

Conflicting interests in private hospital care

MARY ANN O'LOUGHLIN

Mary Ann O'Loughlin is a Director at The Allen Consulting Group¹

Abstract

This article looks at key changes impacting on private hospital care: the increasing corporate ownership of private hospitals; the Commonwealth Government's support for private health; the significant increase in health fund membership; and the contracting arrangements between health funds and private hospitals. The changes highlight the often conflicting interests of hospitals, doctors, Government, health funds and patients in the provision of private hospital care. These conflicts surfaced in the debate around allegations of 'cherry picking' by private hospitals of more profitable patients. This is also a good illustration of the increasing entanglement of the Government in the fortunes of the private health industry.

Introduction

Three forces fundamentally shape the provision of private hospital care: the *providers* of care, the *funders* of care and the *patients* requiring private hospital care.

Over the past few years, there have been significant changes to these forces that have impacted on private hospital care. This article, which focuses on acute private hospitals, discusses four key changes:

- First, the increasing ownership of private hospitals by companies, and in particular by publicly listed companies.
- Second, the increased funding of private hospitals by the Commonwealth Government through the 30% rebate for health insurance.
- Third, the increase in membership of private health insurance, and consequently the increase and change in the population served by private hospitals.
- And finally, the shift to contracting between health funds and private hospitals for the payment of private hospital care.

The implications of these changes for private hospital care are illustrated at the conclusion of the article through the debate over the allegations of 'cherry picking' by private hospitals.

Changes in ownership of private hospitals

Much of the discussion of private hospitals focuses on comparisons between public and private hospitals and the shift in their relative importance in the delivery of health care in Australia. This is a very interesting story showing, for example, that over the 1990s there has been a significant shift in bed-day capacity from public to private hospitals (Bloom 2002, p.21).

But there is just as an interesting story in the changes that have been happening within the private hospital sector, particularly in terms of ownership and what this may mean for service provision.

There are four categories of ownership of private hospitals (Productivity Commission 1999, pp. viii – x):

- *For-profit independent hospitals*: private hospitals whose proprietor does not own any other hospital. These hospitals are often owned by doctors.
- *For-profit group hospitals*: private hospitals whose proprietor owns other private hospitals (such as Mayne Health and Ramsay Health Care.) These hospitals are sometimes referred to as 'chain' hospitals.
- *Religious/charitable hospitals*: not-for-profit private hospitals owned and operated by a religious or charitable body. Some of these belong to groups (such as St John of God, Sisters of Mercy or Sisters of Charity) and others operate as independent hospitals.
- *Other not-for-profit hospitals*: not-for-profit private hospitals owned by someone other than a religious order or charitable organisation. Bush nursing, community and memorial hospitals account for most of these facilities.

Table 1 provides figures on the number of private hospitals and hospital separations according to these four ownership categories over the period 1991-92 to 1999-00. A clear trend over this period has been the increasing corporatisation of private hospitals.

- While overall between 1991-92 and 1999-00 there has been a decrease in the total number of private hospitals (from 319 to 302), there has been an increase in the number of for-profit group hospitals (by 10 hospitals) and a smaller increase in the number of religious/charitable hospitals (by 2 hospitals).
- There was a decrease in the number of private hospitals in the other two categories — for-profit independents and other not-for-profits.
- By the end of the 1990s, hospitals owned by for-profit groups made up 41% of all private hospitals, an increase from 36% in 1991-92.

The story is reinforced by figures for patient separations. In summary:

- There has been a large increase (55%) in separations in private hospitals over this period, from 1,157,000 to 1,799,000.
- With the exception of other not-for-profit hospitals, separations increased in all categories of private hospitals.
- But by far the greatest increase in separations was in hospitals owned by for-profit groups, of 107%.

By the end of the decade, 47% of separations from private hospitals were from for-profit group hospitals compared with 35% in 1991-92. Thus, the decade ended with for-profit groups overtaking religious and charitable hospitals as the main provider of private hospital care.

