are now performed more often in

[4] The following AR-DRGs were not among the 30 most common private hospital separations in 2003-04: retinal procedures and other female reproductive system operating room procedures (patients aged under 65) without malignancy, complications or comorbidities.

private hospitals, including knee replacements, procedures of the digestive system, prostatectomies, chemotherapy and major malignant breast conditions. It is also noteworthy that private hospital separations increased between 2003-04 and 2007-08 across 22 of the 23 Major Diagnostic Categories, with the exception of a small decrease of 62 separations in the burns category (AIHW 2009a).

Increasing teaching role

It appears that private hospitals are increasingly involved in teaching, although data to support this development is limited. The number of private hospitals teaching medical staff, nursing staff and allied health professionals increased between 2005-06 and 2006-07 (table 3.14).

Table 3.14 **Private hospitals with teaching roles, 2005-06 to 2006-07**[a]

	2005-06	*2006-07*	*Percentage change*
Number of private hospitals teaching:			
Medical staff/undergraduates	42	47	12
Nursing staff/undergraduates	163	171	5
Allied health professionals	58	61	5
Number of hospitals with affiliated teaching status	67	64	-5
Nursing staff providing nurse education	272	319	17

[a] Acute and psychiatric hospitals (excludes freestanding day hospitals). Measured in full-time equivalent staff.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0).

On the private sector's take-up of teaching responsibilities, Australasian College for Emergency Medicine noted that:

> Whilst most private emergency departments would embrace and welcome involvement in medicine training, it must be recognised that if students are placed without adequate resourcing and process re-engineering, it is likely that the performance (both financial and throughput) of private emergency departments will deteriorate. (sub. 14, p. 5)