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Public problems: Private solutions? Short-term contracting of inpatient hospital care

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CATHOLIC HEALTH Australia

THE UNIVERSITY OF SYDNEY

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Executive summary

Public patients are routinely being treated in Australian private hospitals. Some jurisdictions have large-scale, planned programs where private or not-for-profit hospitals are contracted by the public sector to treat public inpatients (for example, Queensland's Surgery Connect program). Often, however, 'contracting' is done on an ad hoc or short-term basis where private hospitals are asked, at relatively short notice, to treat public patients in order to relieve pressure on public hospitals.

The findings from this project stem from interviews with 24 senior health executives across Australia. Interviewees were public and private hospital executives and government bureaucrats. All had experience in hospital contracting. The focus of the interviews was their experiences with contracting: why and how contracting arrangements were developed, what worked, what didn't, and what changes to policy and practice were made over time. Interviewees were also asked about their views on the merits of contracting, whether it should be done more often, and if so, what needed to be done to make sure it worked well.

While the views of these senior health executives on this topic were diverse, several clear messages emerged that are pertinent to policymakers working in this area. They are:

- The way we are doing contracting currently in Australia tends to be ad hoc, and this is enormously frustrating to hospital executives in both the public and private sectors. Without greater certainty about the type and volume of patients to be treated, and how long contract arrangements will remain in place, it is unlikely that the full benefits of contracting (such as more timely access to care for public patients, and the more efficient use of resources) will be realised.
- Some private hospital executives are unconvinced of the merits of contracting because they believe it reduces the value of private health insurance and the incentives to develop other private sources of revenue. Their views on contracting raise broader policy questions about the relative roles of public and private hospitals in Australia. These questions need to be addressed if governments intend to expand to use of contracting in the hospital sector.
- State and territory governments (referred to as states) need to develop clear and consistent policies on contracting in the hospital sector. This includes developing fee schedules for different types of services and processes for establishing and negotiating contracts with the private sector. At the same time state-level policies need to be flexible enough to allow local (or regional) health services to make decisions about when, where and how contracting is done in their area. Without significant local level involvement in decision-making, it is difficult to ensure that contracting arrangements between local public and private hospitals (which tend to be more convenient for patients) will work in the longer-term.

Hospital executives have suggested numerous options for reform that have the potential to improve the way we do contracting in Australia. They range from small-

scale reforms, such as contracting over longer time-periods and setting up brokers to facilitate contracting, to larger-scale ones such as establishing contestable funding pools; co-location of public and private hospitals; public-private partnerships; and implementing new hospital financing models (such as Medicare Select). These options, and more, need to be given serious consideration by policymakers if they are to improve the efficiency and effectiveness of our hospital systems.

Contracting in Australian hospitals

Introduction

Public patients are being routinely treated in Australian private hospitals under short-term contracting arrangements. Contracting can be beneficial for public patients if it means they get treated sooner than they would have if they waited for treatment in public hospitals. It can also assist public hospitals address unanticipated surges in demand or reduction in capacity (for example if there is a particularly bad flu season, or if specialist surgeons in a particular area are unavailable for a period of time). There may also be savings for public hospitals if the price paid to private hospitals for contracted care is less than the cost of treating these patients in public hospitals.

Short-term contracting – at least as it currently operates in many parts of Australia – does have some downsides. It can, for example, cost governments more to treat public patients in the private sector if they pay a premium for such care (as they sometimes do). Contracting can also expose governments to criticism that they are channelling funding to private hospitals at the expense of public hospitals, which could do the work if they were given additional funding.

There is also a risk that public patients treated under contract in the private sector will receive fragmented care because clinicians in the two sectors may not be accustomed to working together and do not have easy means of sharing vital information about patient care. Contracting can also have a downside for private hospitals if patients and staff see it as undermining the value of private health insurance, or as a barrier to developing revenue from other private sources.

In this issue brief we do not take a position on the merits of contracting between public and private hospitals. The time for these debates is already over because short-term contracting between public and private hospitals is happening regularly in many states and territories. The purpose of this issue brief is to draw on the knowledge of senior health executives who have experience with short-term contracting and highlight some of the ways in which contracting arrangements could be changed so that they deliver better outcomes for patients, providers and the health system.

The context and influences

Why has short-term contracting in Australian hospitals emerged as an important issue? In the following sections the factors that have influenced its emergence are examined.

Australia's hybrid health system

Australia's health system has always been marked by its complicated mix of public and private funding and service delivery. Roughly two thirds of funding comes from

governments and a third from non-government sources, including individuals, private health insurance funds and injury compensation schemes. About two thirds of health services are delivered by the private sector – ranging from multinational hospital groups, through to general practitioners in sole practice.

This complexity is seen in the financial flows between the sectors. The Commonwealth Government subsidises private health insurance by providing rebates and, through Medicare, pays part of medical fees in private hospitals. Private health insurers pay for patients who elect to go 'private' in public hospitals.

For most of the twentieth century, private hospitals were either small, often clinician-owned operations or more comprehensive organisations run by Catholic and other religious bodies. Since the 1980s the scale and scope of private services has been transformed by the emergence of large for-profit hospital groups, starting with Mayne Health and more recently dominated by the publicly listed Ramsay Group and Healthscope. At the same time, private day clinics have transformed surgical practice.

The Productivity Commission has offered a simple definition of each sector – based on ownership.[1] A public hospital is:

> *'a health care provider facility that has been established under state or territory legislation as a hospital or as a freestanding day procedure unit. Public hospitals are operated by, or on behalf of, the government of the state or territory in which they are established. Public hospitals provide hospital services free of charge to all eligible patients'.*

A private hospital is 'privately owned and managed, charges for services rendered, and offers patients choice of doctor'.[2]

There are some clear differences between the sectors. Importantly, patients in private hospitals have a shorter average length of stay per separation than patients in public hospitals. This appears to be because surgical procedures in private hospitals have shorter associated patient stays than other groups of patients. This reflects the different casemix; private hospitals undertake relatively more surgical procedures than public hospitals.[3] As some specialist services, such as ophthalmology and oncology, have largely moved to the private sector, people without private health insurance have been left in longer waiting lists in the public sector.