Table 1. Private hospitals: numbers and separations by hospital ownership category, 1991-92 to 1999-00

| Ownership category | 1991-92 ² | | 1996-97 ² | | 1999-00 ³ | |
|--|----------------------|-------|----------------------|-------|----------------------|-------|
| | Number | % | Number | % | Number | % |
| Number of hospitals¹ | | | | | | |
| Independent for-profit | 62 | 19.4 | 57 | 17.9 | 59 | 19.5 |
| Group for-profit | 114 | 35.7 | 120 | 37.6 | 124 | 41.1 |
| Religious/charitable | 75 | 23.5 | 75 | 23.5 | 77 | 25.5 |
| Other not-for-profit | 68 | 21.3 | 67 | 21.0 | 42 | 13.9 |
| Total | 319 | 100.0 | 319 | 100.0 | 302 | 100.0 |
| Separations | | | | | | |
| Independent for-profit | 143,000 | 12.4 | 127,000 | 8.3 | 158,000 | 8.8 |
| Group for-profit | 410,000 | 35.4 | 639,000 | 41.5 | 851,000 | 47.3 |
| Religious/charitable | 470,000 | 40.6 | 628,000 | 40.8 | 683,000 | 38.0 |
| Other not-for-profit | 133,000 | 11.5 | 144,000 | 9.4 | 107,000 | 5.9 |
| Total | 1,157,000 | 100.0 | 1,539,000 | 100.0 | 1,799,000 | 100.0 |

Note: 1 Private acute care and psychiatric hospitals.

Sources: 2 ABS data reported in Productivity Commission 1999, Table 2.5 and Table 2.6.

3 Unpublished ABS data.

Corporate ownership of private hospitals

In 1987, the Senate Select Committee on Private Hospitals and Nursing Homes presented its report, *Private Hospitals in Australia: Their Conduct, Administration and Ownership*. Although dealing with all private hospitals, the report focused on 'entrepreneurial medicine', a term that covered all for-profit hospitals, and in particular those owned by private or publicly listed companies. The report presents data on the ownership of private hospitals in 1986, which provides an interesting comparison with today.

The data on ownership of hospitals *within the for-profit group category* in 1986 and 2002 is presented in Tables 2 and 3. For both years the figures are estimates but nevertheless the trends are clear: although in total for-profit groups have not increased in number, they have increased in size, and a much greater proportion of hospitals are now owned by publicly listed companies:

- In 1986, there were 14 for-profit groups that owned between 2 hospitals and 21 hospitals, with an average of 6 hospitals. Of this group, there were 4 publicly listed companies with 17 hospitals, or 20% of total for-profit group hospitals.
- The most recent data for 2002 show that there are now 11 for-profit groups, owning from 2 hospitals to 56 hospitals, with an average of 12 hospitals.
- Furthermore, although there are still only four publicly listed companies, between them they own 104 hospitals, or 81% of all for-profit group hospitals. (If Benchmark lists, as has been suggested by Business Review Weekly, that would take the total to 113 hospitals or 88% of all for-profit group hospitals in publicly listed companies.)

Table 2. For-profit group private hospitals: Ownership, 1986¹

| Hospital operators | Number of hospitals | Number of beds |
|---|---------------------|----------------|
| Hospital Corporation Australia | 13 | 1196 |
| American Medical International | 3 | 244 |
| Consolidated Health Care Group | 21 | 800 |
| Paul Ramsay Group | 8 | 480 |
| Hospitals of Australia Trust ² | 6 | 423 |
| Australian Hospital Care | 6 | 617 |
| Wenkart Group | 6 | 400 |
| FAI/Cumberland Holdings ² | 5 | 250 |
| Health Care Corporation | 4 | 260 |
| Markalinga Trust ² | 4 | 338 |
| Australian Health Resources | 3 | 211 |
| Mutual Community Health Fund | 3 | 208 |
| Health Care Group | 3 | 193 |
| Health and Life Care ² | 2 | 116 |
| Total for-profit group hospitals | 87 | 5736 |
| Total private hospitals | 331 | 21070 |

Notes: 1 Numbers are estimates in some cases.

2 Publicly listed company.

Source: Senate Select Committee on Private Hospitals and Nursing Homes 1987, Tables 1.19 and 7.2.

Table 3. For-profit group private hospitals: Ownership, 2002¹

| Hospital operators | Number of hospitals | Number of beds |
|---|---------------------|----------------|
| Benchmark | 9 | 927 |
| Brighton Hospital Care Group | 2 | 83 |
| Community Private Health Care | 3 | 131 |
| Futuris Group | 2 | 102 |
| Healthscope ² | 17 | 1106 |
| Macquarie Hospital Services | 5 | 256 |
| Mayne Health ² | 56 | 5860 |
| Nova Health ² | 9 | 431 |
| Private Health Services | 2 | 146 |
| Ramsay Health Care ² | 22 | 2380 |
| Sun Healthcare Group | 2 | 94 |
| Total for-profit group hospitals | 129 | 11516 |
| Total private hospitals ¹ | 287 | 24218 |

Notes: ¹ As of April 2002. Does not include private management/ownership of public hospitals.

² Publicly listed company.

Source: Australian Private Hospitals Association 2002, unpublished data.

