
4 Public and private hospitals in the health system

Key points

- Public and private hospitals are similar in a number of ways. A comparison of the types of diagnoses most frequently treated by public and private hospitals indicates that the two sectors offer many of the same hospital services, particularly chemotherapy, renal dialysis and medical obstetrics. More broadly, a number of large metropolitan private hospitals offer a range of services on par with large public hospitals including, in some instances, accident and emergency treatment and clinical training.
- Differences between public and private hospitals in terms of hospital size, location and services are, in part, a function of their business models, government requirements and community expectations.
 - The public hospital sector handles the majority of acute care separations and accounts for most regional and remote hospitals, while private hospitals are more concentrated in metropolitan areas and are more likely to treat patients of higher socioeconomic advantage.
 - The public sector's activity is concentrated on medical cases (including those typically admitted through emergency departments) while the private sector's activity is more concentrated on surgical (typically elective) procedures.
- The overall relationship between the two sectors is not clear cut, especially as the sectors do not operate in isolation, as exemplified by co-located hospitals sharing resources and medical staff working across both sectors. Although differences between and within the sectors make valid comparison difficult, Australia's robust and well-established system of public and private hospitals — and the overlap in their services — enables a comparison of their respective performance to be considered.
- The respective roles, responsibilities and accountabilities of public and private hospitals may change with the new National Healthcare Agreement and the future response of governments to the recommendations of the National Health and Hospitals Reform Commission.

Australia's hospitals are an integral part of the nation's health system, providing an extensive range of services — including acute, emergency, newborn, geriatric, diagnostic, rehabilitation, palliative and outpatient care — designed to fulfil the

health needs of all residents across the nation. As part of Australia's comprehensive system of health services, hospitals contribute to the nation's health outcomes in combination with other key components, including health-promotion strategies, disease-prevention strategies, chronic disease management, other primary care services and accessible aged care. The performances of each of these components are interdependent, such that deficiencies in one part of the health system are likely to place greater demand on another. Shortfalls in the provision of primary care and aged care in some more remote areas of Australia, for example, necessitate that hospitals deliver these essential services to these communities. Hospitals must therefore be evaluated in the context of their roles and responsibilities.

It is clearly recognised that public and private hospitals are driven by different operational motives, typically treat different types of patients, and typically deliver different suites of services. As such, these differences need to be taken into account if comparisons between the public and private hospital sectors are to be valid and useful. Given the broad scope of differences between public and private hospitals, one role of this study is to highlight the complexities and limitations of conducting a comparative assessment. At the same time, this study aims to identify the factors by which the two sectors can be appropriately compared, allowing for the possibility that discernible differences in the services offered by the two sectors may be partly indicative of their respective fields of specialty and relative efficiency.

This chapter looks at the role of public and private hospitals as part of Australia's overall health system. The similarities and differences between the two sectors, and their degree of complementarity and competitiveness, are examined. The possible future directions of public and private hospitals in Australia, including the wider pressures facing the hospital system, are discussed.

4.1 Similarities and differences

The different operational motives of the public and private hospital sectors contribute to differences in the size and location of public and private hospital establishments, as well as in the services they offer and patients they treat. This section elaborates on some key differences between the public and private sectors in the context of the hospital system as a whole, while also recognising their similarities.

Core differences in the operational incentives, roles and responsibilities of the public and private hospital sectors highlight the complexity of directly comparing the sectors on the basis of efficiency. Indeed, study participants have confirmed that efficiency may not be the primary objective of all hospital providers, and that some

explicit objectives of the public sector — the delivery of emergency care, equity of access, and clinical research and training — also contribute to the overall quality of the health system:

[H]ospital performance may not be the greatest priority in the objectives of certain groups. State administrators have different priorities to hospital managers (who may or may not also be clinicians). There are also equity considerations, and many other issues such as the capacity which must be held back when running an emergency department, as well as staff commitments to teaching and medical research — all critical components to a high quality healthcare system, and again reducing comparability of providers. (Centre for Health Economics, Monash University, sub. 7, p. 2)

Given the complexities involved in assessing the comparative performance of the two hospital sectors, this study acknowledges that points of similarity will help identify the factors by which the sectors can be appropriately compared. For example, large private hospitals that treat a similar casemix to the public sector, conduct teaching and research and run emergency departments are likely to be sufficiently similar to many public hospital establishments to merit an evaluative comparison. On the other hand, points of difference between the sectors should not necessarily preclude a comparative assessment, but serve to highlight the factors that must be taken into account in the assessment, and may potentially signal areas of relative efficiency.

Similarities and differences in hospital establishments

The majority of very small hospitals (with 50 or fewer beds) and very large hospitals (more than 200 beds) are public. Moderately sized hospitals (between 51 and 200 beds) are more evenly distributed across the two sectors (table 4.1).

Table 4.1 **Share of public and private hospitals by size^a**

	<i>Public hospitals^b</i>	<i>Private hospitals^c</i>	<i>Australia</i>
	%	%	%
0–50 beds	81	19	100
51–100 beds	46	54	100
101–200 beds	54	46	100
201 beds or more	78	22	100
All hospitals	73	27	100

^a Acute and psychiatric hospitals. ^b Data for public hospitals are for 2007–08. ^c Data for private hospitals are for 2006–07.

Source: ABS (*Private Hospitals*, Cat. no. 4390.0); AIHW (2009a).

Public and private hospitals operate in broadly similar numbers in metropolitan areas. Given public hospitals' service obligations in rural and regional areas, as well as the private hospital sector's commercial considerations, all hospitals in remote and very remote areas of Australia are provided by the public sector (table 4.2).