As a result, the lines between public and private hospital services are blurred. A 2009 Productivity Commission review identified this confusion. It reported that the two sectors were 'complementary' providing distinct services that supplemented one another. However, it also noted that the two sectors share many similar functions, compete for staff, and offer

[1] Productivity Commission (2009), Public and Private Hospitals, Canberra.
[2] Ibid
[3] Ibid

many services that are 'substitutable'. While they have a 'markedly different casemix', their boundaries are blurred and they are effectively 'interdependent'.[4]

This confusion has been exacerbated by the failure of successive reforms of the health system to deal with the question of intersectoral relations. The 1991 National Health Strategy, launched at the beginning of the expansion of for-profit hospital groups, complained that the two sectors 'remain separate entities' and 'tend to be planned and financed in isolation', suggesting that this must lead to inefficiencies. The consequences – and remedies – were left unclear.

Past health reforms have avoided dealing directly with this mixed economy of hospital provision.[5] The Howard government focused on boosting the viability of private hospitals by encouraging private health insurance. The 1999 Productivity Commission study of private hospitals lamented the narrowness of its terms of reference, which blocked any consideration of the whole system. Despite these restrictions, it suggested a few (unheeded) changes to increase efficiency, such as opening up opportunities for private hospitals to do contracting work to relieve pressure on the public system.[6]

The Rudd and Gillard governments concentrated on the funding and governance structures of the public sector. Calls from the National Health and Hospital Reform Commission to build reform around better integration of a strong mixed public-private system fell on deaf ears.[7]

Consequently, formal relations and cooperation between public and private hospitals owe little to broader reforms of hospital funding and service delivery.

At a national level, the Department of Veterans Affairs contracts for services from private hospitals. This scheme was set up to replace the government-owned veteran's hospitals (which were transferred to the states), but does not involve hospital-to-hospital contracting.

There are no other Australian examples of national arrangements, such as the UK Independent Sector Treatment Centres. These privately run units provide surgical services, under contract, to NHS patients.[8] Ramsay Health Care (UK) currently owns nine of these treatment centres.

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[4] Ibid
[5] Boxall, A, Reforming Australia's health system, again, *Medical Journal of Australia*, 2010; 192 (9): 528-530.
[6] Productivity Commission (1999). Private Hospitals in Australia. Canberra.
[7] Foley, M, (2009), A Mixed Public-Private System for 2020. A paper commissioned by the Australian Health and Hospitals Reform Commission. Available at: www.health.gov.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/A Mixed Public-Private System for 2020 (M Foley).pdf
[8] Naylor C and Gregory S (2009). Briefing: Independent Sector Treatment Centres, King's Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/briefing-independent-sector-treatment-centres-istc-chris-naylor-sarah-gregory-kings-fund-october-2009.pdf

In the past, however, there have been numerous examples of short term contracting between public and private hospitals, mainly designed to relieve pressures on the public hospitals. Most appear to have been local arrangements. In the 1980s public health services in the New South Wales (NSW) Illawarra region were regularly contracting with private hospitals for urological services (these arrangements remain in place today).[9] At a national level, in the early 1990s around 16,000 public patients across Australia received treatment in private hospitals under contract from public hospitals. By 1996-97 this had risen to 40,000.[10]

Approaches to contracting in the states

Contracting, then, is not a new phenomenon in Australia and has been undertaken across all jurisdictions in one form or another for many years. Generally it has been undertaken on an ad-hoc and short term basis to address lengthening waiting lists in particular specialties in a local area or, occasionally, in a more general state-wide program such as occurred in NSW in 2005. In NSW in 2006, 1020 public surgical patients were treated privately at public expense.[11]

Health service managers' experiences with contracting – both positive and negative – have helped determine whether contracting arrangements continue on a more regular basis or remain as small-scale, one-off initiatives.

A number of jurisdictions have in more recent times moved to formalise contracting arrangements. The approaches range from relatively hands-off arrangements, like those in New South Wales, where local health districts can determine whether or not they utilise contracting (provided they abide by a set of procurement principles) to much more formalised and structured approaches such those adopted in Queensland and Victoria.

Queensland's Surgery Connect program has been running since 2007 and uses a brokerage system to source private providers wishing to participate in the scheme. If a patient has waited longer than clinically recommended for elective surgery, and the demand for this service can't be met in a public hospital, the patient may be offered an opportunity to be treated in a private hospital through the Surgery Connect initiative.

Depending on the specialty area, the patient is either referred to a private hospital, which is responsible for co-ordinating and paying for all aspects of the patient's treatment, or is referred to a treating practitioner who then co-ordinates (but does not pay for) the hospital accommodation and other services. The Surgery Connect scheme treated 1085 patients in the six months to December 2013.

[9] National Health Strategy (1991) Issues Paper no. 2, Hospital Services in Australia: Access and Funding.
[10] Productivity Commission (1999). Private Hospitals in Australia. Canberra.
[11] Garling Report (2008). Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals.

In addition to the state-wide Surgery Connect scheme, local health districts in Queensland are also able to contract directly with private hospitals in their regions.

Victoria's Competitive Elective Surgery Initiative has allocated up to $165 million for contracts for elective surgery for public patients over the period 2013-14 to 2016-17. This includes $15 million which has been allocated to 17 public and public and private hospital partnerships in 2013-14 to undertake 2,235 operations (around 200 more than would have been undertaken under standard Victorian government funding arrangements). The Victorian Department of Health funds this initiative through a competitive tendering process which is open to both public and private hospitals.

Health reform agreements and incentives to consider contracting

In recent years, the Commonwealth, state and territory (the states) governments have embarked on a series of health reforms, many of them centring on the financing and performance of public hospitals. Three in particular provide the states with some incentives to consider expanding the use of contracting, namely the introduction of National Elective Surgery Targets; activity-based funding for public hospitals; and a national efficient price for inpatient (and some outpatient) treatments.

(a) National Elective Surgery Targets

At a national level, the states have committed to reducing long waiting times for elective surgery as a component of broader health reform (see the National Partnership Agreement on Improving Public Hospital Services, July 2011 and the National Health Reform Agreement, August 2011).

The National Partnership Agreement on Improving Public Hospital Services comprises a National Elective Surgery Target (NEST) with the following aims:

- to increase the proportion of people seen within the clinically recommended time;
- to reduce the average time waited beyond the clinically recommended time; and
- to ensure that the 10 per cent of people who have waited the longest beyond the clinically recommended time are actually seen within the reporting year.