The increased significance of publicly listed companies is illustrated in Figure 1 below which compares the respective shares of ownership of private hospital beds in 1986 and 2002:

- In 1986, the dominant provider of private hospital care was religious/charitable hospitals, with 41% of beds. The for-profit independents and for-profit groups that were not publicly listed had similar shares of 23% and 22% of beds respectively. The category of other not-for-profit hospitals had 9% of beds. Publicly listed groups had only an estimated 5% of beds.
- By 2002, publicly listed companies were now the dominant provider of private hospital care with 41% of private hospital beds, followed by the religious/charitable hospitals with 37% of beds. The other three ownership categories had similar shares of about 7% each of beds.

The past two years has seen a great deal of consolidation among for-profit hospitals. Mayne Health acquired Australian Hospital Care (AHC) and Ramsay Health Care acquired Alpha Healthcare. The other publicly listed company, Healthscope, has also acquired a number of stand-alone private hospitals over this period.

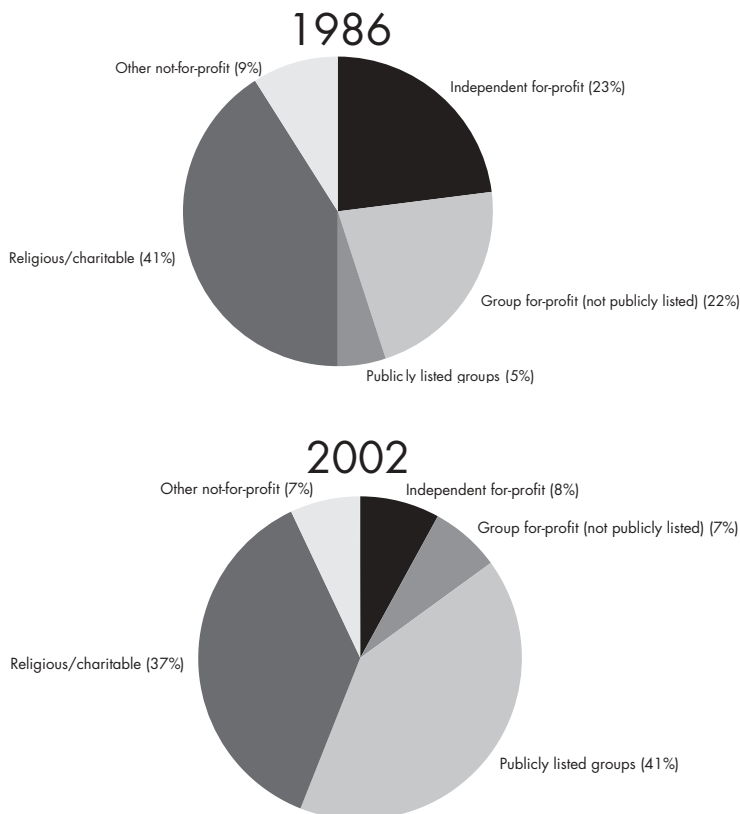
Nova Health is the most recent addition to the publicly listed for-profit groups. Nova Health was formed by bringing together a total of nine private hospitals — six previously stand-alone hospitals and three of which were part of a small group (Nova Health 2002).

Against the expectations of many, vertical integration with other health care facilities has not been a key business strategy of most corporate private hospital groups. In 1987, the Senate Select Committee predicted that (p. xxxii):

In the future it can be expected that the expansion of ownership chains will be not only horizontal but vertical — that is, the consolidation into one corporate entity of the various services provided in the health care sector.

At the time the Senate report was written, four for-profit groups had other health care interests — three had nursing homes and one owned pathology services. The Committee commented (1987, p. 300):

One of the interesting aspects about entrepreneurial medicine in Australia which the Committee has already noted is the connection between private hospitals and nursing homes.

Figure 1 – Private hospital beds: Ownership, 1986 and 2002

Source: Senate Select Committee 1987 and Australian Private Hospitals Association 2002, unpublished data

By 2002 the connection between for-profit hospital groups and nursing homes had been well and truly severed. Furthermore, there has not been the great vertical integration between private hospitals and other health services predicted by the Committee. As of 2002, with the (albeit significant) exception of Mayne Health (which owns hospitals, pathology, diagnostic imaging services, general practices and a pharmaceuticals business), no for-profit hospital group has any other healthcare interests in addition to hospitals. Most of the vertical integration in private health care has been undertaken by pathology, diagnostic imaging and primary care companies (O'Loughlin 2002).

Publicly listed hospital companies face a number of special risks and challenges, which are well illustrated in charting the problems of Mayne Health in early 2002.

