The funding of private hospitals in Australia

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Abstract

Private hospitals are an essential component of Australia's complex mix of public and private health funding and provision. Private hospitals account for 34.3 per cent of all hospital separations, and over half (56.2%) of all same-day separations. The revenue (funding) of the sector approached $4 billion by 1998/99, and as a result of its recent rapid growth capital expenditure in the sector was nearly $550 million in the same year. Private casemix of private hospitals is distinctive, and characterised by a high proportion of surgical procedures in general (48.1per cent), and more than a majority of all services in such areas as rehabilitation, orthopaedics (shoulder, knee, spinal fusion, and hand surgery), alcohol disorders, same day colonoscopy and sleep disorders. This chapter synthesises data from a multitude of sources to produce a comprehensive picture of Australia's private hospital sector and its funding. It examines the funding (revenue) sources of private hospitals, and considers how and why private hospitals approach the issue of funding from a different perspective than their public sector colleagues. To illustrate how Australian private hospitals approach revenue (funding) strategically, a series of indicative types of hospitals is explored.

Introduction

Private hospitals are an essential component in Australia's complex mix of public and private health funding and provision. One of every three patients admitted to all hospitals in Australia is treated at a private hospital (ABS 2001). Private hospitals provide many of the same services as public hospitals, and account for over 6 million patient visits and 34.3 per cent of all hospital patient separations. However, they have a much higher proportion of surgical cases than public hospitals and account for nearly one-half (48.1 per cent) of all surgical episodes (APHA 2000a, p.3). The private sector also provides a significant portion of all obstetrical patient episodes (19.5 per cent) and medical services (20.1 per cent of all episodes). By 1998/99, total private hospital revenue had grown to $3.959 billion, and expenditure to $3.751 billion. Capital expenditure for buildings and major equipment was $549 million per year (ABS 2000, p.3). In short, Australia's health care system is heavily reliant on private hospitals which comprise a significant segment of the Australian economy.

This paper describes and analyses the funding of private hospitals in Australia, and seeks to illustrate important differences between the public and private sectors in relation to funding. In this paper, the term "funding" will be used to denote the broader topic of hospital finance. There are two components of funding that are explored in detail in relation to private hospitals: revenue (defined as operating income) and expenditure. Expenditure is considered primarily in the context of operational expenditure.

Data on patterns of private hospital expenditure, and comparisons between public and private expenditure patterns, have been readily available for several years, not on a hospital-by-hospital basis, but in sufficient specificity to enable comparison or benchmarking of recurrent expenditure expressed as services provided. Especially well documented is expenditure expressed as casemix, a result of extensive support for collection and analysis of casemix data.

Less well documented and understood is the revenue side of private hospital funding, and, in particular, how the private sector approaches the revenue opportunities available within Australia's rapidly changing healthcare

market. This gap in revenue information in the public arena is due in large part to concerns of commercial confidentiality. While this is understandable, the absence of detailed revenue information in the public arena means that the revenue side of private hospitals is not documented at a comparable level of detail and specificity compared with utilisation (expenditure) patterns, and consequently not as well understood, especially by those operating solely within a public sector environment.

Thus, it is well understood that private hospitals have a range of possible casemixes, that these casemixes incur different costs and produce different profit margins, and that any given casemix therefore has a different range of possible impacts on a hospital's profit and loss result. Less well understood is the concept that there is always a wide range of revenue sources from which private hospitals source their revenue, and that each source relates to different demand factors. Public hospitals typically design their casemixes to meet all effective health needs of a given population, and expect to rely primarily, and sometimes nearly completely, on a single revenue source - Government funding. In contrast, for private hospitals, alternative revenue sources, models and mixes are fundamental determinants of financial performance.

Sources of revenue, and their mix, are therefore logically as important to a private hospital as its clinical casemix, in a complementary way. A hospital's revenue mix determines such critical success factors as the reliability of funding over time, and the achievable payment for any given casemix (because funding sources differ in how much they pay for the same episode). A particular revenue mix may result by design or default. That is, a hospital may intentionally pursue a particular revenue mix, using a revenue model or mix as a strategic tool. Or a particular revenue mix may result by default - a lack of thorough business planning and/or poor execution.

Solid financial performance is essential whether a hospital is public or private. But whereas Government may intervene to support the finances of a public hospital, poor financial performance by a private hospital is felt directly and often swiftly. Miscalculation or poor selection among the range of revenue opportunities may depress the results of a private hospital, and its corporate parent (if any), and, in a worst case scenario, trigger a default on loans, and, potentially, lead to insolvency, dereliction of directors' duties and even receivership.

Thus, it should not be surprising to find that private hospitals that must achieve an adequate return on investment - particularly the growing number of investor-owned hospitals - have placed greater emphasis on revenue mix than those whose owners or trustees are under less pressure to achieve such specific commercial objectives. A focus on revenue mix is not limited to the for-profit private hospital sector. Not-for-profit hospitals that have borrowed significant sums at commercial rates in order to build and operate newer hospitals must also ensure a revenue mix that allows them to repay that debt. Even when they have not, owners, directors or trustees may question the logic of operating a not-for-profit hospital if it is losing money in an environment when "free" public hospital services are readily available.

The first objective of this paper is to provide a profile of the private hospital sector in Australia, including important trends over recent years and to analyse patterns and trends in the funding of private hospitals in Australia. The second objective is to demonstrate, by reference to a typology of revenue models, how private hospitals in Australia approach funding strategically. At this point in time, private and public hospitals differ widely in how they address revenue opportunities. Over time, if competition for market share between the two increases, and the public sector is required to introduce more stringent financial planning (such as capital charging), that gap can be expected to narrow.

Private hospitals in Australia - overview

In 1999-2000 there were 302 private hospitals in Australia, down from 323 in 1995-96 (see Table 1 and Figure 1).

Table 1: Relative size of the public and private acute hospital sector - 5 year trends

	1995-96	1996-97	1997-98	1998-99	1999-2000
Hospitals (No. of)					
Public hospitals [1]	756	727	764	755	748
Private hospitals [1]	323	319	317	312	302
Private (%)	29.9	30.5	29.0	329.2	28.8
Private day only hospitals	140	153	175	190	207
Available Beds					
Public hospitals	59,720	56,836	55,735	53,885	52,947
Private hospitals [1]	22,757	22,966	23,091	23,746	23,665
Private (%)	27.6	28.8	29.3	30.6	31.0

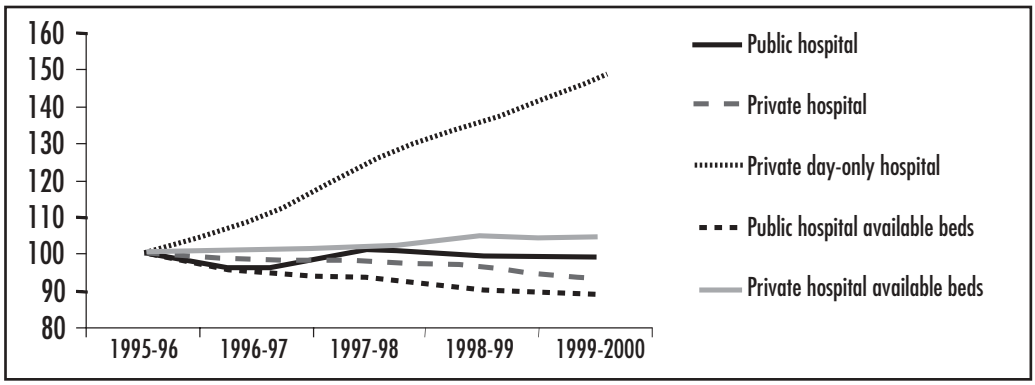
1 Includes both acute and psychiatric hospitals, but not day hospitals

Source: Australian Institute of Health and Welfare, *Australian Health 1996*
Australian Institute of Health and Welfare, *Australian Hospital Statistics 1993-95*: an overview
Australian Institute of Health and Welfare, *Australian Hospital Statistics 1998-99* (and previous years)
Australian Bureau of Statistics, *Private Hospitals Australia, 1999-2000*

Overall, private hospitals comprise just under 30 per cent of all hospitals and just over 30 per cent of available beds. Over the period 1995-96 to 1999-2000 private hospitals increased in size from an average 65 beds per hospital whilst public hospitals shrank from an average of 80 to an average of 71 beds.