While each state starts from a different baseline, the targets progressively tighten each year so that by 2016 all are committed to ensuring that 100 per cent of patients are seen within the clinically recommended times.

To help them achieve elective surgery targets, the Commonwealth has provided both facilitation and reward funding. Over the next three years of the Partnership Agreement (2014-16), the Commonwealth will provide the states with reward funding of up to $24.7m in each year (spread across all jurisdictions) if they reach their targets.

The COAG Reform Council, the Australian Institute of Health and Welfare and the National Health Performance Authority all report regularly on the progress of each jurisdiction towards achieving their targets. These comparative reports attract considerable media attention when they are released and provide a strong incentive for jurisdictions to meet their targets.

(b) Commonwealth Activity Based Funding

One of the key components of health reform in recent years has been a change to the funding mechanism by which the Commonwealth contributes its proportion of public hospital funding to the states. The new mechanism of activity based funding (ABF) provides a Commonwealth contribution for each unit of activity undertaken by public hospitals. This is currently around 40 per cent of the 'efficient price' which is determined on an annual basis by the Independent Hospital Pricing Authority.

The previous funding mechanism utilised 'block funding', which essentially provided a fixed global Commonwealth payment for an expected volume of public hospital activity.

The introduction of ABF funding by the Commonwealth, which does not have a volume cap, may provide an additional incentive to undertake contracting. For example, if public hospital demand is greater than anticipated, the cost of undertaking additional work either in-house or by contracting it out will now, in part, is compensated by a Commonwealth ABF payment. Previously, unanticipated additional activity would have been funded solely by the states – whose response was often to try to reduce access to elective surgery during the particular payment period – leading to longer waiting times.

(c) A national efficient price for hospitals

The price set by the Commonwealth for each public hospital inpatient procedure may also have an impact on the attractiveness of contracting. Where a public hospital can undertake a particular procedure at a relatively low cost, it may be to its financial advantage to specialise in that procedure and contract out other relatively higher cost procedures to another provider (particularly if it can be sourced for a lower price).

The extent to which individual hospitals and hospital networks pursue this strategy, or indeed undertake additional contracting beyond public sector hospitals will, however, be primarily determined by the service level agreements that they have with their state health departments. Under the health reform agreements the states remain both system managers and the majority funders of public hospitals.

Importantly, the COAG health reform agreements recognise that private and not-for-profit hospitals may be contracted to provide public hospital services and such work will attract an ABF payment.

Lessons from practice

General comments

In discussions with the interviewees, there was general agreement about the problems that made it difficult for short-term contracting to work well for patients and health services. Surprisingly, there was also broad agreement about some of the solutions to these problems. This is good news for policymakers as it provides them with some clear lessons to guide policy development.

The interviews reveal, however, that short-term contracting of inpatient care remains highly controversial. Even when addressing the highest level questions, interviewees had widely divergent views – should, for example, governments be encouraging contracting between public and private hospitals at all?

It is not surprising that people working in the public and private sectors had different views. What was surprising was that views differed even within sectors. Interviewees also had very different views about how and when contracting should be carried out, and for which type of patients it should be considered.

These points of contention can be helpful for policymakers working in this area as they highlight the key areas where there are perceived to be problems. While some controversies are always likely to remain, many of the problems could be remedied if given some serious consideration by policymakers.

One of the most important findings from this study is that nearly all interviewees, regardless of sector, expressed a desire for policymakers to do some serious thinking about the relative roles of the public and private sectors in health care. This is the broader structural issue that underpins contracting arrangements in the hospital sector.

Lesson 1: Avoid ad hoc approaches to contracting

One of the most common complaints hospital executives made about contracting is that too often it is done in an ad hoc way. They complained that state governments often made the decision to contract public patient care to the private sector late in the financial year (or immediately before an election), and there was an expectation that the private sector would be easily able to accommodate these requests.

Private hospital executives highlighted several reasons why they found this ad hoc approach frustrating and an obstacle to developing more productive collaboration between the public and private hospital sectors. A common complaint was that the public sector usually gave very little notice that contract work would soon become available. Hospital executives reported, for example, that although patients had been waiting a long time for surgery (years sometimes), they were only released for surgery under contracting arrangement in

bulk lots, and when budgets allowed. For private hospitals, this meant that often they were asked to treat hundreds of elective surgery patients within very short periods of time, and sometimes this was impossible because the hospital was already operating at close to full capacity.

Several interviewees said that this problem was particularly frustrating because it was entirely avoidable. They explained that governments have sophisticated ways of collecting and monitoring waiting list data and know well in advance the precise number and type of patients who have been waiting longer for treatment than clinically recommended. They argued that, armed with this detailed waiting list data, there were no convincing reasons (beyond political ones) that the private hospitals should be given such short timeframes to undertake public sector contract work.

Private hospital executives also complained that requests to do public contract work often came at times of the year when medical specialists were unavailable – for example, during school holidays or when major international conferences were on. Knowing that the availability of key medical specialists would be limited during these periods, this problem was also seen as entirely avoidable.

Some private hospital executives also pointed out that fluctuation in private hospital capacity was relatively predictable – that is, there were certain times of the year where they were very likely to have spare capacity. Executives from both sectors explained that it would be much easier to make contracting work if decisions about patient numbers, types and timeframes were planned well in advance.

Criticisms of the ad hoc nature of much of the contracting in the hospital sector were not confined to private hospitals. Some of the bureaucrats and public hospital executives interviewed were also very critical of ad hoc contracting arrangements because they often resulted in governments paying private hospitals a premium to treat public patients. This was partly because private hospitals had to pay theatre staff overtime so they could treat the extra patients, and they had to pay surgeons and anaesthetists a premium to do extra work. Often in negotiations over medical specialist's fees, private hospitals say they have little choice but to pay higher fees to these specialists, because without their willing cooperation the work would not be undertaken. This situation is particularly pronounced in medical specialties where there are workforce shortages.

One interviewee voiced strong objections to paying private hospitals a premium to do public sector work. She argued that much of the work is considered to be relatively low risk (and therefore profitable) and the public sector could easily do it (and often for less) if they were allowed the opportunity to bid for the extra funding. Once again, she pointed to the ad hoc approach as the problem, explaining that the public sector is capable of expanding its capacity to treat the public patients waiting too long for care if they were given enough time to plan for it and greater assurances about the extra patient volumes.