First, the business model of consolidation is a risky one. The advantages of consolidation only accrue over time, and only if integrated systems can reduce excess capacity, align internal incentives, develop unified cultures and coordinate services. The disadvantages of consolidation are most severe in the short-term, however, as large organisations struggle with duplicative facilities, conflicting goals and expectations, individual sub-cultures, and inconsistent practices. In short, it is often easier to articulate a successful consolidation strategy than to achieve one (Robinson 1999, pp. 159-60).

This is a criticism that has been levelled at Mayne Health. In February 2002 when the Mayne Group delivered a lower than expected profit result, one commentator noted that one of the problems was that Peter Smedley and Stuart James (the CEO and Chief Operating Officer of the Mayne Group) were very good at buying things, but they had 'a reputation for bolting on businesses rather than integrating them' (Gluyas 2002, p. 32).

The pressure of making good returns from growth and consolidation is heightened by the need to make money fast for shareholders. The then Chairman of Revesco (a publicly listed primary health care company which has since been taken over by Gribbles) commented in the company's Annual Report (2000, p.3):

Shareholders should not underestimate the task required to create meaningful earnings outcomes from industry consolidation strategies.

But shareholders do not patiently wait for results, they move on. It's the nature of the beast as demonstrated by the market's reaction to the Mayne Group's fall in earnings. On 23 April 2002, the company announced a profit downgrade because of the poor performance of the hospital sector, resulting in an immediate 28% reduction in the share price. Although analysts agreed with the action taken by Mayne's to correct the situation, they still savaged the stock because they believed it would take 12 months to see the results (Bachelard 2002, pp. 29-30).

Finally, health care brings its own special challenges. A clear difference with other businesses is that health care is highly dependent on the actions and motivations of individual doctors who, because of their independent accountability and authority, hold a great deal of influence over the most important aspects of a hospital's operations. This makes it more difficult to achieve the standardisation of products and processes inherent in consolidation. As explained by Kleinke (2001, pp. 9-10):

A principle struggle in hospital management has always been the constant complicating factor of the de facto veto power by a hospital's nonemployees over nearly every aspect of its day to day operations. Indeed, physicians drive the bulk of a hospital's costs and exercise control over nearly all of its actual employees but have no real vested interest in its success.

Furthermore, doctors control referrals to private hospitals. In the assessment of the profit downgrade by the Mayne Group in April 2002, the financial press made much of the allegedly bad relationships between the company and the doctors who worked at its hospitals, resulting in many doctors either moving completely to other hospitals or moving some of their better remunerated work to other hospitals. Consequently, patient numbers fell at Mayne Health hospitals at a time when other private hospitals were experiencing very high occupancies (Bachelard 2002, p. 29).

According to Robert Gottlieb (2002, p.19):

...the Mayne problem was caused by a simple mistake: not understanding the power of surgeons who very neatly took them to the cleaners...the word spread around the surgeons...that Mayne no longer provided hot breakfasts during surgery; too often it rescheduled operations; the air-conditioning was turned down; and that the hospital employees that they liked had been 'rationalised out'.

In the business of private hospitals, the strategies that determine financial performance, such as consolidation, efficiency improvements and casemix management, can be thwarted by independent doctors. Reflecting on problems in the physician practice management firms in the United States, one commentator wrote (Marsh 1998, p. 79):

...there is quite a challenge involved in managing the shorter-term horizon of investors' expectations...with the longer-term horizon of attempting to change physicians' behaviour and practice patterns.

Commonwealth government funding of private hospitals

The second major change to impact on the private hospital industry has been the increased funding by the Commonwealth Government through the 30% rebate for private health insurance.

Commonwealth funding for private hospitals changed significantly during the 1990s:

- At the beginning of the decade, the Commonwealth spent just over \$100 million on private hospital care. This was 5% of total recurrent funding for private hospitals (AIHW 1996, p. 27; figures are for 1991-92).
- By 1998-99 (the most recent year available), the Commonwealth Government spent \$911 million on private hospitals, which included \$408 million in private health insurance rebates. The Government was now providing 23% of total recurrent funding for private hospitals (AIHW 2001, p. 62).
- The Commonwealth's contribution will increase as the numbers of people with private health insurance, and hence the cost of the 30% rebate, increases. The cost of the rebate is now more than \$2 billion a year (Butler 2001, p. 57).

The last time the Commonwealth Government played such a significant role in the provision of funding for private hospitals was between 1975 and 1987 through the bed-day subsidy. The subsidy was initially \$16 per day per occupied bed in a private hospital, amounting to more than \$140 million in 1985-86 (Senate Select Committee 1987, Chapter Two).