While the number of private hospitals in Australia has remained fairly constant between 1991-92 and 1999-2000, the total number of beds in private hospitals has increased by almost 15 per cent, from 20,745 in 1991/92 to 23,665 in 1999-2000 (AIHW 2000, p.266). This increase is all the more striking when compared with growth trends in the public sector over the same period. The total number of public hospitals increased slightly during the period, but the total number of beds available in public acute hospitals declined by 7.8 per cent (down from 57,053 beds to 52,606 beds nationally) for an overall decrease of 2,177 beds. In short, while total bed capacity appeared to be nearly constant over the period, an important internal shift was occurring: capacity shifted from public hospitals to private hospitals.

Figure 1: Trend in number of hospitals and beds (1995-96 = 100), 1995-96 to 1999-2000



The ratios of hospital beds per population (public and private) confirmed these trends: over the period the availability of public acute hospital beds declined from 3.3 per thousand population to 2.8 per thousand population. Over the same period, the ratio per population of private hospital beds held steady at 1.2 per thousand population.

Two types of private hospitals - investor-owned and not-for-profit

Private hospitals in Australia may be either for-profit (investor-owned) or not-for profit. For-profit private hospitals, whose essential purpose is to generate profits for shareholders, may be privately-held or listed on the Australian Stock Exchange. Not-for-profit private hospitals may be owned by religious or other (including community) organisations. Most not-for-profit hospitals maintain that their major distinguishing feature is that they are "values driven" rather than "profit driven".

Table 2: Private acute and psychiatric hospitals by hospital type, 1999-2000

	Separations		Patient Days		Average Length of Stay	Occupancy Rate
	'000	Per cent	'000	Per cent	Days	Per cent
For Profit	1,009.1	56.1	3,407.1	54.7	3.4	70.7
Not for Profit						
Religious or charitable	682.6	37.9	2,416.7	38.8	3.5	74.3
Other[a]	107.4	6.0	408.1	6.6	3.8	69.1
Total	**1,799.1**	**100.0**	**6,231.9**	**100.0**	**3.5**	**72.0**

(a) Comprising bush nursing, community and memorial hospitals

Source: ABS, 2001, p.14.

Table 2 shows the breakdown of the private hospital sector between "for profit" and "not-for-profit" hospitals. The "for profit" sector accounts for slightly more than one-half of all separations (56.1 per cent) and patient days (54.7 per cent) (private acute and psychiatric hospitals only).

Table 3: Private hospitals in Australia - largest groups, 2001[1]

	National Market		
Group	Hospitals[2]	Beds	Share[3] Per cent
Health Care of Australia (Mayne Health)	59	6,039	25.5
Ramsay Healthcare Ltd	21	2,304	9.7
St John of God Health Care	7	1,249	5.3
HealthScope	17	1,106	4.7
Benchmark Health Care	10	872	3.7

1 Some religious orders own multiple hospitals that operate as independent facilities.

2 Hospitals that are open and running as at 30 August 2001. Some of these hospitals may be management contracts rather than owned by the organisations. Does not include private management/ownership of public hospitals.

3 Shares are calculated as known current beds for the group divided by total national or state beds for 1998-99. This will slightly overestimate market share as the total bed number is increasing.

Source: Individual organisations for ownership, Australian Private Hospital Association
Australian Bureau of Statistics 2001, *Private Hospitals, Australia 1999-2000*, for total available beds (23,665)

Table 3 shows Australia's largest private hospital groups, demonstrating how industry consolidation over the past decade has resulted in two very large listed for-profit private hospital corporations (Mayne Health and Ramsay Healthcare Ltd) and several significantly smaller groups.

Not-for-profit hospitals

Rapid consolidation of Australia's for-profit private hospital sector in recent years has focussed attention on the investor-owned, for-profit segment of the private hospital sector. Yet the not-for-profit segment accounts for nearly an identical volume of activity and expenditure in the private hospital sector.

Not-for-profit hospitals are those that are not operated primarily for the purpose of earning a profit although some do, in practice, operate at a profit. This category includes religious, charitable and community hospitals because of their "not-for-profit" status. These hospitals currently receive considerable tax concessions including:

- Fringe Benefits Tax
- State-based payroll and land taxes
- Income Tax (payable on company profits but not on retained surpluses of "not-for-profit" hospitals)
- Deductible gift recipient status.

Religious hospitals are usually affiliated with a specific diocese or congregation. A religious organisation may operate a group of hospitals that function as a group informally (e.g., are loosely federated for the purpose of purchasing supplies and services or negotiating with health funds), or formally (e.g., are structured as a group, sharing administrative and other resources).

One of the salient features of the private hospital sector not evident from Table 1 is the dominance of Catholic hospitals in the not-for-profit sector. Catholic hospitals account for nearly one-quarter of private hospital bed capacity in Australia today. But because Australia's Catholic hospitals belong to individual orders or dioceses, they generally do not traditionally rank among Australia's largest five hospital groups. In total, there are 130 owners (sometimes called "sponsors") of Catholic health, aged care and community services nationally. The dispersion and organisational independence of the Catholic sector masks its dominant position in the private hospital sector.

The Catholic sector - that is, those hospitals owned and operated by the Catholic organisations - accounts for one-half of the activity in the not-for-profit sector, and includes some 59 hospitals with 8,071 beds. If they functioned as an integrated group, the Catholic hospitals would be larger than the largest "for-profit" group, Mayne Health. Catholic hospitals straddle the public and private sectors both in funding and provision.

The Catholic sector owns and operates 22 "public" hospitals funded by State Governments, and 37 private facilities, funded largely by private sources. A limited number of private Catholic hospitals receive public funding for the treatment of public patients. When taken as a group, the Catholic hospitals are a significant factor in the provision of private hospital care nationally. Moreover, of the 22 public hospitals operated by the Catholic sector, 7 are renowned teaching hospitals (e.g. St. Vincents in Sydney and Melbourne, The Mater Misericordiae in Brisbane, etc.), have extremely complex, and costly, casemixes and undertake substantial medical training and research.

Activity in private hospitals - historical and current

Private hospitals have always accounted for a significant portion of the hospital sector, which in turn accounts for 37 per cent of all healthcare expenditure annually in Australia (Dept of Health and Aged Care, 2000, p.6). Until the mid 1980s, however, their development was incremental, and they provided a reliable but non-competitive counterpart to public hospitals. The profile of private hospitals, and their significance, varied from state to state and there was no truly national private hospital group. Corporate hospital groups were generally modest in size. During the decade of the 1980s a new trend emerged, and private hospital utilisation grew at almost three times the rate of public hospital admission growth (Foley 2000, p.101).