Table 4.2 Public and private hospitals by location, 2009^a

	<i>Public hospitals</i>	<i>Private hospitals</i>	<i>Australia</i>
	%	%	%
Major cities	45	55	100
Inner regional	76	24	100
Outer regional	93	7	100
Remote	100	—	100
Very remote	100	—	100

^a Acute and psychiatric hospitals. Remoteness area based on ABS (2005) Australian Standard Geographical Classification. — Nil.

Source: DOHA (2009c, 2009e).

The need for the public hospital sector to ensure service delivery in rural and regional areas, while also undertaking teaching in the large metropolitan areas, helps to explain the diversity of hospital establishments in the public hospital sector. On the other hand, the different operational objectives of the private hospital sector help to explain why few establishments are small enough to be adversely affected by a lack of economies of scale, and none are located in remote areas where distance and isolation contribute to higher resource costs.

Similarities and differences in services

Patient services

In 2007-08, public hospitals accounted for around 61 per cent of total hospital separations, while private acute and psychiatric hospitals accounted for around 31 per cent. The remainder were separations in private freestanding day hospitals. Public hospitals provided the majority of all types of hospital care with the exception of rehabilitation services, and also accounted for the majority of medical cases handled by Australia's hospital system. In contrast, private hospitals accounted for the majority of surgical and other procedures, performing around two-thirds of all elective surgery (table 4.3). New South Wales Health (sub. 40) commented that private hospitals may be, in effect, more selective in their admissions than public hospitals, because they are less likely to be equipped to treat long-stay or highly complex medical cases. These types of cases are likely to be

redirected to the public hospital sector instead. However, the Australian Private Hospitals Association (APHA) (sub. 25) commented that a number of complex procedures and treatments traditionally associated with public hospitals are now commonly performed in private hospitals.

Table 4.3 Share of hospital separations by sector, 2007-08

	<i>Public hospitals</i>	<i>Private hospitals</i>	<i>Australia</i>
	%	%	%
Separations by type of care			
Acute care	60	40	100
Rehabilitation	39	61	100
Palliative care	79	21	100
Geriatric	74	26	100
Maintenance care	92	8	100
Newborn	79	21	100
Separations by type of diagnosis			
Surgical	43	57	100
Medical	75	25	100
Other	31	69	100
Elective procedures	36	64	100

^a Defined by AR-DRG partition (box 2.2).

Source: AIHW (2009a).

Outside of admitted patient services, public hospitals handled over 90 per cent of the total number of accident and emergency presentations reported in 2007-08 (AIHW 2009a).

A detailed comparison of the types of services provided by the two hospital sectors is presented in the following lists of the 30 most frequent overnight and same-day separations that were treated in each sector in 2007-08, categorised according to Australian Refined Diagnosis-Related Groups (AR-DRGs) (box 2.2).

In a comparison of the 30 most frequent overnight AR-DRGs treated in each sector (which represent 33 per cent of overnight separations in the public sector and 42 per cent of overnight separations in the private sector), only eight AR-DRGs were common to both sectors (table 4.4). These common AR-DRGs mainly relate to obstetrics. Of the 22 overnight AR-DRGs that were distinct to the public sector in this sample, many were the type of separation commonly admitted through emergency departments, such as respiratory and cardiac-related cases, injuries, seizures, and treatment for poisoning and the toxic effects of drugs. All but one of these treatments were medical cases, although the one exception — appendectomy — is a surgery usually performed in emergency circumstances to treat appendicitis. Also distinct to the public sector's most frequent types of separations in this sample

was cellulitis — an infection commonly caused by the *Staphylococcus aureus* bacteria (RCPA 2009), which is a condition used in the monitoring of hospital quality. Of the 22 overnight AR-DRGs that were distinct to the private sector in this sample, many were elective procedures such as knee or hip replacements. All but two of these AR-DRGs were surgical cases.

There appears to be considerably more overlap between the sectors in their same-day separations. In a comparison of the 30 most frequent same-day AR-DRGs treated in each sector (which represented 70 per cent of same-day separations in the public sector and 81 per cent of same-day separations in the private sector in 2007-08), 22 AR-DRGs were common to both sectors, including the four most frequent same-day separations overall (table 4.5). Although differing in order of frequency, the top four activities in both sectors were: renal dialysis, chemotherapy, non-complex colonoscopy and lens procedures. The greater degree of overlap in same-day separations between the two sectors may be partly explained by the fact that same-day separations in both hospital sectors appear to be concentrated among a smaller number of AR-DRGs.

Although the public and private hospital sectors displayed more similarity in their same-day separations than in their overnight separations, the concentration of medical cases in the public sector and surgical cases in the private sector was again apparent. Of the eight most frequent treatments distinct to the private sector in this sample, all but two were surgical cases. All eight of the treatments distinct to the public sector in this sample were medical cases.