Additionally, the ad hoc approach to contracting places a high administrative burden on staff. When a private hospital agrees to do public contract work, staff have to reorganise theatre schedules and staffing rosters in order to accommodate the extra patients. Hospital executives and finance managers also have to negotiate contracts for service delivery in a very short timeframe. Because this work is often complex, detailed and fairly specialised, and done in addition to routine business, it can take a toll on staff.

Despite all the challenges with ad hoc contracting, most (although not all) of the hospital executives interviewed accepted that it was probably part and parcel of working in the hospital sector. They recognised that demand for hospital care sometimes increased suddenly and unexpectedly – for example, when there was a particularly nasty flu season.

Because hospitals cannot do much to increase capacity in the very short-term, many public hospital executives accepted that they sometimes needed to look to the private sector to meet demand. They pointed out, however, that when these short-term solutions were required, it was generally much easier to arrange if the public and private hospitals were already accustomed to working cooperatively together and had established relationships – for example, because they had longer-term public-private partnerships of some sort operating.

Some interviewees explained that one of the challenges with short-term, ad hoc collaborations was that the public sector only tended to do it when it was desperate (for example, when they were at risk of not meeting emergency department or elective surgery targets). Under these circumstances, it was difficult to develop relationships of trust and identify mutual benefits to the arrangements. Instead, the benefits were seen to be one-sided, favouring the private sector.

Lesson 2: Don't assume that the private sector is willing to do public sector contracting work

For short-term contracting to be viable, private hospitals must be willing to treat public patients, but the private sectors' enthusiasm for public contracting cannot be assumed. As one private hospital executive stated: 'we spend a lot of money on increasing the size of [private hospitals] so…we certainly wouldn't want to interrupt our normal business flow by effectively doing a favour for the public hospital system'.

Several private hospital interviewees pointed out that they currently did very little short term contract work, and had no desire to do more of it. One of the main reasons for this was that there was a perception that it undermined the value of private health insurance. As one private hospital executive explained, there were various business and administrative reasons why his hospital did not do contracting work, but the threat public contract work posed to the value of private health insurance was the main reason they steered clear of it.

Most of the private hospital executives, however, were not outright opponents of contracting. Instead, their support for it hinged on how extensively it was done. As one executive explained, timely access to care is one of the key ways private hospitals distinguish themselves from public ones. If contracting expands to such an extent that it radically reduces or abolishes waiting times in public hospitals, private hospitals would no longer have an advantage, and the value of private health insurance would be diminished.

Another private hospital executive concurred with this view. He said that while his hospital group did very little short-term contracting, the real problem arose when contracting became routine practice. This caused people with private health insurance to question why they had bought it as other people could get into the private hospital without it.

Views among private hospital executives on how short-term contracting affected the value of private insurance were not uniform. Several said that there was a perception, particularly among private hospital staff, that public contract work undermined private health insurance. However several others said that opposition to contracting dropped off once they reminded staff that patients were treated equally regardless of who paid the bill, and that contracting helped keep surgeons happy and brought in additional revenue.

Some private hospital executives suggested that their views on contracting were a moot point because they rarely had spare capacity (either surgical theatres or hospital beds). They explained that they had carefully developed business plans that ensured they were operating at near full capacity most of the time. This meant that the massive capital investments made in building and operating their hospitals delivered profits. Some indicated that they would be willing to increase capacity to treat more public contract patients, but to justify the capital investment and business risk, they would need much more secure contracts from the public sector, with guarantees on patient volumes and price, and over longer periods of time.

While some private hospital executives were open to considering contracting under the right circumstances, some others remained sceptical about its merits even if it was done in more strategic manner over the long term. One interviewee said that relying on public contract work as part of the business model always involved a relatively high degree of risk because governments can make changes that quickly undermine the arrangements.

He explained that he had learnt this the hard way. His private hospital had invested in some expensive technology that was not available in the local public hospital on the understanding that they would treat public patients under contract. They arrangements worked well over several years but came to a grinding halt when the public hospital eventually decided to invest in the same piece of technology. As soon as it did, the market they had established for providing this type of care evaporated, leaving them with the expensive technology but much less capacity to generate revenue from it. The lesson he learnt from this was that contract work should be treated as a bonus, an optional extra, rather than something that private hospitals could rely on as part of the business plan.

A public hospital executive (who had previously worked in the private sector) identified another reason why the private sector was sometimes unenthusiastic about short-term contracting work. She had once tried to negotiate an arrangement with a local private hospital to undertake some contract work while they were redeveloping the public hospital, but they were not interested in doing the work because 'they weren't keen on the type of patients' – for example, medical and sub-acute care patients. They were interested in admitting the private patients, even if they were medical or sub-acute patients, but not the public ones. The only exception they were prepared to entertain was admitting surgical patients under public contract arrangements.

Lesson 3: Contracting tends to work better in regional areas

One of the clearest findings in this project was that contracting tends to work better in regional areas than urban areas; in regional areas, contracting is seen as being mutually beneficial to public and private hospitals.

One public hospital executive who had managed hospitals in both regional and urban areas said the differences were stark in his mind. He explained that contracting worked much better in regional areas because there was more certainty about the nature and volume of work over a 12-month period, which meant hospitals could develop a secure business model. He went on to explain that:

> *'the boundaries between public and private are blurred in the bush, and this is a good thing. The public and private hospitals are mutually dependent on one another, so there is an imperative to cooperate…there is also a stronger imperative to survive'.*

Many hospital executives with experience of contracting in regional areas explained that it was successful because it helped both the public and private hospitals solve workforce problems. It is often very difficult to attract medical specialists to regional areas but when contracting arrangements were in place, it was easier to recruit them because of the ready-made opportunities for work in both sectors.

Relatively new specialists and overseas trained doctors often find the opportunities generated by contracting an attractive proposition. Several interviewees pointed out that in regional areas, public hospitals do not always have enough work to offer full-time jobs to less established medical specialists, while private hospitals are also unable to guarantee enough work to entice them. If there are regular opportunities for newer specialists to do public sector contract work, it means they are also able to take up employment in the public sector while also building up a part-time private practice.

Unlike their city counterparts, these medical specialists don't have to spend years building up relationships and a referral base before establishing a private practice (and most do want to do some work in the private sector). These arrangements are mutually beneficial to

public and private hospitals, but patients also benefit because they would otherwise have had to travel to metropolitan areas for care.