The 1990s signalled the beginning of a period of dramatic change in both the funding and structure of the healthcare market, with a continual increase in private sector participation in the provision of healthcare services. In 1989/90, 54 per cent of private patient days were spent in private hospitals; the balance of "private" patients were admitted to public hospitals as "private" patients. By 1997/98, however, with the rapid development of the private hospital industry, 76 per cent of "private" patient beddays were spent in "private" hospitals (Foley 2000, p. 102). In another major shift between the 1980s and late 1990s, the acuity mix of private hospitals increased as health insurance payments began to reflect the wide range of severity and associated costs of increasingly sophisticated and complex patient episodes.

Until the mid-1980s, with few exceptions (notably the distinguished private hospitals with tertiary and clinical training roles operated by religious orders and a few for-profit hospitals), private hospitals were in the main "cottage" hospitals that offered basic elective surgery and the convenience of immediate treatment and choice of doctor (Ibid, p.101). The new insurance reimbursement system provided the incentive for private hospitals to offer a more comprehensive and sophisticated range of services, so that today the casemix of newer private hospitals much more closely resembles that of their public counterparts.

Table 4 shows the five-year trends in private hospital revenue over the most recent years for which these data are available.

Table 4: Australian private hospitals - five year trends

	Financial Year				
	94/95	95/96	96/97	97/98	98/99
Separations ('000)	1,346.7	1,452.3	1,539.4	1,585.8	1,884.2
Revenue Generated ($million)	2,763	3,384	3,374	3,517	3,798
Full-time equivalent staff	36,589	39,100	40,908	41,566	43,053
Gross Capital Expenditure ($million)	354	382	307	376	527

Source: ABS, 2001

Table 5 shows the public-private treatment patterns of privately insured patients immediately before, and since, the introduction of "Lifetime Health Coverage" and the 30 per cent rebate for private health insurance. It shows that the number of insured patients seeking hospital treatment has been increasing steadily. Private hospitals (excluding free-standing day hospitals) account for three quarters of all separations, and a slightly higher proportion (78.4 per cent) of all insured patient-days in hospital. The greatest jump in insured patient episodes in recent quarters occurred in free-standing day hospitals, which registered a huge 56.6 per cent increase in patient episodes in the 15 months between March 2000 and June 2001. During the same period, privately insured patient episodes in private hospitals increased by 20.6 per cent and in public hospitals by 21.9 per cent. Clearly these numbers were accommodated by a reduction in average length of stay in both sectors.

Despite the recent development of the private hospital industry in Australia, significant differences persist between the functions of public and private hospitals, a legacy of private hospitals' historical focus on surgery, and a consequence of payment schedules and incentives that favour particular services (e.g. surgical and procedural) over others in terms of the profit they can generate. Thus, the casemix of private hospitals as a whole in Australia is still predominantly surgical and procedural: 50 per cent of private hospital admissions are for surgical procedures. By contrast, surgical patients account for fewer than 30 per cent of admissions to public hospitals (Foley, p.101).

Table 5: Beddays and separations of insured patients, March 2000 to June 2001

	Mar-00	Per cent	Dec-00	Per cent	Mar-01	Per cent	Jun-01	Per cent
Private Hospitals (excluding free-standing day hospitals)								
Days	1,064,557	79.2	1,125,498	77.5	1,173,761	78.4	1,193,746	77.7
Episodes	301,372	76.9	320,808	75.1	345,272	75.5	363,601	74.7
ALOS	3.5		3.5		3.4		3.3	
Free-Standing Day Hospitals								
Days	37,158	2.8	47,410	3.3	51,937	3.5	58,158	3.8
Episodes	37,192	9.5	47,515	11.1	52,040	11.4	58,258	12.0
Public Hospitals								
Days	242,181	18.0	279,253	19.2	270,962	18.1	284,156	18.5
Episodes	53,431	13.6	58,881	13.9	60,091	13.1	65,118	13.4
ALOS	4.5		4.7		4.5		4.4	
Total								
Days	1,343,896		1,452,161		1,496,660		1,536,060	
Episodes	391,995		427,204		457,403		486,977	
ALOS	3.4		3.4		3.3		3.2	

'ALOS' is average length of stay

Source: APHA, 2001 from PHIAC Quarterly Statistics

Through the 1990s, a more encouraging climate for private sector investment in private hospitals, and the support of State Governments for increased private sector participation in the provision of hospital services to both public as well as private patients, paved the way for a more robust private hospital sector. The listing on the Australian Stock Exchange of most of the largest investor-owned private healthcare groups further cemented the trend and encouraged even more substantial investment in and growth of the sector. These and other factors, notably the continued pressure on Government health budgets, have ensured that private hospitals will remain a significant source of healthcare in Australia into the indefinite future.

Activity in private hospitals - day surgery centres

A significant trend emerging during the decade of the 1990s was the phenomenal growth in "free standing day hospitals" (often called "day surgery centres") as shown in Table 6.

The number of "day surgery centres" has more than doubled over the decade of the 1990s, but the number of beds, or "chairs", has nearly trebled. Day surgeries performing primarily "general surgery" peaked in number in 1996-97, and have declined dramatically since then. By contrast, day surgeries specialising in ophthalmic procedures have more than doubled in number, but the greatest growth by far has occurred in centres specialising in diverse fields ("other"), such as fertility management, plastic surgery, and sleep disorders. Private day surgery revenue has quadrupled over the decade due to the sheer growth in volume of day surgery (Table 6).

Table 6: Number of free-standing day hospital facilities, summary table

	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
Day Hospitals (No. of)									
New South Wales	37	57	63	71	73	81	84	83	83
Victoria	22	23	24	23	23	22	30	41	50
Queensland	4	5	9	11	17	21	26	30	33
South Australia	1	1	3	7	10	12	14	15	18
Western Australia	4	4	7	8	10	9	12	11	13
Tasmania	-	-	1	1	2	3	3	4	4
Northern Territory	-	-	-	-	-	-	-	-	-
Australian Capital Territory	4	4	4	4	5	5	6	6	6
Australia	**72**	**94**	**111**	**125**	**140**	**153**	**175**	**190**	**207**
Day Hospitals by Type									
General surgery	24	37	46	47	54	57	55	33	23
Specialist endoscopy	26	29	30	36	37	37	42	50	53
Ophthalmic	13	14	16	20	23	25	29	33	43
Other[a]	9	14	19	22	26	34	49	74	88
Total	**72**	**94**	**111**	**125**	**140**	**153**	**175**	**190**	**207**

(a) Clinics specialising in fertility management, plastic surgery and sleep disorders.

Source: ABS, 2001

Casemix in private hospitals

Tables 7 and 8 show the relative size of private hospital activity, comparing major indicators in Australian public and private hospitals.

Table 7: Relative size of private hospital activity

	1995-96	1996-97	1997-98	1998-99	1999-00
Private Hospitals					
Separations ('000) [1]	1,577	1,685	1,793	1,875	2,206
Days ('000) [1]	5,893	5,834	5,995	6,045	6,356
ALOS [2]	3.7	3.5	3.3	3.2	3.1
Sameday Seps (%)	48.9	51.0	53.1	54.8	56.2
Occupancy (%)	70.4	69.8	69.5	69.7	72.0
Public Hospitals					
Separations ('000) [3]	3,593	3,642	3,770	3,860	3,872
Days ('000) [3]	16,555	16,532	16,560	16,274	16,230
ALOS	4.6	4.5	4.4	4.2	4.2
Sameday Seps (%)	39.5	41.8	43.1	44.5	45.6
Private Share (of total hospital activity)					
Separations (%)	30.5	31.6	29.5	31.0	34.3
Days (%)	26.3	26.1	26.6	27.1	28.1

[1] Includes free-standing day hospitals facilities. [2]'ALOS' is average length of stay. Includes 'same day' separations. [3]Includes public psychiatric hospitals.