Table 4.4 Thirty most frequent overnight separations in public and private hospitals by AR-DRG, 2007-08^a

AR-DRG	Partition ^b	Description ^c	Public hospitals			Private hospitals		
			Rank	Number of separations	Percent ^d	Rank	Number of separations	Percent ^e
O60B	Med	Vaginal delivery (w/o csc)	1	101 245	4.47	1	34 421	3.39
F74Z	Med	Chest pain	2	52 326	2.31	26	8 427	0.83
G67B	Med	Oesophagitis, gastroent and misc. digestive system disorders (age>9; w/o csc)	3	42 082	1.86	23	9 212	0.91
O01C	Surg	Caesarean delivery (w/o csc)	4	41 510	1.83	3	28 324	2.79
J64B	Med	Cellulitis (age>59 (w/o csc)) or age<60)	5	35 070	1.55		na	
O66A	Med	Antenatal and other obstetric admission	6	33 277	1.47	25	8 504	0.84
O60C	Med	Vaginal delivery (single uncomplicated w/o other condition)	7	24 183	1.07		na	
E65A	Med	Chronic obstructive airways disease (with csc)	8	22 370	0.99		na	
G66B	Med	Abdominal pain or mesenteric adenitis (w/o cc)	9	22 032	0.97		na	
E65B	Med	Chronic obstructive airways disease (w/o csc)	10	21 571	0.95		na	
E62C	Med	Respiratory infections/inflamations (w/o cc)	11	21 547	0.95		na	
E69C	Med	Bronchitis and asthma (age<50 w/o cc)	12	21 328	0.94		na	
F62B	Med	Heart failure and shock (w/o catastrophic cc)	13	21 228	0.94		na	
E62B	Med	Respiratory infections/inflamations (with severe or moderate cc)	14	20 407	0.90		na	
U67Z	Med	Personality disorders and acute reactions	15	20 369	0.90		na	
F71B	Med	Non-major arrhythmia and conduction disorders (w/o csc)	16	20 295	0.90		na	
D63B	Med	Otitis media and upper respiratory tract infection (w/o cc)	17	19 677	0.87		na	
H08B	Surg	Laparoscopic cholecystectomy (w/o common bile duct exploration; w/o csc)	18	18 558	0.82	8	16 815	1.65
G07B	Surg	Appendectomy (w/o csc)	19	18 388	0.81		na	
U63B	Med	Major affective disorders (age<70 w/o csc)	20	17 111	0.76	12	12 217	1.20
I68B	Med	Non-surgical spinal disorders (w/o cc)	21	16 198	0.71	27	8 088	0.80
U61A	Med	Schizophrenia disorders (with mental health legal status)	22	16 002	0.71		na	
X60C	Med	Injuries (age<65)	23	15 743	0.69		na	
B76B	Med	Seizure (w/o csc)	24	15 450	0.68		na	
K60B	Med	Diabetes (w/o csc)	25	14 981	0.66		na	

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Table 4.4 (continued)

AR-DRG	Partition ^b	Description ^c	Public hospitals			Private hospitals		
			Rank	Number of separations	Per cent ^d	Rank	Number of separations	Per cent ^e
L63B	Med	Kidney and urinary tract infections (age>69 or with severe cc)	26	14 831	0.65		na	
X62B	Med	Poisoning or toxic effects of drugs and other substances (age<60 w/o cc)	27	14 672	0.65		na	
L63C	Med	Kidney and urinary tract infections (age<70 w/o csc)	28	14 364	0.63		na	
O60A	Med	Vaginal delivery (with csc)	29	14 282	0.63		na	
F73B	Med	Syncope and collapse (w/o csc)	30	14 040	0.62		na	
E63Z	Med	Sleep apnoea		na		2	34 109	3.36
I16Z	Surg	Other shoulder procedures		na		4	26 536	2.61
I04Z	Surg	Knee replacement and reattachment		na		5	22 184	2.18
G09Z	Surg	Inguinal and femoral hernia procedures (age>0)		na		6	18 605	1.83
D11Z	Surg	Tonsillectomy and/or adenoidectomy		na		7	17 619	1.73
F42B	Other	Circulatory disorders ^f		na		9	15 506	1.53
N04Z	Surg	Hysterectomy for non-malignancy		na		10	14 168	1.39
I03C	Surg	Hip replacement (w/o csc)		na		11	12 697	1.25
M02B	Surg	Transurethral prostatectomy (w/o csc)		na		13	11 721	1.15
K04Z	Surg	Major procedures for obesity		na		14	11 718	1.15
I18Z	Surg	Other knee procedures		na		15	11 396	1.12
F15Z	Surg	Percutaneous coronary intervention ^g		na		16	10 183	1.00
I20Z	Surg	Other foot procedures		na		17	10 104	0.99
I10B	Surg	Other back and neck procedures (w/o csc)		na		18	9 974	0.98
D10Z	Surg	Nasal procedures		na		19	9 929	0.98
N06Z	Surg	Female reproductive system reconstructive procedures		na		20	9 771	0.96
D06Z	Surg	Sinus, mastoid and complex middle ear procedures		na		21	9 574	0.94
J06B	Surg	Major procedures for non-malignant breast conditions		na		22	9 284	0.91
I29Z	Surg	Knee reconstruction or revision		na		24	8 723	0.86

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Table 4.4 (continued)

AR-DRG	Partition ^b	Description ^c	Public hospitals		Private hospitals		
			Rank	Per cent ^d separations	Rank	Per cent ^e separations	
G11B	Surg	Anal and stomal procedures (w/o csc)		na	28	7 897	0.78
J06A	Surg	Major procedures for malignant breast conditions		na	29	7 610	0.75
I30Z	Surg	Hand procedures		na	30	7 527	0.74
Total 30 most frequent overnight AR-DRGs				745 137		422 843	41.60

^a Number of separations ranked according to frequency in each sector, as defined in AR-DRG version 5.1. ^b Med: medical partition. Surg: surgical partition (see box 2.2).
^c w/o: without. cc: complications and comorbidities. cs: catastrophic or severe. misc: miscellaneous. ^d Per cent of total public hospital overnight separations. ^e Per cent of total private hospital overnight separations. ^f without acute myocardial infarction; with invasive cardiac investigation procedure; without complex diagnosis or procedure. ^g without acute myocardial infarction; with stent implantation. na: AR-DRG is not among the 30 most frequent in the sector (data unavailable).