When asked why contracting tends to be easier in regional areas than cities, one regional private hospital executive was quick to highlight the key reasons. He explained that there is a lot of collaboration between public and private hospitals in regional areas out of sheer necessity. They routinely lend each other equipment, run joint training sessions and do short-term contracting because they have to – when there are only two hospitals in town, or the area, there is no one else to ask for help. Private hospitals in regional areas also tend to have lower occupancy rates, and this means there are greater financial incentives for them to enter into contracting arrangements with the local public hospital.

While there are various practical and business reasons why contracting tends to work better in regional areas, several interviewees said that in the end, it came down to relationships. As two executives from a regional public hospital explained: 'we get into argy-bargy every time we have to renegotiate the contract [with the private hospital]' but 'overall we've got a good relationship.'

They went on to give practical examples of how the local private hospital had helped them out – for example, by making beds available when the public hospital was full. Instead of allowing medical and sub-acute patients to take up beds in the surgical wards (thereby limiting the number of surgical patients who could be admitted), some public hospitals have asked their private hospital colleagues to admit them under contracting arrangement.

In another region, public hospital executives explained how they had to make urgent arrangements to use surgical theatres in the private hospital because their units were closed down for a few days. They explained, 'they [the local private hospital] allowed us to do emergency surgery…so in fact where we've had a crisis they've been able to support us.'

Even hospital executives who were relatively unenthusiastic about contracting conceded that long-term contracting arrangements were in place in some of the group's regional hospitals, and were successful because the hospitals had more direct relationships with the community.

Lesson 4: Clear and consistent pricing policies for contracted services are needed

When weighing up whether or not to do contracting work, price is a critical consideration for many private sector executives. However from the interviews conducted in this project, it was clear that there is no consistent approach to pricing public sector contract work, and many different views on how price should be determined.

Some interviewees argued that the price paid to the private sector for contracted work should consider factors such as urgency and volume – that is, private hospitals should be paid higher prices when they are expected to do the work in a short time frame, and lower

prices should be paid when high volumes of work are guaranteed over a longer timeframe. Others argued that a schedule of fees for public contract work should be developed at the state or local level and applied regardless of urgency or volume.

Others advocated for a cost-based pricing method where hospital costs, such as surgeons' fees, theatre costs, wages and overtime, are used to determine a reasonable price for contracted services. And some private hospital executives said that in reality, their views about what was an acceptable price for public contract work depended largely on the price they were paid by private health insurance funds for treating similar cases. It made no sense, for example, for them to admit public patients if they were paid less than what they would be paid by a private insurance fund.

Hospital executives' views on pricing appeared to be closely aligned with their views on the merits of contracting. Private sector hospitals that did contracting because they saw it as part of a broader cooperative and resource sharing relationship across the public and private sectors were more likely to prefer pricing policies that were relatively simple and imposed few additional administrative burdens on staff. However for some of the more business-minded executives, especially in states where contracting was routinely done, the price paid was a major issue that strongly influenced their decisions. Executives from hospitals that only did contracting work if it made good business sense were more likely to have, or support, a rigorous cost-based approach to pricing.

Two private hospital executives (from the same hospital group) explained that they had had very negative experiences when contracting with the state government because of the way pricing was done. In essence, they argued that the government was paying *too much* to the private sector for contracted patients, which ultimately undermined the program.

They considered that the government made two mistakes when setting up contracting arrangements with the private sector. First, they set the price too high as they didn't understand that contract work could be done in the private sector at marginal rates rather than at the full cost. They explained that public sector work was only ever seen as 'cream on the top', which meant that other overheads were covered through routine business.

They believe its second mistake was that although the state department of health set standard rates for medical fees when doing contract work, it then negotiated separately with groups of medical specialists who were not happy with the rate (specialists' rates were originally based on an existing schedule of fees, which had different rates for different specialist groups). Once one specialist group had successfully negotiated for higher fees, other specialist groups began to use similar tactics with equal success. Over time, the price the government paid to the private sector for doing public sector work became difficult to justify, and public patients were instead sent to other public hospitals for treatment, with the private sector missing out altogether.

While pricing policies may appear at first to be an administrative matter, the experiences of those who have done public sector contract work reveal that it is a highly contentions area and pivotal to the success or failure of contracting arrangements. Because private hospital executives have divergent views on what is a fair price for public sector work, it is difficult for policymakers to use this as a guide for how to approach pricing. Perhaps the most useful approach would be for policymakers to first clarify the objective of contracting to the private sector – is it to speed up access to care for public patients, deliver efficiencies, maintain a viable private sector, or something else entirely? – and then determine a pricing policy to meets its objectives.

Lesson 5: Successful contracting involves finding the right balance between state and local level control

State governments have embraced contracting with various degrees of enthusiasm. In some states, formal programs have been established – Queensland and Victoria for example. In others, governments have made the decision to put contracting arrangements in place between hospitals at the local level to solve local problems.

There are examples of long-term, relatively formal arrangements between public and private hospitals in a local area where the private hospital provides certain types of speciality services because it is not economically viable to run them in the public hospital. In regional areas, these arrangements were often developed because expensive equipment and technology was required, and the private sector had already invested in it, or there were workforce shortages and the government had made the decision that it was too costly to pay for fly-in fly-out medical specialists, or fund locums to come to town.

Interviewees indicated many examples of contracting at the local level where collaborative arrangements were put in place to solve local problems. In many cases, the problem was bed shortages (there was a need for overflow capacity on an ad hoc basis) or workforce shortages in some medical specialties (public patients were then treated by specialists working in the private sector). Often, these local level problems were solved simply by public and private sector hospital executives meeting and negotiating a mutually agreeable arrangement. Over time, some of these short-term arrangements have become more permanent ones – for example, for the provision of palliative care services in North Queensland, urology services in regional NSW and ophthalmology services in regional Tasmania. However, in other cases, the arrangements broke down over time as hospital executives encountered many of the problems outlined in this issue brief.

When asked whether contracting was best organised at the state or local level, most interviewees said that the state government had an important role to play in setting the broad policy parameters. They believe that the state government should be responsible for developing a governance framework to ensure that health services are taking a relatively consistent approach, for example on pricing. The also said that the state government should play a major role in contract negotiation and monitoring. Several interviewees explained

that these skills are fairly specialised, making it unrealistic to expect hospital executives at the local level to be able to handle complex negotiations with private sector negotiators, most of whom work in central offices of large private or not-for-profit organisations.