Source: AIHW, 2001 and APHA 2000

Table 7 also shows the significant increase in private hospital activity over the 5 year period - an increase of 23.9 per cent in the number of separations, and an increase of 13.0 per cent in occupied beddays. Most of this increase is attributed to the dramatic increase in day procedures, up from 48.9 per cent of all private hospital activity to 56.2 per cent of private activity over the period (APHA, Ibid, p.2). By 1999/2000 private hospitals accounted for 34.3 per cent of all separations, compared with 32.7 per cent in 1998/99 (AIHW, 2001).

Table 8 shows the distribution of private hospital activity by State. Table 8 also shows the very significant variation across states in the proportion of hospital bed-days and separations that occur in the private sector. In nearly every state one-third or more of all hospital separations occur in private hospitals. The states registering the highest proportion of all hospital separations in the private sector are Victoria, Queensland, West Australia and Tasmania. In all cases the proportion of hospital days registered in private hospitals is lower than the proportion of separations, reflecting the difference in proportion of same day activity, which is reflected in the much shorter average length of stay in private hospitals.

Table 8 - State distribution of private hospital activity

	NSW/ACT	Vic	Qld	SA/NT	WA	Tas
1999-00 Distribution Of national private hospital activity						
Separations (%)	28.2	27.4	20.6	8.7	11.9	3.2
Days (%)	27.4	26.8	22.8	8.8	11.0	2.7
Private Hospital Share of State Hospital Activity						
Separations (%)	32.4	34.1	39.0	* 27.7	37.4	40.4
Days (%)	23.4	30.1	33.2	* 24.2	33.0	32.9

Source: Australian Bureau of Statistics, Private Hospitals Australia 1999-00, Australian Institute of Health and Welfare, Australian Hospital Statistics 1999-00

* NT not available

The casemix of private hospitals is distinctive

Expenditure by hospitals, including private hospitals, is most clearly reflected in a hospital's casemix, the pattern of patient types that is specific to each hospital. As noted previously, the respective casemixes of public and private hospitals in Australia differ significantly and private hospitals are more likely to have a higher proportion of surgical cases than public hospitals.

The differences between public and private hospitals become clear when the 20 most frequent DRGs in public and private hospitals are compared (Tables 9 and 10 below).

Table 9: Separation, same day separation, public patient separation, patient day, average length of stay and cost statistics for the 30 AR-DRGs version 4.1 with the highest number of separations, public (a) and private hospitals, Australia 1999-00

AR-DRG	Public Hospitals	Separations	Cost by Volume ($'000)	AR-DRG	Private Hospitals	Separations	Cost by Volume ($'000)
L61Z	Admit for Renal Dialysis	466,701	206,282	G44C	Other Colonoscopy, Same Day	135,901	90,102
R63Z	Chemotherapy	116,662	70,697	G45B	Other Gastroscopy for Non-Major Digestive Disease, Same Day	95,098	54,776
O60D	Vaginal Delivery w/o Complicating Diagnosis	111,129	254,708	R63Z	Chemotherapy	90,512	57,023
G44C	Other Colonscopy, Same Day	61,141	48,852	C08Z	Major Lens Procedures	72,113	104,852
G45B	Other Gastroscopy for Non-Major Digestive Disease, Same Day	59,905	41,814	L61Z	Admit for Renal Dialysis	62.454	22,483
F74Z	Chest Pain	42,730	57,515	I18Z	Knee Procedures	57,107	79,436
G67B	Oesophagitis, Gastroent, Misc Dig Systm Disders age >9 w/o cat/sev CC	41,509	48,981	D40Z	Dental Extraction and Restorations	55,971	58,770
J11Z	Other Skin, Subcutaneous Tissue and Breast Procedures	37,444	49,651	Z40Z	Follow-up After Completed Treatment W Endoscopy	43,845	28,455
O65B	Other Antenatal Admission W Moderate or No Complicating Diagnosis	36,899	39,371	U60Z	Mental Health Treatment, Same Day, w/o ECT	41,319	9,875
O40Z	Abortion WD&C, Aspiration Curettage or Hysterotomy	36,476	32,938	J11Z	Other Skin, Subcutaneous Tissue and Breast Procedures	34,436	37,053
E69C	Bronchitis and Asthma Age <50 w/o CC	33,133	43,007	O60D	Vaginal Delivery w/o Complicating Diagnosis	33,241	76,886
C08Z	Major Lens Procedures	32,952	64,718	N07Z	Other Uterine and Adnexa Procedures for Non-Malignancy	29,716	37,442
Z40Z	Follow-up After Completed Treatment W Endoscopy	31,151	25,824	O40Z	Abortion WD&C, Aspiration Curettage or Hysterotomy	24,858	22,944
G66B	Abdominal Pain or Mesenteric Adenitis w/o CC	30,336	30,821	F42B	Circ disorders w/0 AMI W invas Card inves proc w/0 complex dx/pr	22,356	39,347
Z64B	Other Factors Influencing Health Status Age >80	30,335	3,088	G09Z	Inguinal and Femoral Hernia Procedures Age >0	19,295	31,837

(a) Separations for which the type of episode of care was reported as acute, or newborn with qualified patient days, or was not reported.

1 Main abbreviations: ALOS - average length of stay; W - with; w/o - without; CC - complications and comorbidities.

2 Similar tables for all AR-DRG's are provided on the Internet at http:/www.aihw.gov.au/publications/hse/ahs99-00.html for Australia and each State and Territory.

Source: AIHW 2000c

In both public and private hospitals, 7 AR-DRGs ranked among the leading causes of separation renal dialysis, chemotherapy, vaginal delivery, major lens procedures, abortions and related diagnoses, "other" skin, tissue and breast procedures, and same day gastroscopy. But there they diverge.

Table 10 (AIHW, 2000c), isolates the DRGs in which the majority of services are provided by the private sector, demonstrating how these 15 DRGs account for fully 40.1 per cent of all separations from private hospitals, and 16.9 per cent of patient days in private hospitals nationally.