Source: AIHW (2009a).

Table 4.5 Thirty most frequent same-day separations in public and private hospitals by AR-DRG, 2007-08^a

AR-DRG	Partition ^b	Description ^c	Public hospitals			Private hospitals		
			Rank	Number of separations	Per cent ^d	Rank	Number of separations	Per cent ^e
L61Z	Med	Admit for renal dialysis	1	815 622	34.82	3	164 469	8.29
R63Z	Med	Chemotherapy	2	121 703	5.20	1	176 290	8.89
G44C	Other	Other (non-complex) colonoscopy	3	53 385	2.28	2	169 234	8.53
C16B	Surg	Lens procedures	4	51 907	2.22	4	121 181	6.11
O66B	Med	Antenatal and other obstetric admission	5	45 835	1.96		na	
Z64B	Med	Other factors influencing health status	6	45 378	1.94	8	77 046	3.88
F74Z	Med	Chest pain	7	36 115	1.54		na	
G45B	Other	Other gastroscopy for non-major digestive disease	8	34 160	1.46	5	97 758	4.93
J11Z	Surg	Other skin, subcutaneous tissue and breast procedures	9	33 188	1.42	13	50 106	2.53
Q61C	Med	Red blood cell disorders (w/o cscs)	10	30 008	1.28	24	16 961	0.86
G67B	Med	Oesophagitis, gastroent and misc. digestive system disorders (age>9; w/o cscs)	11	28 628	1.22		na	
Z40Z	Other	Follow up with endoscopy	12	26 873	1.15	10	62 510	3.15
G46C	Other	Complex gastroscopy	13	23 513	1.00	7	89 533	4.51
O05Z	Surg	Abortion (with operating-room procedure)	14	23 431	1.00	12	50 165	2.53
D40Z	Other	Dental extractions and restorations	15	22 983	0.98	6	91 399	4.61
U60Z	Med	Mental health treatment (w/o electroconvulsive therapy)	16	21 734	0.93	9	75 018	3.78
R61C	Med	Lymphoma and non-acute leukaemia	17	21 578	0.92	27	14 061	0.71
L41Z	Other	Cystourethroscopy	18	20 801	0.89	15	26 074	1.31
X60C	Med	Injuries (age<65)	19	20 723	0.88		na	
G66B	Med	Abdominal pain or mesenteric adenitis (w/o cc)	20	18 412	0.79		na	
I68C	Med	Non-surgical spinal disorders	21	17 057	0.73	18	19 575	0.99
N10Z	Surg	Diagnostic curettage or diagnostic hysteroscopy	22	16 288	0.70	22	17 291	0.87
N09Z	Surg	Conisation, vagina, cervix and vulva procedures	23	16 174	0.69	29	12 754	0.64
L67C	Med	Other kidney and urinary tract diagnoses (w/o cscs)	24	15 231	0.65		na	
I30Z	Surg	Hand procedures	25	14 286	0.61	23	17 288	0.87
I18Z	Surg	Other knee procedures	26	14 115	0.60	11	52 630	2.65

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Table 4.5 (continued)

AR-DRG	Partition ^b	Description ^c	Public hospitals			Private hospitals		
			Rank	Number of separations	Per cent ^d	Rank	Number of separations	Per cent ^e
Q60C	Med	Reticuloendothelial and immunity disorders (w/o malignancy; w/o csc)	27	13 921	0.59	na	na	
N07Z	Surg	Other uterine and adnexa procedures for non-malignancy	28	13 787	0.59	14	43 463	2.19
I74C	Med	Injury to forearm, wrist, hand or foot (age<75; w/o cc)	29	13 517	0.58	na	na	
G11B	Surg	Anal and stomal procedures (w/o csc)	30	11 873	0.51	20	18 525	0.92
N11B	Surg	Other female reproductive system operating-room procedures (age<65) (w/o cc) ^e		na		16	22 819	1.15
J08B	Surg	Other skin graft and/or debridement procedures (w/o csc)		na		17	22 770	1.15
C03Z	Surg	Retinal procedures		na		19	19 401	0.98
J10Z	Surg	Skin, subcutaneous tissue and breast plastic operating-room procedure		na		21	18 323	0.92
F42B	Other	Circulatory disorders ^f		na		25	16 862	0.85
B05Z	Surg	Carpal tunnel release		na		26	15 269	0.77
V62B	Med	Alcohol use disorder and dependence		na		28	12 972	0.65
D13Z	Surg	Myringotomy with tube insertion		na		30	12 043	0.61
Total 30 most frequent same-day AR-DRGs				1 642 226	70.11		1 603 790	80.87

^a Number of separations ranked according to frequency in each sector, as defined in AR-DRG version 5.1. ^b Med: medical partition. Surg: surgical partition (see box 2.2). ^c w/o: without. cc: complications and comorbidities. cs: catastrophic or severe. misc.: miscellaneous. ^d Per cent of total public hospital same-day separations. ^e Per cent of total private hospital same-day separations. ^f without malignancy. ^f without acute myocardial infarction; with invasive cardiac investigation procedure; without complex diagnosis or procedure. **na** AR-DRG is not among the 30 most frequent in the sector (data unavailable).

Source: AIHW (2009a).