The introduction of the 30% rebate and the contribution of such a relatively large Commonwealth subsidy for the private hospital industry has its share of critics (for example, Duckett and Jackson 2000 and Richardson et al 2000). Furthermore, the success of the policy in terms of achieving the Government's objectives is regularly monitored (for example, through the quarterly figures of private health fund membership), keeping the pressure on the Government over the effectiveness of the policy.

A clear downside of such a politically sensitive policy is that, if things go wrong in private hospitals, people understandably look to the Government to fix them as a large 'underwriter' of the industry. There is a strong view that a sector that gets such significant support through taxpayers' money must be accountable for how that money is spent.

In this case, however, a problem for the Government is that its funding of private hospitals is largely indirect, in the form of rebates to people who take out private health insurance (and in most cases this is paid directly to the health funds) or of partial reimbursements to patients of their medical costs. Hence, the Government's ability to influence private hospitals is limited, without changing legislation and/or regulations. This uneasy situation for the Government is illustrated by the case of the allegations of 'cherry picking' by private hospitals discussed later in the article.

Changes in coverage of private health insurance

The third key change for the private hospital sector is a consequence of the Government's policies to support the industry: the increased coverage of private health insurance.

During the 1990s membership of private health insurance dropped to a low of 30% of Australians from a high of 50% in 1984. By 2000, however, this trend had turned around so that 45% of Australians were covered by private health insurance. This is a remarkable turnaround, achieved in a short two years (PHIAC 2002).

Analysis by Butler shows that by far the main reason for the turnaround was not the 'carrot' of the 30% rebate but the 'stick' of the Government's policy of Lifetime Health Cover. The introduction of the 30% rebate saw coverage increase only slightly, before resuming its downward trend. However, under Lifetime Health Cover a cost-penalty to the price of health insurance premiums was introduced from 15 July 2000 for people purchasing private health insurance beyond the age of 30 years. This led to a rush of people taking up insurance before this date to beat the penalty (Butler 2001, pp. 58-60).

Given the long-term decline in health insurance membership and the fact that it was not arrested by a 30% reduction in the price of the product, it would be reasonable to assume that most of the people who rushed to take out private health insurance before the introduction of Lifetime Health Cover were not keen on the product. Because of this, they are likely to be very sensitive to premium increases. And they are also likely to be fairly demanding customers who want to see value for the money they spent on health insurance. They will want to see differentiation with the public system to which they previously had access for free. Otherwise, they may feel they have been conned into the equivalent of a tax increase for health services that the 55% of Australian who did not take out private health insurance are not required to pay.

More generally, through the political debate surrounding the introduction of the 30% rebate and Lifetime Health Cover, the community's knowledge and awareness of private health insurance has been raised considerably. Expectations about what the product could deliver were raised also through the industry's advertising campaign promoting private hospitals with the slogan 'Always there with Extra Care'.

However, there is an obvious tension between delivering on consumers' expectations of extra care from private hospitals and their desire to keep the cost of premiums down.

Contracting between private hospitals and health funds

The tension comes to the fore in the negotiations between health funds and private hospitals over the rates a hospital receives from the funds for patient care and services. These contract negotiations are the fourth major change in the private hospitals industry to be discussed. They are particularly significant as they determine most of a hospital's revenue and most of a fund's outgoings.

Since 1995, health funds have been allowed to contract with hospitals for services under the National Health Act. As noted by the Australian Competition and Consumer Commission (ACCC) (2000a, p. 133):

Prior to the amendment, health funds were generally passive price takers with hospitals and their associations requiring higher fee levels each years...The 1995 legislation changed these market relationships considerably, and in particular transformed the health funds from passive price takers to active purchasers of services. As a result, hospitals were forced to look at the way they are managed with a focus on increasing cost efficiencies.

The new contracting arrangements underpin a transition in the basis on which health insurance funds pay private hospitals. Historically, funds paid per-diem rates to hospitals for patient bed days. The trend now is to a model based on the per-episode cost of treatment, regardless of the number of patient days actually incurred for treatment. An episode is defined as all the health care services typically provided to an individual patient presenting with a specific diagnosis or corresponding to a specific casemix (Bloom 2002, p. 34).

A clear impact of payment on the basis of a standard episode is that risk is shifted from the funds to the hospitals. A review of the new contracting arrangements by the ACCC concluded (2000b, p. 25): 'There is no doubt that profitability in the private hospital sector has been reduced as a result of the contracting environment.'

The change in the negotiating arrangements between health funds and private hospitals has encouraged larger groupings of hospitals, including corporatisation, to improve hospitals' relative bargaining strength in contract negotiations. Group hospital networks can have significant negotiating resources and access to the data of many hospitals on which to negotiate, whereas independent hospitals cannot jointly negotiate with health funds unless authorised by the ACCC (ACCC 2000a, p. 142; Productivity Commission 1999, p. 83). One of the reasons given for the formation of the Nova Health group of nine hospitals was to gain the benefits of centralised negotiations with health funds and of aggregated information on clinical, utilisation and length of stay data (Nova Health 2002, p. 20).