Table 10: DRGs for which majority of separations are from private hospitals, 1998-99

DRG	Description	Number of separations for private hospitals	Percentage of all separations	Number of beddays in private hospitals	Percentage of all beddays
Z60C	Rehabilitation, Sameday	4,771	98.4	4,771	98.4
K07Z	Obesity Procedures	2,105	81.7	5,044	68.9
V62B	Alcohol Use Disorder and Dependence, Sameday	2,575	79.3	2,575	79.3
N11B	Other Female Productive System O.R. Procs Age<65 W/o Malignancy W/o CC	9,593	79.2	10,432	74.2
J06B	Major Procedures for Non-Malignant Breast Conditions	9,629	78.1	16,979	73.4
I16Z	Other Shoulder Procedures	14,149	76.5	32,511	76.5
K04Z	Major Procedures for Obesity	1,035	76.2	3,572	68.6
J10Z	Skin, Subcutaneous Tissue and Breast Plastic O.R. Procedures	15,684	73.3	23,142	71.9
C04Z	Major Corneal, Scleral and Conjunctival Procedures	1,582	71.2	1,872	45.5
I18Z	Knee Procedures	50,490	69.5	65,824	67.0
D40Z	Dental Extraction and Restorations	51,843	67.9	53,091	67.0
I09B	Spinal Fusion W/o Catastrophic or Severe CC	2,119	67.8	19,504	71.0
I22Z	Major Wrist, Hand and Thumb Procedures	1,920	67.0	3,218	64.5
G44C	Other Colonoscopy, Sameday	119,459	66.6	119,459	66.6
E63Z	Sleep Apnoea	11,454	66.2	12,003	59.4
Private Hospitals' Total for Australia		**1,828,004**	**32.8**	**5,456,403**	**29.0**

Source: Australian Institute of Health and Welfare, *Australian Hospital Statistics 1998-99*

Expenditure by private hospitals

In 1998-99, the total expenditure on health care in Australia was $50.3 billion dollars, $2,671 per person, or 8.5 per cent of GDP (Commonwealth Department of Health and Aged Care, 2000, p.3). Non-Government sources accounted for 30.0 per cent of this funding in 1998/99, down from 31.1 per cent in 1997/98 and 33.1 per cent in 1996-97.

Private hospitals accounted for 8.3 per cent of recurrent health expenditure, less than half of doctors' services (which accounted for 19.3 per cent of all recurrent expenditure) and only slightly more than residential aged care (7.5 per cent of all recurrent expenditure in the same year). By contrast, public hospitals accounted for 29 per cent of all recurrent heath expenditure.

What are the major features of funding and expenditure patterns in private hospitals in Australia? Significant trends emerge over time, and between different types of hospitals. The average expenditure per patient per day in private hospitals has increased steadily over time, from $462 to $552 (e.g. about 20 per cent) over the five year period 1993/94 through 1998/99 (ABS, 2000, p.6). The average cost per patient typically increases in direct relation with the size of the hospital. In 1998/99, the average cost per patient per day in private hospitals with more than 200 beds was $718, nearly twice the cost at hospitals with 25 or fewer beds ($393 per patient per day) (AIHW 2000b). The differences are most likely a function of the more sophisticated and therefore more resource intensive services provided in larger hospitals, with a more complex casemix, although acuity levels are increasing in hospitals as a group, with day only hospitals taking an increasing proportion of lower acuity patients.

The average cost per patient per day also differs between private hospitals with different ownership structures. The most costly on a per patient day basis are the religious or charitable hospitals ($664 per day in 1998/99), compared with other not-for-profit hospitals ($552) and for-profit hospitals ($557). But facile explanations of these differences should be avoided, since the difference may be attributable to the high proportion of religious hospital patients who receive highly specialised and sophisticated, and therefore costly, treatment, or it might be a consequence of a higher cost structure resulting from other factors.

Revenue and expenditure in private hospitals

Expenditure in both public and private hospitals can be categorised into two main headings, recurrent and capital. Recurrent expenditure is often mistakenly interpreted to be the "real" measure of health care expenditure, because it has historically been the main focus of public hospitals.

Tables 11 and 12 contain consolidated revenue and expenditure figures for private acute and psychiatric hospitals, and for free standing day hospitals. Table 11 provides a detailed breakdown of expenditure patterns by category of expenditure, for the year 1998-99. As expected, salaries and wages are the single largest component of the recurrent budget of private hospitals. Other data show that the proportion spent on wages varies up to 4 percentage points depending on the state and the size of the hospital (ABS 2000, pp.11, 18).

Table 11: Private acute and psychiatric hospitals, revenue and expenditure, 1998-99

NSW/ ACT	Vic	Qld	SA/	NT	WA	Tas	Aust
Revenue ($'000)							
Patient Revenue	1,070,735	994,801	733,934	285,792	427,480	122,571	3,635,311
Recoveries	90,611	79,252	42,387	17,252	22,823	7,430	259,755
Other (a)	36,716	27,071	30,338	6,623	15,275	1,047	117,069
Total	**1,198,062**	**1,101,123**	**806,658**	**309,666**	**465,578**	**131,048**	**4,012,135**
Patient Revenue as a Proportion of Total Revenue (%)	89.4	90.3	91.0	92.3	91.8	92.9	90.6
Recurrent Expenditure ($'000)							
Wages and salaries including on-costs	618,297	604,392	447,928	172,766	246,496	80,949	2,170,827
Drug, medical and surgical supplies	222,035	165,583	114,534	43,949	67,773	16,914	630,788
Food supplies	20,008	26,849	14,599	6,133	8,646	2,572	78,807
Other domestic services	20,936	18,154	18,586	6,834	9,663	2,937	77,109
Administrative expenses	92,704	84,217	44,389	25,211	34,426	10,793	291,741
Repairs and maintenance	19,199	24,135	13,426	6,632	7,628	2,503	73,522
Other	141,410	134,356	87,125	39,273	55,031	14,045	471,240
Total recurrent expenditure	**1,134,589**	**1,057,685**	**740,586**	**300,797**	**429,663**	**130,713**	**3,794,034**
Wages and salaries including on-costs as a proportion of total recurrent expenditure (%)	54.5	57.1	60.5	57.4	57.4	61.9	57.2
Average recurrent expenditure							
Per separation ($)	2,233	2,149	1,997	1,925	2,007	2,267	2,109
Per patient day ($)	664	632	522	548	628	664	609
Gross capital expenditure ('000)	**71,747**	**69,004**	**147,497**	**7,523**	**21,385**	**8,097**	**325,254**

Source: ABS: Private Hospitals Australia, 1999-2000, 4390.

Table 12: Free standing day hospital facilities, revenue and expenditure

	1991-92	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
Total revenue($'000)	45,486	85,805	99,305	119,215	145,278	161,400	191,614
Patient revenue (%)	90.0	96.4	94.8	94.7	95.7	95.5	95.5
Total recurrent expenditure ($'000)	35,360	70,044	80,238	95,410	122,311	137,480	162,710
Wages and salaries including on-costs (%)	41.1	40.9	42.8	40.1	41.7	41.5	41.2
Per Separation ($)	287	369	384	422	450	455	466
Gross Capital Expenditure ($'000)	**6,052**	**16,717**	**16,775**	**21,017**	**26,967**	**21,629**	**26,489**

Source: ABS: Private Hospitals Australia, 1999-2000, 4390.

How private hospitals are funded

Private hospitals have historically relied on revenue either from private health insurers, or directly from patients in the form of out-of-pocket, fee-for-service payments, or from specific Government programs. The proportion of revenue deriving from private health insurance funds compared with "out-of-pockets" varied before and after the introduction of Medicare, and with private health insurance coverage levels (Duckett 1999, pp.98, 101).

Recent developments in private hospital funding

In recent years other sources of revenue for patients treated in private hospitals have become more significant. A major factor in this trend has been the determination of governments to encourage greater private sector involvement, and hence competition, by enabling the private sector to gain access to public funds that were previously only available to public hospitals. The competition this sets up between public and private providers of hospital services will, it is asserted, generate improvements in efficiency and productivity, ultimately driving down the total cost of healthcare. Private hospitals co-located on public hospital campuses were an early incentive to greater private sector investment in, and provision of, healthcare services.

