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RACP Submission: The growth of private patients in public hospitals

September 2017

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to comment on the Australian government's paper on 'Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals' (the Options Paper). The RACP is the largest specialist medical college in Australasia and trains, educates and advocates on behalf of more than 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand; the majority of whom work in public and private hospitals and therefore have direct experience of this matter.

The Options Paper highlights that:

- the growth in privately insured hospital episodes in public hospitals over 2011 to 2015 (9.2%) exceeds that of privately insured hospital episodes in private hospitals over the same period (5.3%)
- there has been a rising share of public hospital separations funded by private health insurance (PHI) in all States and Territories and nationally at least since 2011, and;
- the growth of private patients in public hospitals in recent years now exceeds the growth of public patients in public hospitals.

The Options Paper draws a link between these trends and two issues:

- Recent data released by the Australian Institute of Health and Welfare (AIHW) shows a median waiting time of 42 days for elective surgery in a public hospital for public patients compared to 20 days for private patients. It is implied that this disparity in waiting times might indicate the development of a two-tiered system in the public hospital system, with private patients receiving preferential treatment.
- It is argued that the growth in numbers of private patients is contributing to increases in PHI premiums, and indeed has led to 2016 PHI premiums being 2.5% higher than they otherwise would be.

The RACP's view is that the potential link between these issues is not at all clear. More data and analysis is needed to better understand these issues and their causes.

Public hospitals need to be sufficiently funded to provide the care that is needed by the populations they serve and the current system in place recognises that they secure funding from a range of sources. Any change to one source of funding would therefore have an impact on these services, and it's important that this be recognised and taken into account with any proposed reforms.

We fully support the principle that healthcare funding structures need to be neutral in terms of any influence on patient status and ensuring they receive the care they need; they should not have adverse consequences of incentivising provision of care to one particular group at the expense of another. We therefore support further work by the Independent Hospital Pricing Authority (IHPA) in cooperation with the Australian jurisdictions to better understand the issues involved and advise on policies to achieve this principle of competitive neutrality. Our submission expands on these points.

We also wish to highlight that this is an extremely complex area and urge that appropriate consultation is undertaken on any proposed changes. The RACP would appreciate being involved in further consideration on this matter.

Is the growth of private patients in public hospitals contributing to a two-tiered healthcare system?

The RACP is committed to the principle of equitable access to healthcare. As the public hospital system was established to achieve this aim, we would be significantly concerned if there was evidence that this was being undermined with patients who elect to be treated as private being given preferential access to public hospital services.

However, while the AIHW data cited certainly warrants further investigation, this data is the first time that AIHW has presented a breakdown of waiting times in public hospitals by private versus public patients. It is not clear from data on just one year whether this is an ongoing trend and, if it is, what the causes might be. It

is not at all clear that the disparity in waiting times for private versus public patients in the public hospital system is necessarily solely or primarily the result of a growth in patients who elect to use their PHI being privileged over patients who elect not to use their PHI.

It is important that further work be undertaken to fully explore more data on this matter, and consider all possible drivers of any disparity. For instance, it is possible that other aspects involved are the result of systematic diagnostic (and other) differences between patients who elect to present as private compared to patients who do not.

There are a small number of studies that show a disparity in waiting times between public and private patients in public hospitals, however these question the size of the difference and its impact on patient outcomes.

One study based on a year's worth of data on elective surgery in NSW found evidence of a waiting time gap even after taking account of clinical need, though the disparity was lower the more urgent the need for surgery.¹ However this study concluded that even if admission rank was based solely on clinical status, this would only lead to a trivial reduction in the waiting times of public patients.

Another study, based on the same data, concluded that private patients with similar clinical needs tend to be assigned higher urgency of admission and have more hours of ICU and more procedures performed during the hospitalization.² However this study also found that the waiting time disparities did not result in any significant disparity in terms of health outcomes.³

Thus it needs to be explored whether, in non-emergency cases, clinicians may prioritise private patients if in their clinical judgement this is unlikely to result in different health outcomes.

Nonetheless the results of these studies should be interpreted with caution, as they are based on one year of data for elective surgery. More studies are needed looking at broader and longer-term data to ensure important public health policy decisions are made based on solid evidence and in-depth consideration of potential adverse consequences..

Is the growth of private patients in public hospitals leading to increased PHI premiums?

The Options Paper argues that 2016 PHI premiums are higher than would be the case if the rate of growth of private patients in the public system was the same as in private hospitals over the period since 2011. However this assumes that the additional patients who elected to use their PHI in the public system could have easily substituted for a private hospital bed without any change in the effectiveness or quality of treatment received. In reality there may be more complexities involved.