Larger groups of private hospitals also have advantages of scale in managing the financial risk inherent in episode payments. To do this, hospitals need to manage quality of care (to ensure patients get better as soon as possible) and efficiencies (to ensure services are provided as cost-effectively as possible while the patient is in care). And hospitals also have to manage their patient casemix. Different case mixes incur different costs and revenue, and hence produce different profit margins. As noted by Bloom, for private hospitals alternative casemix and their associated revenue are fundamental determinants of financial performance. For example, payment schedules tend to favour surgical and procedural patients over medical patients (Bloom 2002, pp. 20 and 25).

That managing casemix is an important driver of profitability has been duly noted by the financial press. The response by Mayne Health to the developments in contracting was explained in the Business Review Weekly (Quinlivan 2002, p. 52):

There has been considerable investment in information technology over the past two years, including sophisticated sets that should allow the company to better manage its mix of patients and procedures. Health funds have been pushing private hospital operators to shift to funding on a case-mix basis, which provides incentives for the hospitals to keep patients' stays as short as possible. Mayne's new systems are said to be state-of-the-art and should help the hospitals achieve the right balance between profitable surgical procedures and other, less profitable, hospital treatment.

In addressing the challenge of the shift to funding based on episode payments, hospitals run into issues surrounding their relationships with doctors. While private hospitals increasingly have an onus to manage costs and casemix in order to manage their contracts with health funds, their costs and casemix are significantly determined by non-employed doctors. Moreover, doctors are not paid on an episode basis but on a fee for service basis. Fee for service payments have distinctly different incentives for providers than episode payments.

Furthermore, the assumptions of the two payment types differ fundamentally. Fee for service is an individually patient-centred model, with payment based on whatever the individual doctor (and other providers) determine as necessary for that patient. Episode payments are based on standard treatments as defined by a clinical pathway, protocol, or benchmarking (Bloom 2002, p. 34; Randel et al. 2001, pp. 46-7). But, as explained by Kleinke (2001, p. 120):

Doctors practice medicine one patient at a time. This is how they are trained, and this is how they respond to data that purport to measure their outcomes.

From the patient's perspective, there is also likely to be resistance to standard rather than individually-determined treatments. Private patients have either been paying for health insurance for a considerable length of time or have been close to coerced into paying for it under Lifetime Health Cover. Patients want individually based care, to reflect their individual payments for that care.

Understandably, health funds put forward the view in negotiations with hospitals of the necessity to manage the scarce resources of health care. This is particularly important to funds to keep the cost of membership premiums down. However, at the same time, private patients view health insurance as a way of avoiding the scarcity of the public system, and are encouraged to do so by industry advertising campaigns. This is well illustrated by private patients' attitudes to maternity care. Commenting on the experience of a private patient who needed a caesarean delivery, a recent article reported (Metherell and Robinson 2002):

She expects to stay six days, but a friend who had to go public for her first baby recently had been discharged after only three days, even though she too had needed a caesarean. Longer stays are a key perk of going private, along with luxuries missing from public hospitals such as better food, single rooms, pay television and bar fridges.

This is a good example of conflicting interests in the provision of private care. The funds may pay the hospital a standard five day episode payment for the caesarean so the hospital has a clear incentive to manage the patient's length of stay within this period. But the patient, presumably in consultation with her doctor, expects to stay six days as a private patient. All involved, however, at a macro level have an interest in keeping premiums down.

The case of cherry picking

This article has discussed four key changes in the forces shaping the provision of private hospital care:

- the increased corporate ownership of private hospitals, bringing with it a focus on achieving satisfactory returns for shareholders through growth and consolidation strategies;
- the increased Commonwealth Government funding of private hospitals, and the consequential entanglement of the Government in the fortunes of the industry;
- the significant increase in coverage of and community awareness of private health insurance, and the obvious tension between delivering on consumers' expectations for extra care from private hospitals and keeping the cost of premiums down; and
- the introduction of contracting between health funds and private hospitals, which has been associated with the shift to episode payments for private hospital care, requiring private hospitals to manage efficiencies and casemix to maintain profitability. But much of a hospital's costs and casemix are determined by independent doctors.