Teaching and training

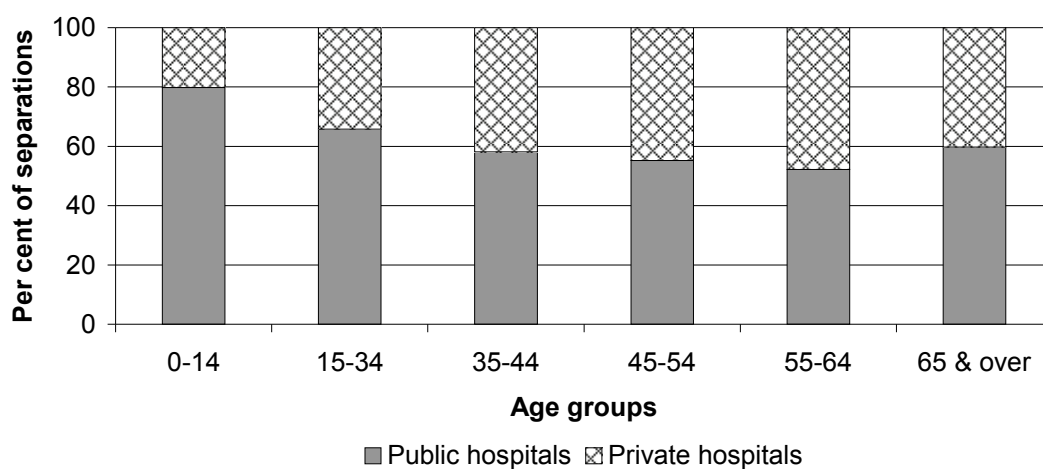
An historical difference between the public and private hospital sectors has been their teaching and training responsibilities. As noted in earlier chapters, the public sector delivers the vast bulk of teaching and training, although private sector involvement is increasing, and recent government programs are facilitating this expansion (DOHA 2009g). Catholic Health Australia (CHA) (sub. 20) noted that many large Catholic hospitals have much in common with large public hospitals through their involvement in teaching and research, and the APHA (sub. 25) noted that the private hospital sector provides a significant volume of training and education to undergraduate medical and nursing students that is not funded by government. It has been argued that greater responsibility for teaching should be assigned to private hospitals, in order to offer more training opportunities in areas of private sector specialisation (Crotty 2005).

Similarities and differences in patients

Patient demographics and socioeconomic status differ between the public and private hospital sectors. Although the public hospital sector handles the majority of separations for patients of all age groups, some variation is apparent (figure 4.1). Children and young people comprise a larger share of the case load of public hospitals, with 28 per cent of patients admitted to public hospitals being under 35 years of age. In private hospitals, the age group with the highest proportion of patients admitted is 50 to 64 years (27 per cent). Patients aged between 75 to 84 years comprise 15 per cent of those admitted to both public and private hospitals, while those aged 85 and over comprise 6 per cent of those admitted to public hospitals and 5 per cent of those admitted to private hospitals.

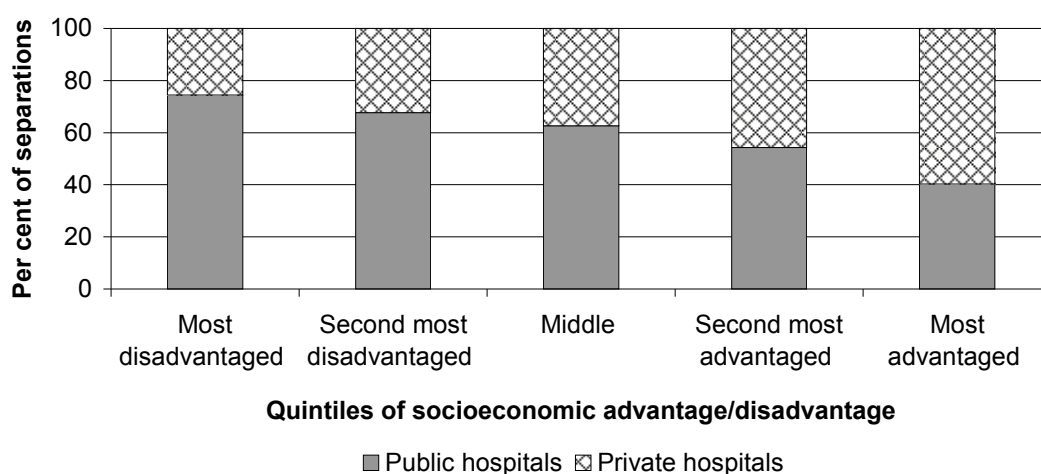
A higher proportion of patients in public hospitals are from disadvantaged socioeconomic areas, compared to patients in private hospitals. Even so, around 26 per cent of patients from the most disadvantaged areas were treated in private hospitals treated in 2007-08 (figure 4.2). Around 40 per cent of patients from the most advantaged socioeconomic areas were treated in public hospitals.

Figure 4.1 Share of separations by sector and patient age, 2007-08



Source: AIHW (2009a).

Figure 4.2 Share of separations by sector and socioeconomic status of patients, 2007-08^a



^a Quintiles of socioeconomic status based on ABS (2006) Index of Relative Socioeconomic Advantage/Disadvantage score based on the patient's area of usual residence.

Source: AIHW (2009a).

In 2007-08, the majority of patients electing to be treated as private patients were treated by private hospitals, while public hospitals treated nearly all public patients (table 4.6). Public hospitals treated 14 per cent of patients using private health insurance to fund their hospital stay. Private hospitals treated 62 per cent of Department of Veterans' Affairs patients in 2007-08.

Table 4.6 Share of patient separations by sector and funding source, 2007-08

	<i>Public hospitals</i>	<i>Private hospitals</i>	<i>Australia</i>
	%	%	%
Public patient	98	2	100
Private health insurance	14	86	100
Self-funded	17	83	100
Department of Veterans' Affairs	38	62	100
Compensation or other ^a	47	53	100
All funding sources	60	40	100

^a Includes workers compensation, other compensation, motor vehicle third party personal claim, other public authorities and other funding sources.