They also argued that state governments should take a leadership role in developing policies on contracting. Because public hospital budgets are determined largely by state governments, their decisions have a major impact on waiting times and whether or not patients need to be treated in the private sector. Only they can provide some certainty about the volume of work. Without greater certainty, many in the private sector see contracting as an unattractive proposition because they are at the behest of what happens in the public sector.

One state government bureaucrat explained that they were aware that hospitals wanted more certainty about contracting, and that governments often paid a premium for contract work because they couldn't provide it. However the political and budget cycles in government mean that they are unable to give certainty beyond a year. He anticipated that the planned introduction of three-year budgeting cycles would allow governments to enter into longer contracts with private hospitals in the future.

Views about the role that the state governments should play in contracting were not uniform. Most interviewees recognised the key role governments have in setting policies on contracting however they stressed the importance of avoiding a one-size-fits-all approach. They say that the contract must be flexible enough to accommodate local factors, such as fluctuations in hospital capacity dependent on local workforce availability or private sector capital investment decisions. Some interviewees pointed out that the problem with having regional health authorities and state governments solely in charge was that they were 'not across the detail' of service delivery, so often they didn't realise they had a problem at the local level.

One interviewee argued against the idea of the state government taking a lead role in initiating contracts between public and private hospitals. Reflecting on her experiences in setting up contracting arrangements between co-located public and private hospitals in South Australia, she said that the arrangements worked well because executives from both sectors were deeply involved in setting them up. They had a detailed knowledge of the contract – what was in, what was out – and this meant there were very few disputes once it was up and running. The people involved in operationalising the contract were the same ones who had negotiated it, so there was a lot less game playing and politics once it was signed off.

She did acknowledge, however, that there could be benefits in having the state government involved. She speculated that negotiating contracts centrally might offer some protection for working relationships at the local level particularly during negotiations when relationships between hospital executives were at greatest risk of going sour.

Consideration also had to be given to history – that is, to past and existing relationships between the public and private hospitals in an area. In some of the reported cases, hostilities between the two sectors had built up over time, making it very unlikely that centrally imposed contracting arrangements would succeed.

Conversely, in some areas strong and cooperative relationships between the local public and private hospital had developed over time, making it difficult, or even impossible, to scale them back without huge disruptions to business models, working relationships and patient care.

The most common benefit interviewees identified for contracting at the local level was that it helped develop strong, cooperative relationships between the public and private sectors and consequently, it was then much easier to resolve issues that arose once the contracting arrangements were in place.

One interviewee explained that the process of shifting patients from the public to the private sector and back again had the potential to substantially disrupt the patient journey. She explained that it was only possible to do short-term, or ad hoc, contracting work if the two hospitals had forged strong, cooperative relationships over time. Other interviewees supported this argument, explaining that these longstanding relationships of trust meant that the two sectors were willing and able to cooperate when crisis arose, such as the forced closure of theatres or breakdown of essential equipment.

While local relationships are important, some interviewees warned against relying too heavily on relationships between individuals because people could be very parochial and unduly influenced by local power dynamics. Relying too much on the strength of personal relationships also made the success of contracting arrangements vulnerable to changes in personnel. As some interviewees explained, they had seen well established contracting arrangements suddenly come to an end when the hospital chief executive (from the public or private sector) left the job.

For policymakers, finding the right balance between state and local level control is no doubt challenging and will vary across jurisdictions; what works in Queensland, for example, is very unlikely to work just as well in Tasmania. The lesson is that a distinction needs to be made between governance and procurement issues (which were best dealt with at the state level), and operational issues, such as those concerning clinicians and providers (which were best dealt with locally). The balance between state and local responsibility is also likely to change over time as hospitals and policymakers become more experienced in dealing with the challenges that arise when responsibilities are devolved to local health districts.

Options for reforming current practices

'Contracting…in theory I don't mind it, but how you do it is really important'.

The key question federal and state health policymakers need to address is not whether hospitals should contract out, but rather how they should do it. As this Issues Brief highlights, there is much to learn from those senior hospital executives with experience in contracting. When asked, many of them had well thought through views on reform options that might improve the way we do contracting now, and make better use of the resources of both the public and private health sectors. Some of those options, and the reasons practitioners advocated them, are outlined below.

Option 1: Establish contracts over longer periods

One of the most commonly recommended reform options suggested by interviewees (and perhaps the simplest) was to make contracts between the public and private sectors over longer periods of time. Interviewees argued that this should be relatively easy to do. The public sector has good data on patient waiting times and usually knows well in advance how many patients are likely to exceed clinically recommended waiting times, thereby triggering the possibility that they would receive their care under contract arrangements with the private sector.

The main obstacles to implementing this reform are bureaucratic and political, according to several interviewees. They argue that certain state health departments or area health authorities were not willing (or able) to do the planning needed to ensure that longer-term contracting arrangements could be put in place. One senior bureaucrat agreed with this view, pointing to budgetary processes as the main obstacle. He claimed that state governments' ability to plan well in advance was limited because budgeting was done annually. He hoped that the planned introduction of three year budgeting cycles in his state would allow the government to make longer-term contracting arrangements, and that this would go a long way to addressing the complaints made by the private hospital sector.

Option 2: Adopt the brokerage model

Several private hospital executives from the same hospital group in Queensland were strong advocates of the brokerage model that had once been integral to the Surgery Connect program in that state. They explained that when Surgery Connect started, they won the contract for brokering public patients care to the private sector. For a set fee, they made all the arrangements for public patients to receive care in a private hospital, including travel and post-discharge follow-up.

Over time pubic waiting lists were substantially reduced, but the brokerage model came under attack because of the cost to government of brokerage fees. The executives recognised the problem and tried to remedy it by suggesting to the state government that

brokerage fees be reduced when the volume of patients was high, thereby reducing the overall cost of the scheme. This suggestion, however, was not taken up.

Instead, the state government decided to take responsibility for arranging care for public patients and shifted the brokering service to the Queensland health department. Another major change was that public patients who were waiting too long for care were no longer automatically contracted to receive care in the private sector. Health department officials also looked for treatment options in the public sector.