Some of our members who work in both the public and private hospital systems have experienced cases where public hospitals were more likely to adhere to 'best practice' care paths (which would be associated with shorter lengths of stay). Due to the historical evolution of Australian healthcare, each system plays to different strengths and this means that public hospitals are more efficient than private hospitals in some settings. Thus it would be wrong to assume that there would be lower claims on the Health Funds if all the patients that elected to be treated privately in public hospitals were moved to the private system. This would be strongly affected by the conditions being treated by the public hospitals. For instance, there is strong evidence that patients with higher disease severity tend to get transferred from private to public hospitals while eligible patients with lower disease severity tend to be moved into the private system⁴. For a significant share of patients who elect to use their PHI, they may have no alternative other than to seek the treatment they need in the public system. This may include rural and remote patients or patients requiring paediatric services.

¹ Johar M, Savage E. Do Private Patients have Shorter Waiting Times for Elective Surgery? Evidence from New South Wales Public Hospitals. *Economic Papers: A journal of applied economics and policy*, 29: 128–142.

² Shmuelia A, Savage E. Private and public patients in public hospitals in Australia. *Health Policy* 115 (2014) 189–195.

³ Shmuelia A, Savage E. Private and public patients in public hospitals in Australia. *Health Policy* 115 (2014) 189–195.

⁴ Cheng TC, Haisken-DeNew J, Yong J. Cream skimming and hospital transfers in a mixed public-private System. *Social Science & Medicine* 132 (2015) 156e164.

Is 'cost shifting' the main driver for the growth of private patients in public hospitals?

The Options Paper presupposes that 'cost shifting' is the main driver for the growth of private patients in public hospitals. There are two threads to the cost shifting argument presented in the Options Paper:

- Firstly there is concern that current Commonwealth activity based funding (ABF) of public hospitals does not sufficiently account for the additional revenue that public hospitals obtain from private patients via health funds e.g. commercial mark-ups for prostheses and accommodation charges above the default PHI bed day rates. Thus it is argued that existing private patient adjustments (PPAs) to ABF as defined by IHPA leave too great a difference between total payments received from private patients (after taking into account both the contribution of Commonwealth ABF and health fund payments) and payments received for public patients. This creates an incentive for public hospitals to enrol as many of their patients as possible as private.
- Secondly there is the concern that **even if** existing IHPA private patient adjustments were sufficient, some service level funding agreements between State and Territory governments and Local Health Networks do not implement any or sufficient PPAs. This means in effect that overall, public hospitals in these jurisdictions get more total payments per private patient than they do per public patient. In support of this contention, the Options Paper cites IHPA commissioned research which documents at least four jurisdictions which engage in these practices. The same IHPA commissioned research has also documented cases where public hospitals have employed people with the main responsibility of signing up and billing private patients.

It seems clear from this that cost shifting is responsible for some of the growth of private patients in public hospitals. Hospitals are under significant funding pressures and given that funding can come from three different sources (Commonwealth, State and private health funds), it is understandable that they leverage all available funding sources to enable them to provide the care needed by their patients.

Nevertheless the strength of existing incentives, especially for some States, to encourage more patients to elect to be treated privately in public hospitals does not necessarily make this the sole or even main driver of recent increases in private patient enrolment. There may be legitimate reasons, some of them clinically based, why patients are increasingly electing to be treated privately.

While State hospital initiatives to raise awareness of the option to be treated privately may be enticing more patients to elect to do so, it may be that patients choose this option because of benefits other than 'jumping the queue', such as private rooms, or to exercise the choice to be treated by a particular doctor.

The significantly higher growth of private patients among those admitted via emergency status (compared to elective status) could indicate that 'cost shifting' is a driver, but may also reflect demographic changes in combination with the restricted capabilities of the private system. In the experience of some geriatricians, many private hospitals have limited capacity or lack the special facilities needed to admit frail aged patients or patients with dementia or delirium either electively or urgently. The increasing incidence of complex and multiple morbidities associated with the ageing of the Australian population may therefore be resulting in more of such patients being channelled into the public hospital system, coupled with their desire to utilise their private cover.

Further analysis is needed to determine the extent to which these population pressures may be contributing to private patient growth in the public hospital system. Suppressing private demand in these cases may be counterproductive and lead to a further diminution of the value of PHI coverage, leading to a further drop-off in PHI coverage.

Options analysis

All the options presented in the Options Paper have the effect of suppressing the growth of private patients in the public hospital system and reducing the value of existing PHI policies to their holders, insofar as they impose limits, whether directly or indirectly, on the situations under which policyholders will be able to claim PHI benefits.

It is important to recognise that suppressing or capping the growth of private patients in public hospitals will have implications for the capacity and resourcing of the public hospital system. In particular, many specialists

rely on private practice income earned in public hospitals to supplement salaries to a competitive level. Sometimes this private income is shared with hospitals and may go to special purpose funds for work related costs such as indemnity insurance and membership fees. Based on the experience of our members, we understand that this private patient income is also used to fund further research, training and education initiatives, which ultimately contributes to the productivity and effectiveness of the clinical workforce.