Source: AIHW (2009a).

4.2 Relationship between the two sectors

Based on the differences in the business structures, responsibilities, services and patient profiles of public and private hospitals, there is strong support from study participants that the two sectors are fundamentally different, as noted:

[I]t is critical to emphasise that the public and private hospital sectors are driven by different requirements. The core function may be to assemble infrastructure, workforce and knowledge around the care of patients to improve their health, but the associated 'imperatives' have created two very different structures. (Royal Australasian College of Surgeons, sub. 30, pp. 1-2)

The two sectors have fundamentally different roles in that the public health system is required under the National Health Care Agreement to treat all patients that present for care, while the private sector provides preferential access to care for those who can afford it. (Tasmanian Department of Health and Human Services, sub. 37, p. 3)

[P]ublic and private hospitals serve different populations, do different things, operate in very different ways and are funded differently. (Australian Healthcare and Hospitals Association, sub. 33, p. 2)

For the most part, private hospitals are quite different from public hospitals in size and types of services offered. For example, private facilities in the mental health sector provide treatment for quite distinct conditions to those treated in the public sector. The majority of chemotherapy treatment for people with cancer is delivered in the private sector. Most of the rehabilitation for people who have had accidents, injuries or falls is provided in private hospitals ... And nearly all in-hospital specialist palliative care services for the dying are provided in private hospitals, especially in regional Australia. (APHA, sub. 25, p. 3)

A key difference between the sectors is the type of product they deliver. For certain types of care offered by both sectors, private hospital services can be accessed

relatively sooner, and with the added benefits of private ward accommodation and a choice of doctor, subject to a patient's willingness-to-pay. Based on this distinction, the two sectors are effectively delivering differentiated products. As CHA commented, the private sector has to distinguish itself from the public sector in order to attract demand:

Given that privately insured patients have already paid for public insurance under Medicare, the private health sector, in order to attract additional funding from individuals, needs to provide a different patient experience to the public sector — particularly in areas where seemingly similar clinical services are offered. (sub. 20, p. 6)

These fundamental differences in public and private hospitals suggest that the two sectors may be described as complementary, in the sense that they provide a different range of services which supplement that of the other. Many interested parties held this view, at least with respect to some services (ACSQHC, sub. 24; Rhonda Kerr and Associates, sub. 34). Queensland Health noted:

In general terms, ... the provision of public and private health care [is] predominantly complementary rather than competitive. Therefore any competitive analysis will need to carefully address the complexities of the environment in which health care takes place across the public and private systems. (sub. 27, p. 1)

On the other hand, some study participants commented that there is little evidence that the two sectors are complementary (Centre for Health Economics, Monash University, sub. 7), while other participants pointed towards the sectors' similarities. As well as offering many of the same services, the two sectors effectively compete for the same resources, such as trained medical staff (Rhonda Kerr and Associates, sub. 34). The noted similarities between public and private hospitals suggest that, at least in some aspects, the two sectors may be described as competitive markets, sharing common functions and offering substitutable services.

Many study participants, however, concluded that the relationship between the public and private sectors is not clear cut. While some public and private hospital establishments share common features and may be seen to operate in competition, others are sufficiently distinct that they may be viewed as complementary components of the total hospital system. On this point, APHA noted:

Private hospitals are in some aspects similar to public ones. 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. For the most part, private hospitals are quite different from public hospitals in size and types of services offered. (sub. 25, p. 3)

Likewise, the Australian Medical Association (AMA) observed that the similarities between the sectors are restricted to a select number of features:

There are some limited areas where the two hospital sectors can be seen as being in competition with each other. However, the two sectors do have quite markedly differing casemix. (sub. 28, p. 2)

Defining the profiles of the public and private sectors is further complicated by signs of increasing overlap and interaction between them, as the Australian Government Department of Health and Ageing observed:

The boundaries between public hospitals and private hospitals and the services provided within each sector are becoming increasingly blurred. Examples include: public hospitals provide services to private patients, while private hospitals provide services to public patients; ... emergency care is provided by public hospitals and also by some private hospitals; the education and training of healthcare professionals is now occurring in some private facilities. (sub. 32, p. 12)

Similarly, the Royal Australasian College of Surgeons observed that the private hospital sector is increasingly adopting some of the traditional characteristics of the public sector:

Historically [in the private sector] there has been an emphasis on elective or semi-elective presentations. However, there has also been a growing recognition that patients present as emergencies, and this has seen the development of emergency departments in the larger private hospitals. Patients are also referred by medical practitioners, usually specialists. Consequently another focus of the private hospital sector has been on securing a steady referral of patients, which has driven its development. (sub. 30, p. 2)

Furthermore, defining the responsibilities and incentives of each sector is complicated by the fact that a single provider can deliver services in both sectors, as CHA commented:

In the case of the Catholic hospitals, the delineation between public and private is further confounded by the fact that a number of Catholic healthcare providers operate significant hospitals in both the public and private sectors including the St Vincent's Health Australia, Little Company of Mary Health Service and the Mater Health Service in Brisbane. (sub. 20, p. 5)

The strength of interaction between the two sectors has led some to describe them as 'interdependent' (Queensland Health, sub. 27, p. 2), reflecting the fact that the services and functions of each sector help to support the other. The interaction between the sectors may be demonstrated by, for example: the sharing of resources in co-located establishments; medical staff working across both sectors and the exchange of spillover benefits (the private sector benefiting from the public sector's investment in medical training and research). The AMA identified the benefits of Australia's dual hospital system:

[T]he plural nature of the public and private hospital system is one of the strengths of Australia's health system. It is readily apparent that taxpayer-sourced funding cannot

bear the whole load of financing health care ... Australia gets its best results when the two sectors have a strong symbiotic relationship ... It makes no economic sense to have duplicated and underutilised resources in both sectors if there is scope for resources to be shared. (sub. 28, pp. 1–2)

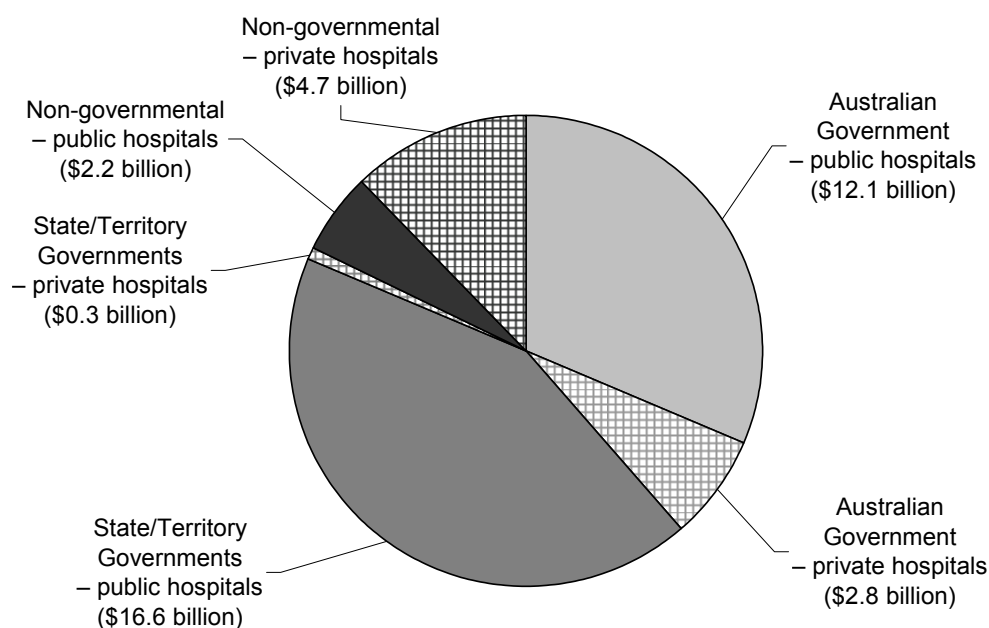
4.3 Possible directions for hospitals

Australia's hospital system is under pressure, largely due to the impact of population ageing and the associated fiscal burden, but also due to technological advancements, heightened community expectations regarding access to health care, and trends in the health status of the population. These factors are changing not only the type of hospital services sought by patients, but also how and where treatment is delivered.

Under these pressures, healthcare expenditure currently consumes around 9 per cent of Australia's GDP, of which the equivalent of 3.5 per cent of GDP is allocated to hospitals (AIHW 2009c). In 2007-08, Australian Government expenditure on hospitals amounted to \$14.9 billion, most of which was allocated to public hospital services (figure 4.3). Around 13 per cent of the Australian Government's hospital expenditure was used to fund private health insurance premium rebates. In the same year, state and local government expenditure on hospitals amounted to \$16.8 billion, almost all of which was directed to public hospitals. Non-governmental expenditure on hospitals amounted to \$6.9 billion, most of which was directed to private hospitals. From 2005-06 to 2007-08, total government expenditure on public and private hospitals increased by 12 per cent and 9 per cent respectively. Over the same timeframe, non-governmental expenditure on public and private hospitals increased by 17 per cent and 7 per cent respectively (AIHW 2009c).

Accounting for growth in both demographic and non-demographic factors (such as medical developments), the Australian Treasury estimated that from 2006-07 to 2046-47, Australian Government expenditure on hospitals (including private health insurance rebates) will increase from 1.2 to 2.3 per cent of GDP, equivalent to a three-fold increase in real expenditure per person (Treasury 2007). Consistent with these figures, the Commission estimated that Australian Government expenditure on hospitals (excluding private health insurance rebates) will increase to 2.25 per cent of GDP by 2044-45 (PC 2005). It estimated that state and territory government expenditure on hospitals will increase to 1.9 per cent of GDP by 2044-45, up from 1.2 per cent of GDP in 2002-03 (PC 2005).

Figure 4.3 Funding sources of public and private hospitals, 2007-08^a



^a Expenditure on public hospital services and private hospitals.

Source: AIHW (2009c).

Given the intensified demand for hospital services, matched with increasing budgetary pressures, current policy reforms are focused on generating greater efficiency, accountability and performance quality within Australia’s hospital system, and across both public and private sectors. This is especially the case with the new National Health Agreement (NHA) agreed to by COAG in late 2008. Other reform proposals, such as the recommendations of the National Health and Hospitals Reform Commission (NHHRC), are consistent with these directions.

COAG reforms

The NHA aims to change the future delivery of public hospital services. It was agreed to by COAG in December 2008 and took effect from July 2009. The Australian Government and all state and territory governments are signatories to the agreement, which declares as one of its objectives that Australians ‘receive appropriate high quality and affordable hospital and hospital-related care’ (COAG 2008d, p. A-4). The agreement is intended to improve the efficiency of service delivery in the public hospital sector, while also reflecting the community service obligations of small and regional hospitals.