The issue of who should be responsible for brokering care for public patients was hotly contested. The private hospital interviewees argued that they had provided a better service for patients and they could have done it at a lower cost if their suggested changes were adopted. They also claimed that under the new system, medical specialists have a perverse incentive to keep people on the public waiting list as it means they will eventually be released for treatment under Surgery Connect, and the doctor can then charge much higher fees to see the patient in the private sector.

The health department officials who took over the brokering argued that the key advantage of the Surgery Connect program was that it could buy care from any hospital, public or private. With greater competition, there were potential benefits to the government on the price paid for care. They did admit, however, that there was a problem with some medical specialists gaming the waiting list system.

Despite the disagreement on how to operate the brokering system, most hospital executives and bureaucrats in Queensland agreed that the Surgery Connect program had been very successful in reducing the number of public patients on the waiting list for surgery.

Option 3: Co-locate and share hospital infrastructure

Several interviewees who had worked in places where public and private hospitals were co-located suggested that it facilitated successful contracting between the two sectors. One of the main advantages of co-location was that longer-term arrangements could be put in place where services were shared between the two hospitals rather than duplicated in each of them.

In one such location, a private hospital provided palliative care, oncology and renal services for both public and private patients in the area. With these long-term service delivery arrangements in place, both the public and private hospital could make informed decisions about investment in expensive technology where the other hospital was able to provide services. Because the hospitals were co-located, there was minimal inconvenience for patients and hospital staff.

Two public hospital executives also spoke favourably about a model operating in their local area where infrastructure in one specialty area was shared between public and private sectors – it is likely that similar small-scale arrangements are in other places around Australia. They explained that local contracting arrangements were developed for the provision of cardiac services soon after the public hospital was redeveloped. Public hospital executives realised that the cardiac unit they had built was too large, but the co-located private hospital was running short of space.

In response, a private company (owned by the public hospital cardiac specialists) established a private cardiac catheter laboratory alongside the public hospital cardiac ward. The private company leased the space from the public hospital, funded the establishment of the laboratory, and were subsequently contracted to provide a certain volume of services to the public hospital. The cardiac medical specialists worked in both the public and private sectors; they were employed as staff specialists in the public hospital under terms and conditions that allowed them to also work as visiting medical officers.

Hospital executives who had been involved in co-location and infrastructure sharing arrangements were positive about them, suggesting that they worked well because there was genuine benefit to both the public and private hospitals. One of the reasons they said it worked so well was that medical specialists work across both sectors. This means that when public patients are treated in the unit, the public hospital does not have to pay for medical fees, as the specialists are treating the patients in their public capacity. The overall price for care, therefore, is lower than it would be if the public patient was contracted to receive care in the private sector (where medical fees are charged).

Another advantage was the quality of the relationships, with flexibility and trust being paramount. As one executive explained, the arrangements in his hospital had lasted for more than 20 years because ‘there is a disproportionate amount of trust’ between parties, made possible because medical specialists were able to move freely between the public and private sectors. He also highlighted that the co-location model was good for patient care. Because the two units were so closely integrated, it was easy to transfer them from the private unit to the public one if anything went wrong with their procedure, thereby reducing the risk of adverse events.

The only potential downside identified to these arrangements was the perception that it was all too ‘in-house’, with contracts handed to the private sector owners and operators without considering alternatives that might be better. One interviewee pointed out that the providers had to tender for the business, and had won it because they offered the best price.

Option 4: Establish contestable funding pools

When asked about potential ways of making short-term contracting work better, several interviewees suggested that contestable funding pools should be set up. Under this

arrangement public and private hospitals would be in competition to treat public patients who had been too long on the list waiting for elective surgery. The Victorian government has already adopted this model; in 2012-13 it made $44 million available as part of the Competitive Elective Surgery Initiative, and in 2013-14, it increased the funding pool to $420.7 million over four years.

Interviewees had various reasons for supporting this model, including:

- it gives the public sector a chance to do some contracted elective surgery, which tends to be fairly routine and therefore margins are relative easy to make;
- doing more contract work in the public sector means better continuity of care for patients;
- the government ends up paying less to treat patients; and
- it means that each sector is doing what it does best – the public sector doing more complex work (such as burns and transplants) and the private sector doing more routine elective surgery.

One public hospital executive, while supportive of the model, warned that the public sector would need time to adjust if it was to successfully compete with the private sector for elective surgery work. He explained that while public hospitals wanted to treat the people on the waiting list for elective surgery, they couldn't do it because they didn't have the theatre or bed capacity. He went on to say that to be able to compete with the private sector for this work, the public hospitals would need to have access to more infrastructure funding. Without it, they would 'just get slaughtered'.

Option 5: Establish more public-private partnerships

A number of interviewees spoke about their experiences with public-private partnerships (PPPs). One public hospital executive that had extensive experience with PPPs highlighted some successes and challenges with the model. He explained that in some locations, they had worked well because they provided certainty and security and allowed hospital administrators to plan over longer periods of time. For public hospitals they also facilitate the recruitment of more and better quality staff for whom working in a private hospital is an attraction. One private hospital executive also argued that sharing expensive infrastructure (for example, theatres and delivery suites) leads to efficiencies for both the public and private sectors.

Some of the downsides to PPPs were also highlighted. In one case, a private hospital was returned to the public sector after five or six years where the arrangement was expected to last 20 years. The main reason the partnership failed was that the private hospital (which was in a regional area) did not do enough to grow its private capacity in the first few years. Instead, it had become reliant on the public sector work and after several years, the private operators determined that the business model was not sustainable.

Another private hospital executive emphasised the importance of the political climate to the success of PPPs. When reflecting on the experience of the Port Macquarie hospital experience with PPPs, he argued that the hospital was very successful both clinically and financially. Recruiting staff to the hospital was also easy. The problem, however, was the politics surrounding it; when the Coalition state government lost power and Labor was elected, the arrangement began to unravel because, he said, Labor was opposed to any form of privatisation.

Many of the other challenges with PPPs identified by interviewees were the same as those identified with short-term contracting. For example: it was important for executives to develop skills and experience in negotiating contracts; arrangements worked better when there was genuine collaboration and real relationships, rather than just contractual relationships; and relying too much on key personnel posed a risk when personnel changed. However, as one public hospital executive explained, 'we need to continue to think our way through [PPPs]…but given the health system's expertise applied over the last six to seven years, I'm optimistic'.

