

Response to

Productivity Commission Discussion Draft Report : Public and Private Hospitals

As suggested in some submissions, there is room for public, not-for-profit private, and private hospitals to operate in a complementary fashion, particularly as there is certainly no shortage of individuals seeking healthcare. Thus, the significance of competitive neutrality could be minimised by taking a big-picture, industry-wide view of the issues.

Many submissions have pointed out, quite correctly, the difficulties and risks in making decisions based on incomplete or inadequate data such as that currently available, however it is also recognised that there is substantially increasing pressure on the health system, and that a start must be made to review and where possible improve its performance in all sectors, even though complete data are not available.

The submission by NSW Health , recognised by the Commission on page 257 of the Draft Report (Section D.6) that the cost comparisons confuse UCC with accounting profit is a fundamental issue to this cost based analysis of public and private Hospital performance. The differences in cost and revenue streams between the public and private hospitals has been given acknowledgement, but seriously incomplete analysis. This will certainly bias efficiency measures in different areas, sometimes favouring the public, and sometimes favouring the private hospitals.

By all means, strive for a useful comparison of the public and private hospital performance indicators, but be sure that all inputs and costs are properly accounted for, or their influence, if unable to be accurately measured, is flagged.

The Terms of Reference of the Commission for this study specifically refer to a requirement to “take into account the costs of capital, FBT exemption, and other relevant factors.”

I submit that the final part of this term of reference, the “other relevant factors”, broadens the scope of the Enquiry to the extent that a thorough analysis would be very difficult to achieve in the timeframe provided, and that therefore it is understandable that the Draft Report does not include an exhaustive analysis of the cost and revenue components applicable to public and private hospitals.

Comment on Appendix D.5

Data on the use of capped FBT exemption across public hospitals in NSW is collected by NSW Health, but is not readily available to individuals. However, anecdotal evidence suggests that there is wide variation in uptake between different institutions, possibly due to marketing or “menu” issues. This variability casts doubt on the stated assumption that use of the capped exemption is the same across public and private not-for-profit hospitals, and theoretically the same if the benefit were available to “for-profit” private hospitals.

The analysis and attribution of the value of the FBT benefit also fails to take into account a number of pertinent factors. [Please note that as a member of the public, who is not an accountant, my understanding of the issues is not comprehensive].

Response by Mark Hanlon to the Productivity Commission Draft Report on Public and Private Hospitals
November 5th, 2009

In NSW Public Hospitals, the benefit from tax saved by Salary Packaging is split with 50% going to the employer. Further, the employee pays the administration fee for salary packaging. This further diminishes the benefit to the employee, reducing any notional effects on competitive neutrality. It also means that the reduction of private hospital labour costs by 0.7% is incorrect.

The Commission has indicated that it has not considered the value of uncapped FBT exemptions. However, these also show variability between different public hospitals, and across different occupations and socioeconomic groups. For example, The Children's Hospital at Westmead charges a visitor parking fee that is approximately three times the rate charged at the adjacent adult hospital.

The Commission also has not commented on the strategic value of investment in labour, job creation, by the public sector. State governments would have to divert more funds for job creation if public hospitals paid payroll taxes. The concept of a Government taxing itself, eg through payroll tax, is bizarre ! The investment offset, in order to maintain employment levels, has to be taken into account in any analysis of the social benefits of the exemption from payroll tax of public institutions – certainly any employment in the private sector is efficiency and cost-effectiveness based.

Extract from two submissions in particular tend to contradict the private sector submission that FBT exemption creates a competitive advantage for the public hospital employers :

“The attraction of better financial rewards and conditions in the private sector has resulted in surgeons and other proceduralists moving increasingly or exclusively to the private sector.” (*A Healthier Future for all Australians*, NHHRC Final Report, June 2009, p. 51)

And :

(a) In the 'comparable' group, the **costs of allied health services are not in fact comparable across the sectors**. They are all included in the public hospitals, but in the private hospitals they are provided by private professionals who bill the patients directly, in the same way that doctors do. Some of those costs (usually about half) are reimbursed by the private health insurance funds under their 'general' or ancillary benefits, but there is no way to identify the in-hospital component of those benefits with current data.

Not all of the revenue sources for public hospitals appear to have been disclosed by NSW Health. As previously indicated, the Children's Hospital at Westmead benefits by charging more than a million visitors a year a parking fee 3 times higher than that of the adjacent adult hospital. Hospitals, public and private, benefit from unofficial subsidies based more on the relationship between the commercial supplier and the procurement officer, than on strict cost evaluation. Such relationships in the rail transport sector have recently attracted public attention, and it is only a matter of time before these informal arrangements between health providers and health manufacturers come to the public attention in a similar way, as is happening overseas in regard to the relationship between certain types of surgeon, and the medical supplier, Medtronic.

This is not to say that these relationships are corrupt, nor that benchmarked consumer charges are not unreasonable. However, some institutions benefit more than others from commercial relationships despite all of the anti-fraud and anti-corruption policies currently in place.

I would also suggest that, however inadequate the existing reporting arrangements may be, they should not be abandoned until more appropriate measures are adopted and implemented.

For as long as the genuine data collection does not provide a true reflection of costs and revenue in relation to outputs of private and public hospitals, the status quo should remain.

The intention of this enquiry into the comparative efficiency of public and private hospitals is admirable, and something that all, whether employees or users of the system, would endorse. However, it is important that critical and lasting decisions should not be based on incomplete information. In particular, any changes to the systems currently in place, whether these relate to the Medicare surcharge, or to the application of specific taxes or levies, must be evidence-based.

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