More recent arrangements that provide still other sources of revenue for the private sector include:

- A greatly expanded number of co-locations, a commercial arrangement between Government and a private hospital operator whereby the private hospital is located on the same site or in close proximity to each other (e.g., the Royal North Shore Hospital and the North Shore Private Hospital in Sydney).
- The operation of a public hospital by a private operator under contract to Government (e.g. Modbury Hospital in South Australia)
- Privately owned and operated hospitals providing, under contract, services to a defined population (capitation-based) or providing specific services. (e.g., Port Macquarie and Hawkesbury Hospitals in NSW; Hollywood and Greenslopes Hospitals in W.A. and Qld respectively).

Table 13 (the most recent available data) breaks down total health expenditure (recurrent expenditure only) by the source of funding (revenue) and the area in which it is spent for all hospitals in Australia. The table shows clearly the contrast in sources of funding between private and public hospitals. The table shows how reliant private hospitals are on revenue from health insurance funds, which in the year shown accounted for $2.295 billion of total private hospital funds of $3.658 billion (62.7 per cent). But the remaining 37.8 per cent of funds from "other" sources and from individuals paying "out of-pocket" are not insignificant. Over recent years an increasing proportion of funding for private hospitals has derived from "other sources". The proportion of revenue private hospitals receive from private health funds (insurers) has declined concomitantly.

Table 13: Total health services expenditure, current prices, Australia, by area of expenditure and source of funds [a], 1997-98 ($million)

Area of Expenditure	Government Sector			Non-Government Sector				
	Commonwealth[a]	State and Local	Total	Health Insurance Funds [b]	Individuals	Other[c]	Total	Total Expenditure
Total hospitals	6,343	6,437	12,780	2,607	418	1,095	4,120	16,900
Recognised public hospitals	5,771	6,080	11,851	311	79	595	986	12,836
Private hospitals	550		550	2,295	321	493	3,109	3,658
Repatriation hospitals	15		15					15
Public psychiatric hospitals	7	357	365		18	7	25	390
Nursing homes	2,575	137	2,712		608		608	3,320
Ambulance	90	281	370	106	129	38	273	643
Total institutional	**9,007**	**6,855**	**15,862**	**2,712**	**1,155**	**1,133**	**5,000**	**20,863**
Total non-institutional	**11,956**	**2,197**	**14,154**	**1,721**	**6,452**	**805**	**8,978**	**23,132**
Total recurrent expenditure	**20,964**	**9,053**	**30,016**	**4,434**	**7,606**	**1,938**	**13,978**	**43,994**
Capital expenditure	70	1,400	1,470	na	na	na	994 [d]	2,464
Capital consumption	34	538	572	na	na	na		572
Total health expenditure	**21,068**	**10,990**	**32,058**	**na**	**na**	**na**	**14,972**	**47,030**

(a) This table shows the amounts provided by the Commonwealth Government, State and Territory Governments, local government authorities and the non-government sector to fund expenditure on health services. It does not show gross outlays on health services by the different levels of government or by the non-government sector.

(b) PHIIS subsidies of $252 million paid directly to funds are included in the Commonwealth column and are subtracted from the health insurance funds column. PHIIS benefits paid in the form of tax rebates ($207 million) are not designated as Commonwealth funded expenditure in this table but are included as Commonwealth funded expenditure in Table 5.

(c) 'Other' includes expenditure on health services by providers of Workers' Compensation and Compulsory Motor Vehicle Third Party insurance cover.

(d) Capital outlays for the non-government sector cannot be allocated according to 'source of funds'.

(e) Private capital consumption (depreciation) expenditure is included as part of recurrent expenditure.

Source: AIHW Health Expenditure Database, 2001.

A table with more recent and detailed data would show two very important new trends. First, since all Repatriation hospitals have either ceased operation or had their ownership transferred in recent years, their patients have been redistributed in higher proportions to private hospitals. Hence, the revenue provided previously to Repatriation hospitals is now being channeled, in increasing proportion, to private hospitals. Second, private hospital insurance coverage, which surged in 1999-2000, appears to have peaked in late 2000 after several quarters of continuous increase. The increase was triggered by the Commonwealth Government's "carrot and stick" approach to the serious and seemingly permanent decline in private health insurance coverage since the mid-1980s. The "30 per cent rebate" on private health insurance coverage was the "carrot". The "stick" is the increasing scale of insurance premiums the older the age at enrolment in a private health fund. The premium increases by 2% for each year of age at entry into health insurance beyond 30 years of age.

How public and private hospitals obtain funding

One of the fundamental differences between public and private hospitals in Australia in relation to funding (revenue) is the very different way that revenue is obtained and used. The greatest difference occurs in how each obtains and accounts for investment capital, the funds used for major construction and equipment, including

modernising the physical plant, acquisitions, and new construction such as co-located hospitals. Private hospitals must usually borrow from commercial sources, e.g., retail or investment financing institutions, at commercial rates, in order to obtain investment capital. For some non-for-profit owned hospitals, it may be possible to obtain funds through the parent organisation, either as a loan or grant. Investor-owned institutions must borrow on commercial terms. This "cost of capital" is a major factor in the development and commercial behaviour of private hospitals that does not apply to publicly owned hospitals at this time. (A new accounting requirement for publicly owned hospitals, "capital charging" is discussed later in this section.) The ever-present pressure to service debt on schedule, and accrue equity, places on private hospitals a heavy burden that is not experienced by their public counterparts.

With regard to operating revenue, private hospitals have a range of sources of operating revenue, the most important of which are private health insurance; private, out-of pocket payments; revenue from Government or statutory bodies (in particular Veterans' Affairs, Workers Compensation and Compulsory Third Party or CTP); contracts with public hospitals or Ministries of Health and Treasury; and revenue from overseas patients. In theory a "capital" factor is built into the funds received from each of these sources.

At the time of writing 44 health insurance funds were registered in Australia (PHIAC, 2002) most operating either locally, or available only to a restricted population (such as members of a particular occupational group). Private hospitals receive payment for the treatment of enrolled health fund members after treatment is provided. The basis on which health insurance funds pay private hospitals is in transition from the historical model, which incorporated scheduled payments for use of operating theatres, prostheses, patient beddays, and other costs, to a model based on the per-episode cost of treatment and other inovative arrangements. 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". The episode refers to the units of care (including goods as well as services, provided by a clinician or other provider) that are considered standard treatment (as defined by a clinical pathway, protocol, or benchmarking with 'peer' groups - similar hospitals or other health care providers).

The Department of Veterans' Affairs is Australia's first and largest national purchaser of hospital services. It funds, or purchases from, both public and private hospitals, on behalf of Veterans and their eligible dependents. Its annual budget for health care, aged care and related support is $2.3 billion (Lyon, 2000, p.223), for an eligible population of some 400,000 WWII Veterans and their widows, whose average age is approaching the mid-seventies - a group of intensive users of hospital services - as well as some 100,000 younger Veterans.

DVA typically funds all costs of treatment, rarely requiring co-payments. DVA often negotiates "preferred provider" relationships and contracts. Nearly half of DVA's funds for hospital treatment are paid to private hospitals (Lyon, 2000, p.233), by 1996/97, compared with a mere 16 per cent five years earlier. DVA funding comprises a very significant source of revenue for private hospitals.

Patients treated at private hospitals may pay for some, or all, of their treatment themselves - "out-of-pocket". They may be obliged to do so if they have a required excess or the cost of hospital treatment exceeds the payment levels approved by their health insurance fund ("the gap" which the Government and private health insurance funds are endeavouring to eliminate). Or they may simply pay for the entire treatment "out-of-pocket", either because the front-end deductible (excess) on their private health fund is very high, or because they have no private health insurance ("self-insured"). In some cases the treatment itself may simply not be covered by private health insurance, and out-of-pocket payment is the only option.