Among the changes, the agreement proposes a range of measures designed to:

- move towards activity-based funding in public hospitals
- reduce average waiting times for elective surgery
- improve access to rehabilitation, post-acute and transition care services
- improve the quality of data on services to non-admitted patients
- improve comparative assessment of the public and private hospital sectors
- increase levels of informed financial consent for private patients in both public and private hospitals
- increase hospital quality and safety by building on the priorities of the ACSQHC.

Although the NHA reforms are primarily applicable to the public hospital sector, measures to monitor the progress of the NHA objectives will apply to the private hospital sector where relevant (COAG 2008d). Further details on the NHA are provided in appendix B.

The National Partnership Agreement on Hospital and Health Workforce Reform, agreed to by COAG in 2008, sets specific measures for the public hospital sector to:

- introduce a nationally consistent approach to activity-based funding (starting development in 2009-10 and implementation in 2013-14)
- improve health workforce capability and supply
- enhance the provision of sub-acute services
- relieve pressure on emergency departments (COAG 2008e).

Among the key budgetary measures to support the two agreements, COAG agreed to the following funding allocations:

- \$60.5 billion as a Specific Purpose Payment to the states to facilitate the objectives of the NHA
- \$750 million as a National Partnership (NP) payment in 2008-09 to relieve pressure on public hospital emergency departments
- \$500 million in 2008-09 to provide 1600 more sub-acute care beds
- \$1.75 billion as an NP payment over five years from 2008-09 to expand training programs — especially in regional hospitals — in addition to funding by state governments (COAG 2008b).

The total funding package delivered to the states as part of the NHA represents an increase of \$22.4 billion compared to the previous Australian Health Care

Agreements. The funding is targeted to facilitate higher throughput in public hospitals, with public statements suggesting the extra funding will enable 370 000 more separations, 350 000 more emergency department presentations and 2.5 million more outpatient services over four years from 2008-09 (COAG 2008a).

National Health and Hospitals Reform Commission

In June 2009, the NHHRC presented a suite of recommendations to the Australian Government proposing, among many changes, a redesign of the funding and governance arrangements of the health system, higher standards of service delivery, expanded clinical training programs and improvements in the reporting of hospital performance indicators (NHHRC 2009). Among an extensive list, the NHHRC specifically recommended:

- the use of activity-based funding for both public and private hospitals, covering inpatient, outpatient and emergency services
- the use of National Access Targets to ensure timely access and safe care in hospitals
- data reporting requirements for both public and private hospitals
- that a greater share of responsibility for the funding and delivery of health services be transferred from the states and territories to the Australian Government.

Although the recommendations of the NHHRC are largely consistent with the NHA — including the move towards activity-based funding to drive higher efficiency — some distinct changes in funding and governance arrangements are proposed. The NHHRC's recommendation that the Australian Government assume full funding responsibility for public hospitals over time would introduce a more centralised approach to health services, compared to the NHA's more collaborative Commonwealth–State approach.

Also distinct from the NHA, the NHHRC proposed a new model for health care in Australia more generally, called Medicare Select, which would build on the existing Medicare scheme. Under this new model, all patients would be covered by a 'health and hospital' plan to access their universal service Medicare entitlements, but given greater flexibility to switch to a private provider without forgoing their Medicare entitlements. The proposed new model is intended to promote greater competition between public and private health service providers, thereby improving resource efficiency.

The recommendations of the NHHRC report are currently under consideration by the Australian Government.

Private health insurance

Currently, around 45 per cent of Australians have private health insurance, which is a relatively high rate compared to most other OECD countries (OECD 2003; PHIAC 2009c). There are a number of possible reasons for Australia's high rate of coverage, including the desire for security and peace of mind expressed by those who choose to take out insurance coverage (ABS 2009b). Australia's high rate of private health insurance coverage can also be attributed, in part, to three policy measures: the Medicare Levy Surcharge, the Private Health Insurance Rebate and Lifetime Health Cover. These measures are intended to encourage those with the capacity to pay for their own private health insurance to do so, particularly at a younger age, and to maintain their membership throughout their lifetime. These policies are based on the principle that healthcare fees should be aligned, to some degree, to patients' capacity to pay. By encouraging the take-up of private health insurance, these policies are also intended to help relieve demand on the public hospital sector.

As part of the 2009-10 Budget, the Australian Government proposed a reduction in the rebate for high income earners, on the rationale that the existing scheme disproportionately favours high income earners and demands unsustainably high levels of government funding¹ (Australian Senate Community Affairs Legislation Committee 2009). In 2007-08, Australian Government expenditure on private health insurance rebates across all health services amounted to \$3.6 billion, representative of a 16 per cent increase from the preceding year (AIHW 2009c). If the proposed rebate reduction does affect private health insurance membership rates, it may redirect some patients from private to public election status and consequently shift demand for certain hospital services such as elective procedures. However, the Australian Treasury estimated that the proposed changes would not significantly reduce private health insurance membership (cited by Australian Senate Community Affairs Legislation Committee 2009). Other analysts have commented that that Treasury's estimates may be understated (Access Economics, commissioned by CHA, 2009).

The NHHRC proposed that the role of private health insurance should be examined alongside its proposed healthcare model, focusing on the way in which private

¹ This includes rebates claimed through the taxation system and rebates paid directly to health insurance funds which allow them to reduce premiums.

health insurance would complement the new system of ‘health and hospital plans’, and the potential impact of the new model on the viability of private health insurance membership and expected premiums (NHHRC 2009).

FINDING 4.1

Although there is significant diversity within and across the public and private hospital sectors in Australia, there are a number of key similarities between public and private hospitals that enable and encourage comparison between the sectors. It is acknowledged that there are some differences in the activities undertaken by public and private hospitals and that the sectors do not always service a comparable patient population, which makes comparisons more difficult.