These changes highlight the often conflicting interests of the hospitals, doctors, Government, health funds and patients in the provision of private hospital care. The conflicts surfaced in the debate around the allegations made in October 2001 of 'cherry picking' by private hospitals. The initial allegations concerned claims that Mayne Health was favouring the admission of profitable surgical patients at the expense of less profitable medical patients (Moynihan 2001a, p. 1). As the debate continued, the allegations were extended to other private hospital operators (Evans 2001, p. 7).

This article does not address the question of the truth of the allegations. Rather, it discusses how the debate around the allegations proceeded, thereby illustrating the views of the different players involved. In particular, it shows the changes in the Commonwealth Government's view as it became more embroiled in the issues.

In summary, the main points put forward in the press coverage were (see Moynihan 2001a and Toy 2001):

- The allegations of cherry picking were denied by Mayne Health, although newspapers reported anecdotal evidence from doctors that private hospitals were turning away patients who were not profitable and selecting more profitable surgical patients.
- The newspapers also reported anecdotes of privately insured patients who were not able to get a bed in private hospitals when they presented with medical conditions, leaving them to question the value of their health insurance.
- Speaking on behalf of the private hospitals, Michelle Green, chief executive of the Private Hospitals Association of Victoria, took the opportunity to criticise the funding arrangements with health funds, arguing that there are incentives in the system that encourage cherry-picking as the funds do not pay hospitals enough to care for sick, elderly patients.
- For their part, the health funds denied funding arrangements were a disincentive to treat medical patients.

It is doubtful that allegations of cherry picking by private hospitals would have got much of a run in the major Australian newspapers if they had surfaced a few years ago. What gave the story great currency and interest was the fact that the Commonwealth Government, whether it liked it or not, was enmeshed in the debate, and during an election campaign.

At first, the Government tried to downplay the issue. The then Minister for Health called on the AMA to provide evidence, saying without this the claims could not be investigated (Moynihan 2001b, p. 9). This response was strongly criticised (The Age 24 October 2001, p. 16):

... the response to the accusations of the federal Health Minister, Michael Wooldridge, is evasive and unacceptable... Dr Wooldridge should realise that to continue to evade the issue will simply encourage his critics to portray the rebate as a \$2 billion-a-year subsidy to the private hospitals.

It was this take on the issue — accountability for the expenditure of public funds — that ensured the issue remained in the limelight. The view was forcefully put in the Australian Financial Review (Moynihan 2002b):

That private corporations might seek to maximise profits by cream-skimming is hardly surprising. But as those corporations are now the beneficiaries of so much public largesse, in such a sensitive sector as health care, the Government will clearly have to come up with effective regulation.

Eventually, the Government did respond under a new Minister, and considerably raised the heat with talk of penalties and regulation. A Working Group was established to discuss the issues and the Government announced a review of the regulation of private health insurance 'to ensure that Australia's nine million health fund members continue to get maximum value for money' (Patterson 2002).

At the time of writing this article, it was not clear what specific action the Government might take. But what is clear is that the Government now 'owns' the problem — or at least the task of attempting to find a solution to the problem. But finding a solution brings one face to face with the challenge of reconciling the conflicting and complex interests in private hospital care.

For instance, at its source, any problem of cherry picking is a consequence of private hospitals responding to the incentives of funding arrangements from the health funds. Private hospitals argue that health fund payments for medical patients are inadequate, so to reduce incentives for cherry picking would require an increase in reimbursements and/or a more generous payment schedule that acknowledges the difficulties of managing the length of stay of patients with complicated and/or chronic medical conditions. Without this, any significant increase in the treatment of medical patients would put pressure on private hospitals' revenue. Although always an important issue for a private hospital, the great increase in the corporate ownership of private hospitals has brought with it a particularly acute focus on revenue.

But clearly any increase in revenue to private hospitals could increase costs to health funds, in turn putting pressure on premiums. Any increase in premiums would then flow through to an increase in the cost of the 30% rebate for the Government.

Consumers and doctors also have interests to be taken into account. If private hospitals do not have a great deal of spare capacity as is claimed, treating additional medical patients can only come to some extent at the expense of treating surgical patients. This would only shift consumer disappointment to another set of consumers — patients seeking elective surgery, a significant driver of health fund membership. Furthermore, a lot of the material for the press stories surrounding the cherry picking allegations came from doctors who could not get their medical patients into private hospitals; the same sort of complaints would come from other doctors if they were unable to get their surgical patients into hospitals.

Before the introduction of the 30% rebate and Lifetime Health Cover, the Government probably could have successfully avoided the issue of the allegations of cherry picking by private hospitals, leaving it to the market to sort out. However, through its policy interventions the Government has backed the industry and at the same time raised consumers' expectations. The Government has little choice now but to take responsibility for the significant investment of taxpayers' money. But as history shows, intervening in markets is not straightforward nor without risks, often entailing a suite of consequential impacts to manage.

