Grattan Report: Mythbusters

The Grattan Report 'Saving private health 1: reining in hospital costs and specialist bills' makes some claims regarding private health care that do not stand up to scrutiny. There are also glaring inconsistencies between this repot and 'Saving private health 2: making private health insurance viable'.
Below are some of the myths accompanied by the facts.

Myth: The report claims that the major driver for increase in benefit outlays is increases in hospital payments – accounting for almost two-thirds of the increase.

Busted: Private hospital payments account for almost two-thirds of total benefit outlays from hospital insurance, so they would be expected to account for two-thirds of the increase. In 'Saving private health 2: making private health insurance viable' the report states that "Ageing is the most important factor in premium growth."

The report ignores that fact that in the past ten years there have been significant technological advances in health, such as robotic surgery that have delivered benefits to patients. Treatments and surgeries are now routinely provided successfully to patients who would have been considered untreatable only a few years ago. However, 'Saving private health 2: making private health insurance viable' says: "Australians are using the health system more as they get access to new technologies, treatments and services."

By looking at increases over decade, the report ignores the fact that private hospitals are already driving efficiencies just at the time when the age and complexity of patients has been increasing.

- The average length of stay in the private hospital sector has decreased by 20 percent[1].
- The complexity of overnight patients in private hospitals has increased by nine percent[2].
- Total expenditure per separation has increased in real terms by just three percent over the decade as whole and has in fact decreased in real terms in five of those years.
- In the year ending Monday 30 September 2019, private health insurance benefits paid to private hospitals increased four percent but this was entirely due to increased utilisation. The benefit paid per separation actually decreased in real terms[3].
- Expenditure growth in the public hospital system was 4.2 percent in real terms over 2014-15 to 2017-18. In the private hospital system it was only 2.6 percent.

Costs have increased but so have health outcomes for patients and cost increases would have been much worse if hospitals were not already driving efficiencies year on year.

Myth: There are no incentives for private hospitals to improve efficiency or quality. Grattan report: p9

Busted: The report ignores the fact that vast majority of private hospitals contract with health insurers to provide services on a 'case payment' basis. This means that for a set benefit paid by the insurer, the hospital must provide for all of the patient's care even if the patient needs to stay in hospital for longer than

[1] AIHW Health Expenditures, Private Hospital expenditure by source of funds and AIHW Admitted Patient Care (various years)
[2] AIHW Admitted Patient Care (various years)
[3] APRA

planned. Contract hospitals, sometimes referred to as 'members choice' hospitals, cannot pass hospital costs onto patients. The only out-of-pocket charge they can raise is the 'excess' charge that has been agreed to by the member and their health insurer.

Contracts are renegotiated every two-to-three years giving insurers the opportunity to press for savings and increased efficiencies. Some health funds also apply penalties incentivising private hospitals to ensure the best quality care.

On top of this, private hospitals know that patients are free to choose and doctors are able to recommend that patients be admitted to other private hospitals. For this reason most private hospitals publish safety and quality data on corporate websites and on MyHospitals.gov.

Finally, private hospitals must also compete against an alternative perceived to be 'free' at the point of care – public hospitals.

Myth: Private hospitals need to be more efficient – saving $1 billion. Grattan report: Chapter Three.

Busted: This chapter seeks to assert that private hospitals are less efficient than public hospitals and they need to be made to be more efficient. First, the analysis fails to show that private hospitals are less efficient. Second, the report falsely assumes that a reduction in private hospital lengths of stay would produce the savings claimed.

By the authors' own admission, their analysis is incomplete and 'has drawbacks'. By focusing on length of stay as a proxy for cost, this analysis ignores other drivers of efficiency including theatre utilisation and capital investment. In fact, the report acknowledges 'there may be dimensions of efficiency where private hospitals are more efficient than public hospitals", but for some reason did not include them in the report.

<u>Ignoring capital costs</u>
This chapter focuses on recurrent costs but capital costs also need to be taken into account. The private sector meets both the costs of capital investment and the costs of providing services. In the public sector infrastructure is paid for by capital funding from government, on top of the funding paid to meet the costs of treating patients. This report ignores the impact of public sector capital costs – another instance of comparing apples and oranges. The private hospital sector provides 34,300 licensed beds, a resource that would cost taxpayers more than $34 billion to replicate in the public sector.