For some years contracting between the public hospital system and private hospitals had been restricted to selected specialist hospital services, such as ophthalmic surgery, usually where medical specialist services were locally available in private hospitals, but not in sufficient supply in public hospitals. But in the late 1990s the wave of privatisation introduced new models of public-private partnerships such as co-located hospitals and "outsourcing" of public patients to private hospitals on a larger scale. As a consequence, contracting out became more common, and more varied. Contracts for private hospitals to treat publicly-funded in-patients are typically negotiated on a casemix cost basis with patient volumes capped. Although the contracted price for treating public patients is intended to include a contribution towards capital cost, and other aspects of these contracts are carefully negotiated, some private hospitals have found that instead of contributing to their overall profitability, contracts for treating publicly funded in-patients have not consistently proven profitable.

Workers' Compensation Funds and the Compulsory Third Party (CTP) funds are both collected for the purpose of ensuring appropriate treatment, in hospitals and other facilities, for those injured in work-related settings in the first instance, and in the case of CTP, in road traffic accidents.

The treatment of overseas patients in Australian private hospitals is a very specialised market. The overseas patients treated in Australia's private hospitals are a distinct group from the patients treated in public hospitals under Commonwealth-negotiated agreements and are Government funded. Overseas patients treated in Australia's private hospitals are most likely seeking specialist medical advice and procedures - such as cardiac surgery - that they perceive to be of better quality in Australia than in their country of residence. They typically pay "out-of-pocket", and for a small number of private hospitals, comprise an important, if not large, source of funding.

Private hospitals also obtain revenue from other Commonwealth Government sources. They also benefit from the effect of the 30 per cent Government rebate for private health insurance enrolment, though not as direct revenue. Pharmaceutical Benefit Scheme funding to the extent that patients are directly purchasing drugs in hospital and occasionally for Medical Benefits Scheme payments for in-hospital treatment. Only the 30 per cent rebate can be quantified and attributed to private hospitals.

In addition to these sources, private hospitals receive revenue from sources that are not directly patient related. The most important of these are parking facilities (which may be operated directly by the hospital, or by a third party), retail shops on the hospital premises (which may contribute a percentage of income as well as rental fees), grants and private donations to hospital-affiliated foundations, including research foundations, and bequests. Each of these sources can represent a significant contribution.

In summary, private hospitals in Australia have a range of funding or revenue sources. Many have found it profitable to develop business strategies based on a particular revenue mix. In the preparation of financial models and business cases, a specific revenue mix is typically assumed, in the same way that the operating model of the hospital assumes a particular casemix.

Some of the revenue sources described above also imply patients with particular medical needs, preferences, and budgets. For example, Veterans' Affairs patients, the majority of whom are old or very old, tend to have complexities and co-morbidities, cluster in particular DRGs, and require a range of ancillary and support services. DVA funding has historically tended to be generous compared with other revenue sources. Overseas patients, often prefer a luxurious environment, frequently bring their families, and may need a host of hospitality-type services. They are, as a rule, less price sensitive than other sources of revenue. Obviously patients requiring in-patient treatment as a result of serious motor vehicle or work-related injuries will require post-trauma treatment as well as extensive rehabilitation and their principal diagnoses are more likely to include specific orthopaedic, spinal, neurological and similar, than, say, DVA-funded patients. Publicly-funded patients treated under contract would be expected to receive a level of service and amenity comparable to the local public hospital, and the private hospital might be under strict cost and quality guidelines for their treatment.

In sum, each of these revenue or funding groups requires a distinct combination of service and amenities and doctor and nurse ratios and specialisations, so that a profitable private hospital must fashion itself - its business strategy, its services, staff and amenities - to serve the market represented by each revenue source. The next section examines hypothetical revenue models, each presuming a different "mix" of revenue sources.

Revenue as a tool of private hospital business strategy

Private hospitals and public hospitals in Australia both operate in a complex environment. Private hospitals often argue that public hospitals have much less stringent financial constraints: the "playing field is not level", they argue, because public hospitals receive an agreed and reliable annual operating budget from Government, and additional funding for major capital works. They are not in practice responsible, as private hospitals are, for provisioning for capital depreciation and replacement. While capital charging is being introduced progressively by State Health Departments, at the time of writing was still a theoretical exercise (Southwell, 2000). They are funded for whatever casemix they attract.

Private hospitals, by contrast, must somehow attract sufficient patients, of an appropriate casemix, to generate a combination of costs and revenue that enables them to break even and achieve an acceptable return on investment. Publicly-listed private hospitals have a large institutional and retail shareholder base intently watching their financial performance. Nor is the playing field level, they contend, with regard to not-for-profit hospitals, which are not only tax exempt in most regards, but may also receive a financial "cushion" from their owners.

So it is not surprising that investor-owned private hospitals have been the most assiduous of all hospitals in employing revenue as a strategic tool. That is, they have identified alternative sources of revenue as a strategic factor, and target the sources of revenue that best suit their commercial and corporate objectives. The revenue mix of a private hospital is as much a strategic factor as casemix in achieving financial targets. In practice, the two are linked, of course, because casemix is one important determinant of revenue. And making a hospital attractive to funders - whether they are private insurers, the Department of Veterans Affairs, or State Departments of Health and Treasuries - requires specific effort.

Newer not-for-profit hospitals that have entered the market with substantial capital finance from private markets face a similar imperative. If they are to deliver services and still meet their capital repayment schedule, they, too, must consider how they can attract both the casemix and revenue or funding mix to meet these obligations - even if they do not return a profit. Thus targeting funding sources, and achieving the desired revenue mix, is an important commercial objective.

Obviously the several funding sources described above can be combined in different proportions to produce different revenue (funding) mixes. Not surprisingly, hospitals vary widely in the proportionate mix of the different funding sources they attract. For many private hospitals, particularly those in regional and rural locations, funding sources and their mix are to a large extent determined by the socio-economic characteristics of the location. Within any location, or catchment area, among the most important factors are:

- the socioeconomic profile of the population (especially private insurance coverage, but also proportion of Veterans and overall level of disposable income);
- the presence or absence of other suppliers of hospital services and their casemix and marketing strategies; and
- the casemix of patients that can be attracted by the services offered by the hospital - e.g., day-only surgery, obstetrics - the effective and lateral need and demand.

All form part of the "business environment" that determines the possible funding mix of a private hospital.

Hypothetical "funding (revenue) models" of private hospitals are identified below (Table 14). They are intended to demonstrate how widely revenue (funding) models can vary among private hospitals. None of these types accurately reflects the revenue mix of any specific hospital. They could not, as there is too much variation within each category. They are presented to illustrate how the range of potential revenue sources enables a private hospital to build up a distinct revenue model. They are also intended to highlight the possible range of variation when all sources of revenue, differences in casemix, and features of the local environment (such as the possibility of contracting for public patients, the presence of a high concentration of Veterans, etc.) are taken into consideration.