Endnote

1. Mary Ann O'Loughlin worked for Mayne Nickless, a publicly listed health care company, between 1996 and 2000.

References

- Australian Bureau of Statistics (ABS) 2001, *Private Hospitals 1999-00*, Catalogue No 4390.0.
- Australian Competition and Consumer Commission (ACCC) 2000a, *Report to the Australian Senate on Anti-Competitive and Other Practices by Health Funds and Providers in Relation to Private Health Insurance for the Period Ending 31 December 1999*, ACCC, Melbourne.
- ACCC 2000b, *Report to the Australian Senate on Anti-Competitive and Other Practices by Health Funds and Providers in Relation to Private Health Insurance for the Period Ending 30 June 2000*, ACCC, Melbourne.
- Australian Institute of Health and Welfare (AIHW) 1996, Australia's Health Services Expenditure, 1982-83 to 1994-94, *Health Expenditure Bulletin* No 12.
- AIHW 2001, Australia's Health Services Expenditure to 1999-00, *Health Expenditure Bulletin* No 17.
- Bachelard, M. 2002, 'The surgeons who stitched up Smedley', *The Australian*, 27-28 April, pp. 29-30.
- Bloom, A. 2002, 'The funding of private hospitals in Australia', *Australian Health Review*, vol 25, no 1, pp 19-39.
- Butler, J. 2001, 'Policy change in private health insurance: Did the cheapest policy do the trick?', in G. Mooney and A. Plant (eds), *Daring to Dream: The Future of Australian Health Care, Essays in Honour of John Deeble*, Black Swan Press.
- Duckett, S. and Jackson, T. 2000, 'The new health insurance rebate: An inefficient way of assisting public hospitals', *Medical Journal of Australia* 172, pp. 439-42.
- Evans, S. 2001, 'Unhealthy number of elderly patients turned away', *Australian Financial Review* 8 December, p. 7.
- Gluyas, R. 2002, 'Health funds copy Mayne line', *The Australian* 4 March, p. 32.
- Gottlieb, R. 2002, 'Group falls headlong into the price-earnings trap', *The Australian* 25 April, p. 19.
- Kleinke, J.D. 2001, *Oxymorons: The Myth of a U.S. Health Care System*, Jossey-Bass, San Francisco.
- Marsh, L. 1998, 'The doctor's bottom line', *Health Affairs* vol 17 no 4 pp 75-9.
- Metherell, M. and Robinson, M. 2002, 'Baby booms leaves no room at the private inn', *Sydney Morning Herald* 10 April.
- Moynihan, R. 2001a, 'Doctors take on Mayne', *Australian Financial Review* 22 October, p. 1.

- Moynihan, R. 2001b, 'Sickness at heart of health system' *Australian Financial Review* 24 October, p. 9.
- Moynihan, R. 2002a, 'Elderly losers in health system', *Australian Financial Review*, 28 February.
- Moynihan, R. 2002b, 'How healthy are Howard's reforms?', *Australian Financial Review* 28 February.
- Nova Health 2002, *Prospectus*.
- O'Loughlin, M.A. 2002, 'The role of the private health care sector', presentation to *Towards Opportunity and Prosperity: 2002 Economic and Social Outlook Conference*, University of Melbourne.
- Patterson, Senator K. 2002, 'Government to reform regulation of private health insurance', Media Release 2 April.
- Private Health Insurance Administration Council (PHIAC) 2002, *Industry Statistics, Membership and Coverage*, at www.phiac.gov.au.
- Productivity Commission 1999, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra.
- Quinlivan, B. 2002, 'Medicine Man', *Business Review Weekly* April 4-10, p. 52.
- Randel, L., Pearson, S., Sabin, J., Hyams, T. and Emanuel, E. 2001, 'How managed care can be ethical', *Health Affairs* vol 20 no 4 pp. 43-56.
- Revesco Limited 2000, *Financial Report for the Year Ended 30 June 2000*.
- Richardson, J. 2000, 'The reform of public hospital funding in Australia', *Working Paper* no 100, Centre for Health Program Evaluation, Monash University.
- Robinson, J. 1999, *The Corporate Practice of Medicine*, University of California Press, Berkeley.
- Senate Select Committee on Private Hospitals and Nursing Homes 1987, *Private Hospitals in Australia: Their Conduct, Administration and Ownership*, AGPS, Canberra.
- The Age* 24 October 2001, 'Competing for a bite of the cherry', p.16.
- Toy, M.A. 2001, 'Are private hospitals giving the elderly a fair go?', *The Age* 31 October, p. 15.