Therefore, any reductions in private practice sourced income in public hospitals may have the following potentially adverse consequences:

- It may result in the public hospitals being less able to recruit and retain qualified staff, thus reducing availability and proximity of suitably qualified specialists to the public hospital system
- Public hospitals may face additional funding pressures and may have to cut back on research, training and education, among other valuable forms of investment which currently contribute to the safety, quality and effectiveness of the public hospital system.

There are some differences between these five options in how they achieve these effects but the ultimate effects are not in question:

- Under Option 1, the incentive for patients to elect to be treated privately is reduced by restricting the claim to only medical costs and excluding other costs. Theoretically public hospitals can then recover non-medical costs directly from the patient. In practice this is likely to lead to fewer patients electing to be treated privately.
- Under Option 2, the incentive for patients to elect to be treated privately is reduced because hospitals will be required to collect any excess payable by the patient. While theoretically this measure also does not directly cut into hospital revenues (and in fact mandates them to collect more) in practice the waiving of out-of-pocket costs is a significant incentive for patients to elect to use their PHI in the public hospital system. Again, this is very likely to reduce the number of patients electing to be treated privately. Unlike the other options, this one works through intervening directly through the governance of public hospitals rather than through the changes to PHI product design which characterises Options 1, 3 and 4.
- Under Option 3, all patients admitted to public hospitals through the emergency department would not be allowed to elect to be treated privately at all. This option directly reduces the value of PHI. There is also the potential that this may pose a risk to patient health if it results in patients delaying going to ED and instead seeking alternatives where they can use their PHI.
- Under Option 4, no benefits would be paid for those public hospital services assessed as having no (or limited) choice of doctor. Option 4, like Options 1 and 3, intervenes directly into PHI product design but seems to be the most complex of the product design interventions as it would require appropriate definitions of which hospital services involve genuine choice of doctor.
- Under Option 5, IHPA and the States would need to work together to ensure that
 - o IHPA's private patient adjustment ensures more substantive revenue neutrality between Commonwealth payments for public patients and private patients
 - o State ABF is harmonised with Commonwealth ABF so that Commonwealth private patient adjustments are also reflected in State private patient adjustments.

Of the five options presented, Option 5 would involve the most long term commitment and coordination. Also of all the options presented, it is the only one that does not involve direct interference with or regulation of either PHI product design or hospital governance. Instead, it directly addresses the key reason for cost shifting incentives. Thus insofar as cost-shifting is one of the drivers behind the growth of private patients, Option 5 is the best tailored response for addressing cost-shifting.

In principle the RACP supports Option 5 insofar as it has one important benefit that is not associated with the other four options; namely that the amount by which it attempts to reduce private patient growth would be properly calibrated and principle-based to reflect the ideal of competitive funding neutrality between public and private patients. We support this important principle of competitive neutrality as consistent with support for the broader principle of universal access to healthcare. The methodologies used to achieve this calibration should ideally be open and transparent and subject to periodic evaluation and review through IHPA and other inter-governmental consultations.

The other benefit of Option 5 is that because it requires a longer term process, it allows for a more considered process of deliberation before any far-reaching changes are made. This in turn would support a greater

likelihood of avoiding the unintended consequences already described. Thus on balance we support progressing towards Option 5 as a means of addressing the issues raised by the growth of private patients in public hospitals. At the same time, we reiterate that more analysis is needed to properly establish whether the recent data does indeed reflect a growing trend and the links between any trend, increases in PHI premiums, and waiting times for public patients.

Summary and recommendations

Substantially more research is needed to be able to truly understand whether there are links between the recent growth of private patients in the public hospital system, waiting time disparities between private and public patients, and recent upward pressures on PHI premiums. While the Options Paper presents a prima facie case for concern, there may be alternative explanations for some of these trends. For instance:

- waiting time disparities between public and private patients in the public hospital system may be the result of systematic differences between patients who elect to present as private compared to patients who do not
- the growth in emergency admissions of private patients into the public system may be partly driven by the increasing incidence of complex and multiple morbidities associated with the ageing of the Australian population and the lack of sufficient private facilities to accommodate this type and size of demand.

Suppressing the growth of private patients in public hospitals without fully understanding the causes can lead to unintended consequences including:

- increased cost of care and poorer health outcomes if there are insufficient private facilities to meet the needs of patients with complex and multiple health needs who would have been better treated by the public hospital system
- a further reduction in the value of PHI policies leading to further reductions in PHI coverage, especially for those patients who do not have easy access to private health facilities
- public hospitals being less able to recruit and retain high-quality staff, thus reducing availability and proximity of suitably qualified specialists to the public hospital system
- public hospitals facing additional funding pressures and having to cut back on research, training and education.
- More generally, from a combination of the two previous points above, adversely affecting the ability of public hospitals to deliver the level of services required by the populations they serve at current levels of safety, quality and effectiveness.

In principle, to address the issues raised in the Options Paper, the RACP supports Option 5 because it facilitates a principles-based process for achieving competitive funding neutrality between public and private patients. We support this important principle of competitive neutrality as consistent with support for the broader principle of universal access to healthcare.