Option 6: Separate the purchaser and the provider

This final reform option advocated by some interviewees is the boldest: the introduction of Medicare Select, a competitive insurance model outlined by the National Health and Hospitals Reform Commission in 2009.

One of the core features of the model is the formal separation of the funder and provider roles in health care, giving patients more choice about receiving treatment in the public or private sectors. The supporting arguments are that it would allow the public and private sectors to compete on an equal footing; it would be the most efficient use of resources in the sector; and patients would have the right to choose both the doctor and the system for their treatment.

While interviewees recognised that this option was a major reform, some were convinced that it was possible for the government to introduce such a change over time.

Conclusion

Australia is facing major changes to the way we fund health care. The pressures on sustainable funding are most intense in the hospital system. Public hospitals are the largest single area of health expenditure in Australia; they accounted for almost a third of all recurrent expenditure in 2011-12. The state and territory governments contributed about 53 per cent of total recurrent funding for public hospitals in 2011-12, and the

Commonwealth Government about 38 per cent. Both levels of government have good reasons to scrutinise spending on public hospitals.[12]

Contracting with private hospitals has the potential to contain public sector costs, but this potential can only be realised if private hospitals deliver care for public patients at lower costs than public hospitals. This paper does not provide 'hard data' on the costs of public contracting, so it is not able to determine whether or not there any financial benefits. Because there is no publicly available, robust and comparable national data on the costs of treating public patients in public and private hospitals, it is not yet possible to explore this issue in any detail.

The Productivity Commission encountered similar problems with robust comparable data on public and private hospital costs when it examined the performance of the two sectors in 2009.[13] Since then, some work has been done to improve hospital data collection and reporting – for example, by the Independent Hospital Pricing Authority, the Department of Health, and the Australian Health Ministers' Advisory Council's National Health Information Standards and Statistics Committee. This work needs to be advanced so that it can be used by to inform policymaking in this area.

Policymakers can make some changes that will improve contracting arrangements in Australia, even in the absence of robust financial data. Some relatively small-scale reforms options suggested by hospital executives are outlined in this paper – for example, establishing contracting arrangements that run over longer periods, and setting up brokers who can help find hospitals (public or private) that are able to do elective surgery work when it is needed. These reforms would take away the rationale private hospitals have for charging a premium when treating public patients, and would create financial incentives for governments to scale-up hospital contracting.

Larger-scale reforms are likely to be controversial as contracting touches on many vexed and unresolved issues in our mixed health system. These range from using government funds to pay for care in to private hospitals, allowing public hospitals to admit (and charge) private patients, and the role of private insurance in the context of Medicare. Policymakers will have to tackle these contentious issues if they want to continue to use the resources of the private sector to solve access issues for public patients.

[12] Australian Government, Australian Institute of Health and Welfare (AIHW), *Health expenditure Australia 2011–12*, Health and welfare expenditure series no. 50. Cat. no. HWE 59, 2013, Canberra.
[13] Australian Government, Productivity Commission 2009, *Public and Private Hospitals*, Research Report, Canberra.

Data and methodological approach

The analysis in this paper comes from qualitative interviews with 24 interviewees, all of them with substantial practical experience with public sector contracting. A full list of de-identified interviewees is provided below. Interviewees were senior executives (chief executives and other executive team members) from public, public-private and not-for-profit hospitals, and some senior state-level bureaucrats.

Interviewees were recruited through the researchers' networks, so it was a convenience sample. Because funding for this project was limited, it was not possible to ensure that interviewees were representative of hospital executives overall. Interviewees from all three hospital sectors, however, were recruited and participated in the research. As a collective, they had experience with hospital contracting in every state and territory of Australia, except the Northern Territory. Some interviewees worked for national organisations, so they were able to speak about contracting in multiple jurisdictions. Some had worked in different jurisdictions and different sectors throughout their career, so they were able to speak about these various experiences during interviews.

All interviews were conducted by one member of the research team between May 2012 and January 2013. Most interviews were conducted face-to-face, with a few conducted over the telephone. On average, interviews lasted between 45 mins to one hour.

All interviewees gave their express consent to have interviews recorded digitally, and were given the opportunity to review the draft paper and make any corrections to comments attributed to them. Subsequently, any references to specific interviewees were removed because once information on interviewees' state, sector and position was listed (see list below), it was possible to individuals, even though data was de-identified.

Interview voice recording were stored digitally on a password protected computer. Only the researcher who conducted the interviews had access to the data.

All interviews were transcribed and a thematic analysis was conducted. The key organising framework for analysing data was around ascertaining interviewees:

- views and experiences of contracting,
- perceived barriers to contracting, and
- potential reforms that could improve contracting.

Interviewees were also asked about their views on the impact of recent national health reforms (for example, activity-based funding) but very few had thought in depth about the implications for contracting, so this data was not used in the paper.

List of de-identified interviewees

Interview 1
- Executive, not-for-profit public and private hospitals
- National organisation

Interview 2
- Executive, for-profit private hospital group
- National organisation

Interview 3
- Executive, public hospital
- NSW

Interview 4
- Executive, not-for-profit private hospital/s
- Queensland

Interview 5
- Executive, not-for-profit public hospital
- NSW

Interview 6
- Executive, not-for-profit private hospital
- Queensland

Interview 7
- Bureaucrat
- SA

Interview 8
- Executive, public and not-for-profit hospitals
- Queensland

Interview 9
- Bureaucrat
- Queensland

Interview 10
- Executive, public hospital
- Queensland

Interview 11
- Executive, public hospital
- Tasmania

Interview 12
- Executive, public hospital (also experience in private hospital)
- SA

Interview 13
- Executive, not-for-profit private hospitals
- WA

Interview 14
- Executive, public hospital
- NSW

Interview 15
- Executive, not-for-profit private hospital
- Victoria

Interview 16
- Executive, not-for-profit private hospitals
- Victoria

Interview 17
- Bureaucrat
- Tasmania

Interview 18
- Executive, public hospital
- Tasmania

Interview 19
- Executive, public hospital
- NSW

Interview 20
- Bureaucrat
- Queensland

Interview 21
- Executive, public and not-for-profit private hospitals
- National organisation

Interview 22
- Executive, public hospital
- NSW

Interview 23
- Executive, not-for-profit private hospitals
- Queensland

Interview 24
- Executive, public hospital
- NSW

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