<u>No valid comparison</u>
This analysis also fails to establish a valid comparison between public and private sector efficiency. It is really difficult to compare public and private sectors. This data does not tell the whole story. This analysis takes no account of key differences between public and private sector data and between data from different states.

- In the public system patients can be transferred to 'out-patient clinics' or 'hospital in the home' meaning that their on-going care does not show up in this data even though they are still being cared for by the hospital.
- Some public patients have very short lengths of stay because they are transferred out to another hospital either because they need a higher level of care or to shift them to a smaller hospital to free up beds in the higher level facility.
- The analysis differentiates between cases with catastrophic complications and the rest but falls to acknowledge that even when there are no 'catastrophic complications', there are still many reasons why some patients need to remain in hospital.
- The analysis uses presence of other diagnoses on admission to measure 'within-DRG complexity'. This is a measure which is known to be under-reported in the private sector because this information is collected by doctors prior to the patient's admission but it is not part of the data

collected by the hospital. Public hospitals have a financial incentive to record as much 'complexity' as possible – a practice known as 'up-coding' - while private hospitals are paid only for the treatment they provide.

- The analysis fails to differentiate between 'care-type', meaning acute and sub-acute episodes are not differentiated even though these have different length of stay characteristics.

Are public hospitals discharging patients too soon?

Efficiency must be matched with quality. If patients are discharged too soon they are at higher risk. Australian Institute of Health and Welfare (AIHW) data shows that two percent of public hospital hip-replacement patients have an unplanned readmission within 28 days[4]. In the private sector, this risk is halved and around 70 percent of hip replacement patients are well enough to be discharged straight home. Therefore, rather than indicating greater efficiency, shorter length of stay in public hospitals may indicate patients being discharged too quickly.

No savings in reducing length of stay

The report inaccurately assumes a reduction in private hospital lengths of stay would produce the savings claimed because of the weaknesses in the analysis already detailed above but also for the following reasons:

- Private health insurers pay for the majority of private hospital care on a case-payment basis. This means there is already a strong financial incentive for the private hospital to ensure that length of stay is as short as possible. The effectiveness of this incentive is reflected in the progressive reduction in average length of stay over time and the factor that 70 percent of acute private hospital services are provided on a same day basis[5].
- Most of the costs occur at the start of the hospital admission meaning that savings are not directly proportional to the percentage of days reduced. This is particularly so for surgical admissions which account for 40 percent of private hospital separations.
- Even when private health insurers pay for hospital services on a per diem basis, 'step-down' rates are calibrated to reduce after a set number of days. Again savings would not be proportional to the percentage of days reduced.
- For most DRGs, including the two examples cited in the report – hip replacement and obstetrics – the short lengths of stays provided by the public hospital mean that public hospital services invest additional resources in providing pre-admission clinics, outpatient clinics and home-based services to patients after discharge. Hip replacement patients are transferred to hospital-in-the-home, age-care equivalent care and non-admitted rehabilitation. New mothers discharged quickly from public hospitals attend outpatient clinics or receive home visits from midwives who provide education and support and ensure that mother and baby are well. In the private sector, these services are provided prior to discharge. Any marginal savings achieved by a shorter length of stay in private patients would need to be reallocated to post-discharge services not currently paid for by private health insurers – a point acknowledged on page 27 of the report.

Finally, if savings of nine percent in hospital benefits were obtainable, an estimate which APHA disputes, this would only be obtainable from the benefits paid to overnight private hospitals (i.e. not to day hospitals or public hospitals) – based on benefits paid for the year ending September 2019, this would at most yield a hypothetical saving of only $835 million, not the $1 billion suggested in this report.

The potential savings might that accrue from delivery of services on a same-day basis combined with necessary pre-admission and post-discharge care services however cannot be generalised across private hospital sector services as a whole and the estimates provided in this report are exaggerated.

[4] AIHW Admitted Patient Care

[5] AIHW Admitted Patient Care

Myth: Low-value care in private hospitals: "There is a higher incidence of low-value or unnecessary care in private hospitals'. Grattan Report: p38.

Busted: The most important thing to know is that the data cited is old and predates the introduction of the Choosing Wisely Australia campaign.