Table 14: Hypothetical revenue models, private hospitals - summary

Revenue model	Revenue characteristics	Comments
Type 1 - "Standard" Revenue Mix	Approximately 1/2 of revenue from private health funds;1/4 from self-insured; smaller percentages from DVA, Workers Comp & CTP, Overseas. High deductible and out-of-pocket 15 per cent	Diversified revenue streams likely to reflect private health coverage of local catchment
Type 2 - Veterans Affairs Patients	Product of transfer of DVA patients to private hospital. Very high proportion of revenue from DVA	Hospital will need to diversify revenue streams over time as older Veterans decline in number.
Type 3 - Private Psychiatric Hospital	Depending on local enrolment levels in private health funds and specific services could rely on majority of self-funded patients,.	Vary in revenue composition depending on location and amenities.
Type 4A - Private Hospital with Modest Proportion of "Outsourced" Publicly-funded Patients -	Hospital's revenue model relies heavily on outsourced patients	Medium- to long-term revenue flows uncertain as depend on periodic contract negotiations.
Type 4B - Private Hospital Largely Reliant on "outsourced" Publicly-funded Patients	Hospital likely to be built to accommodate predictable casemix, which will be negotiated directly. Type 4B hospitals are often co-locations or constructed under other formal agreement with Government	Depending on terms of contract, revenue flow could be reliable or somewhat unpredictable over time. Financial impact on private hospital's performance contingent on hospital's capacity to predict costs accurately and negotiate accordingly.
Type 5 - Free-standing Day Surgery	Most likely to depend on self-insured and high-deductible patients	Revenue flow highly dependent on activities of private hospitals and other day surgery centres in catchment area.
Type 6 - Private rehabilitation hospital	Reliant for a higher proportion of patient revenue on Workers Comp, CTP, DVA and other compensable patients	

Again, none of the revenue models depicted above is intended to reflect accurately the revenue profile of any specific hospital. However, the types serve as a basis for consideration of the differences amongst private hospitals in the mix of revenue sources they receive. "Type 1" illustrates a "standard" mix of revenue sources, demonstrating that more than one-half of hospital revenue is sourced from private health funds, but "self-insured" patients are also significant, as are patients who pay "out-of-pocket" for other reasons. The 15 per cent of patient revenue sourced from Veterans' Affairs, Workcover, and similar sources is on the comparatively high end of the spectrum, but could easily be the case. While by no means all hospitals have "overseas" revenue, it is included here to indicate that this might be a very small proportion of total revenue.

Type 2 is reflective of only a few of hospitals in Australia, and is included merely to indicate that specific circumstances, such as the devolution of hospital treatment for Veterans, can create a very niche market for acute hospitals. In this instance, the model reflects the revenue pattern of hospitals catering specifically to Veterans' patients, effectively replacing previous publicly owned and operated Veterans' hospitals. Hospitals of this type are heavily reliant on a particular organisational and patient base. Obviously this affects their casemix and makes it worthwhile, indeed, imperative, to custom design services and the way they are delivered to suit that particular clientele.

Type 3 refers to yet another specialised type of private hospital, a "psychiatric" hospital. The high proportion of self-insured patients reflects three peculiarities of mental health treatment in Australia today: the limited services available through the public hospitals that pushes some uninsured clients into the private sector; the limited coverage available through private health funds; and the desire to keep confidential one's treatment for mild mental illness (e.g. depression and addictive disorders) by seeking discreet treatment in a private hospital.

Type 4a is designed to indicate that in recent years private hospitals have been developed in response to opportunities to provide treatment for publicly-funded patients under contract with the local health authority or State Health Department. The 70/30 proportionate split here does not reflect any real contract, but is illustrative of the fact that these opportunities typically do not preclude private hospitals from treating privately-funded patients, but that their business case is built heavily upon a guaranteed flow of public patients over a period of approximately 20 years.

Type 4b, by contrast, typifies a private hospital that provides selected services to publicly-funded patients in order to augment the services otherwise available locally or regionally to publicly-funded patients. The private hospital might negotiate periodic contracts for one or more type of service, such as ophthalmic surgery, if, for instance, specialists are not performing such procedures in public hospitals in the region. Clearly the private hospital is not heavily reliant on funding from the public sector, but in fact 10 per cent of revenue at the margin may be sufficiently high so that this source of revenue is vital to the hospital's financial performance.

Type 5 reflects the revenue sources of an indicative free-standing day surgery, and demonstrates how day surgeries, with their wide range of "simple" and quick procedures, can draw more heavily on the self-insured/self-funded market than other, more costly hospitals.

Finally, Type 6 attempts to capture yet another specialised market, treating patients with injuries and disabilities that are covered by non-health-related funding such as Workers Compensation and other ("compensable") sources such as CTP (Comprehensive Third Party insurance). The injury-related nature of this funding means, among other things, that the casemix of these hospitals is slanted more towards trauma and rehabilitation than the average hospital. The specialised nature of patients with brain injury and other extensive rehabilitation needs places these hospitals in yet another category in terms of their range of services, physical facilities, and average cost per patient episode, as well as revenue sources.

The future

One of the salient features of Australia's healthcare system is its continuous, incremental change. Thus it can be predicted with a fair degree of certainty that the funding of private hospitals, including both revenue and expenditure, will continue to evolve.

Several factors signal that some change in direction will occur in the not-too-distant future. For example, the full impact of a very major change in the flow of funds to private hospitals, the introduction in July 2000 of "Lifetime Health Cover", and the stabilisation of private health insurance coverage following the introduction of the 30 per cent rebate, is only now emerging, as newly-insured begin to seek treatment in private hospital.

Next, any national or state election that brings with it possible changes in health policy and funding parameters will affect the prospect of specific funding sources and expenditure patterns. For instance, recent legislation makes it possible for private health insurance to cover "hospital in the home", post-acute care, and other forms of "substitutable" care.

There is little doubt that further actions will be taken to support two directions: the reimbursement of private hospitals on an "episode" basis, benchmarked nationally and locally; and "closure of the gap", that is, elimination of "out-of-pocket" payments required of privately insured patients by many private hospitals.

The funding of private hospitals in Australia has been poorly documented and analysed to date, and little understood by those not directly involved in the private hospital industry directly, or indirectly, as are private health insurers. This is the dual consequence of the recent and rapid development of private hospitals, and the confidential nature of much private hospital data. The funding of private hospitals differs significantly, in both revenue and expenditure, from the funding of public hospitals. The difference has been described by one authority who said that the focus for public hospitals is typically expenditure, whereas the focus of private hospitals is revenue and profits. The literature, which has until now concentrated on public hospitals, is thus rich in expenditure data, but impoverished in information about revenue and profits. This paper has attempted to describe and analyse both the expenditure and revenue characteristics of private hospitals in Australia, and to contrast public and private hospitals with regard to funding.

The analysis has shown that although private and public hospitals share a number of "top 20" diagnosis related groups, indicating that private hospitals are increasingly looking like public hospitals in regard to casemix, there are still major differences between the two. For one, private hospitals are more likely to have a surgical and procedural casemix, and cater in particular to obstetric patients, reflecting their assessment of the most attractive service profile and profitable casemix. With regard to revenue, as distinct from publicly owned and operated hospitals, private hospitals are under great pressure to ensure that they target revenue sources and mixes that will deliver the revenue/cost that will enable them to repay the cost of capital, and achieve their profitability targets. Public hospitals have no such imperative to date. Thus, private hospitals construct - or should be constructing - revenue models based not only on specific casemixes, but also on specific revenue mixes.

Private hospitals differ widely amongst themselves in their revenue models, as illustrated by the typologies developed in this paper. Finally, private hospitals must factor in both capital and recurrent expenditure and revenue, in contrast to public hospitals in Australia, in which the main emphasis is still on recurrent expenditure, with capital investments treated separately, and very hypothetically, in comparison with private hospitals.

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