Choosing Wisely Australia was launched in 2015. Research in the private sector cited by the Grattan Institute relies on data from 2010 to 2014. The number of private patient knee arthroscopies performed in Australia has declined by 36 percent since then, from more than 58,000 to 37,000[6]. More up-to-date data released by the Victorian government shows that knee arthroscopies for people over 50 take place in public hospitals in Victoria at four times the rate of private hospitals[7], demonstrating the Grattan Institute assertions are false.

Key recommendations from the MBS Review initiated by the Federal Government are only now in the process of being implemented. Changes introduced on Sunday 1 December 2019 restricting the circumstances in which a colonoscopy can be funded through the MBS (and by implication by private health insurance) will progressively change clinical practice over the next five years as time-based restrictions come into full effect. Most of the clinical sub-committees responsible for MBS services delivered in the private hospital sector have yet to provide final recommendations to the Federal Government.

To say that rehabilitation admissions in the private sector are 'low value' or 'unnecessary' because they have grown faster than admissions in the public sector ignores the fact that the two data sets are not comparable. Rehabilitation in the public sector is often counted as a 'non-admitted' service even when it is provided by public hospital service; such services are not included in the data used by this report. Furthermore, growth in private sector separations is the result of a shift to more efficient day programs and growing demand for care.

To propose the private hospital sector should provide no more than 55 or even 80 percent of any elective procedure or that 'about half of all admissions are inappropriate' is by implication to say that public hospital waiting lists should be even longer and to fail to recognise the crucial role of the private hospital sector in the provision of services such as chemotherapy and mental health.

Myth: Single bill: "We propose this 'single bill' approach to be extended to payment to private hospitals". Grattan report: p25

Busted: While the simplicity of a single bill would undoubtedly be attractive to consumers, the report conveniently overlooks the practical barriers to achieving this goal.

Hospitals do not employ doctors. Hospitals are in no position to tell doctors what to charge, neither can they tell them what prostheses to use, procedures to perform, consultations to make or test to order. Specialist doctors apply to private hospitals to be credentialed to use hospital facilities. Hospitals credential doctors to perform procedures within their scope of practice. This means that the hospital has been provided with confirmation that the doctor is qualified to provide an agreed set of services and the hospital has confirmed that it can provide appropriate supports and technology.

In the plans suggested by the Grattan Institute, private hospitals would negotiate with doctors to set the fees they charge. This would mean hospitals are deemed quasi-employers of doctors, which would drive up the indemnity costs of private hospitals and it will drive up premiums.

[6] MBS data
[7] Victorian Agency for Health Information Health system performance: how does Victoria fare nationally and internationally?, 2019

The report fails to identify the legislative mechanism that would force private specialists to negotiate their fees with hospitals. It is settled law in Australia that the relationship between a doctor and a patient is a private contract and the Constitution prevents the Government from regulating doctors' fees.

The report's recommendations regarding prostheses are confused. On the one hand, the report calls on the Federal Government to tender for prostheses and on the other hand the report expects private hospitals to both identify well-priced prostheses and 'resist pressure from specialists'.

Myth: "The $2 billion opportunity". Grattan report: Chapter Six

Busted: The report overestimates the savings potentially available through reduction to overnight hospital length of stay and speculates without showing any rigorous analysis about the savings available from reductions in 'low value care'

What the report mentions only in passing is that 10 percent of the total inflation-adjusted increase is due to public hospitals chasing private health insurance dollars. During the decade analysed in this report, growth in private patients in public hospitals averaged 6.3 percent per annum, a rate of growth which exceeded the growth in private health insurance policy holders and a rate which is only explicable by the aggressive and deliberate policies adopted by State governments. Over the same period the increase in private patients in private hospitals and day surgeries averaged just 3.6 percent. These government policies have set revenue targets for public hospitals and allocated resources to the collection of private health insurance revenue even when the clinical care provided to the patient is identical to that which they would have received as a public patient.

This is a waste of private health insurance benefits – waste which has delivered no benefits to patients.

The report states this practice is 'perverse and contrary to the intent of Medicare' yet makes no attempt to quantify its impact on health insurance premiums or public waiting lists.

Stopping public hospitals from 'harvesting' private patient revenue could save health funds $1.5 billion each year that would result in a six percent reduction on premiums for every health insurance policy holder.

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The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. The private hospital sector treats 4.5 million patients a year, including treatment of a third of chemotherapy, 60 percent of all surgery, 74 percent of all elective musculoskeletal surgery and 80 percent of rehabilitation.