KPMG

GOVERNMENT ADVISORY SERVICES

ADVISORY

Review of the impact of the new Medicare Levy Surcharge thresholds on public hospitals

Year 2 Review Report

2011

AUDIT ▪ TAX ▪ ADVISORY

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The findings in this report have been formed on the above basis.

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Contents

Acronyms

ABS	Australian Bureau of Statistics
the Act	Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008
AHMC	Australian Health Ministers' Conference
AHS	Australian Hospital Statistics
AHS -ESWL	AHS reports on elective surgery waiting list activity and waiting times
AIHW	Australian Institute of Health and Welfare
ATO	Australian Tax Office
AWOTE	full-time adult average weekly ordinary time earnings
DRG	Australian Refined Diagnosis Related Group Version 5.1
DVA	Department of Veterans' Affairs
ESWL	Elective Surgery Waiting List
HIRMAA	Health Insurance Restricted Membership Association of Australia
MDS	Minimum Data Set
MLS	Medicare Levy Surcharge -'the Surcharge'
NHS	ABS National Health Survey
NMDS	National Minimum Data Set
PHIAC	Private Health Insurance Administration Council
RP-ESWL	Elective Surgery Waiting List Reduction Strategy reports to AHMC

Summary

Purpose of the review

1.1 The Medicare Levy Surcharge (the Surcharge) is levied on taxpayers above certain income thresholds who do not hold appropriate hospital insurance. Introduced on 1 July 1997, the Surcharge was intended to encourage higher income earners to purchase private hospital insurance. The level from which the Surcharge applied was originally set at an annual taxable income of $50,000 for singles and $100,000 for families and couples. The threshold increased by $1,500 for the second and each subsequent dependent child.

1.2 These thresholds remained unchanged until amended by the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008 (*the Act*). *The Act* lifted the Surcharge thresholds to $70,000 for singles and $140,000 for families and couples, effective from 31 October 2008. It also introduced indexation of these thresholds, linked to the annual increase in the Australian average full-time ordinary earnings, as reported by the Australian Bureau of Statistics (ABS) in December of each year.

1.3 *The Act* requires an independent review of its operation for the first three consecutive years following the changes to the Surcharge. The review is to examine the impact of *the Act* on public hospital activity, operating costs and elective surgery waiting lists. KPMG was engaged to undertake this review.

Method

1.4 This report is the second report completed under the requirements of *the Act*. *Review Report 1* was tabled in Parliament on 22 June 2010.

1.5 *Review Report 1* was primarily restricted to the analysis of public hospital and elective surgery data collected prior to the introduction of the Surcharge changes and made no findings with respect to the impact of the Surcharge on public hospital activity, public hospital operating costs or elective surgery waiting lists. This report builds upon the historical trends in public hospital and elective surgery activity identified in *Review Report 1*.

Limitations

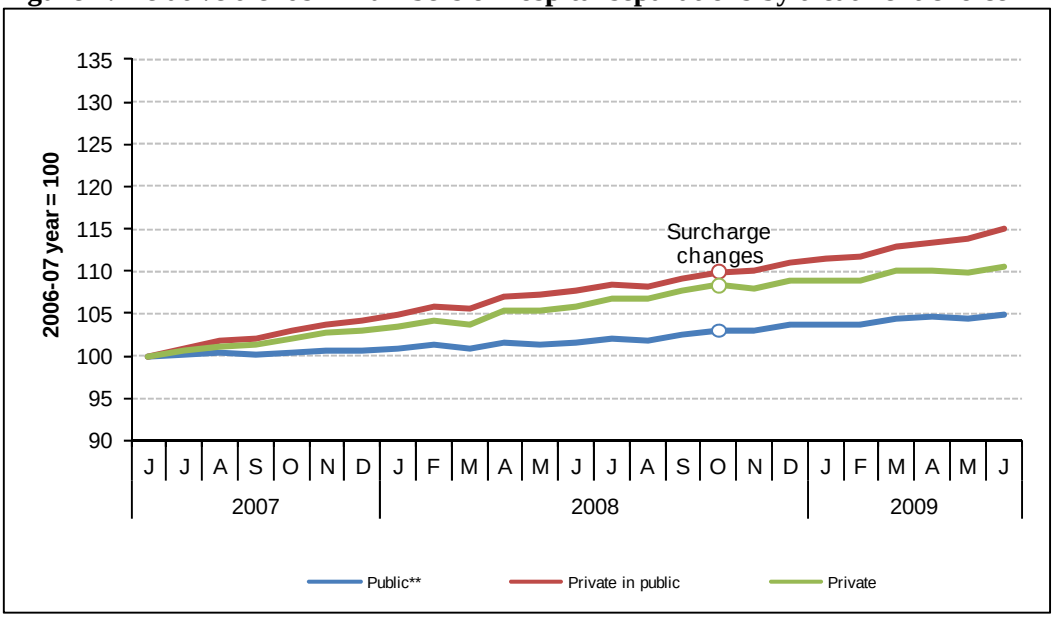
1.6 Though providing initial findings, the period of time covered by the data available at the time of this report was insufficient to enable definitive conclusions to be drawn on the influence of change in Surcharge thresholds on public hospital activity, public hospital operating costs and elective surgery waiting lists. The final report, *Review Report 3*, will further test the preliminary findings contained within this document.

Key findings

Impact on public hospital activity

1.7 Public and private hospital data was available to June 2009, providing eight months data subsequent to the Surcharge changes. As illustrated in Figure 1, trends in public and private hospital separations remained relatively constant over the period examined. As such, it is concluded that changes to the Surcharge did not affect activity trends within the period for which data was available.

Figure 1: Relative trends in numbers of hospital separations by treatment choice



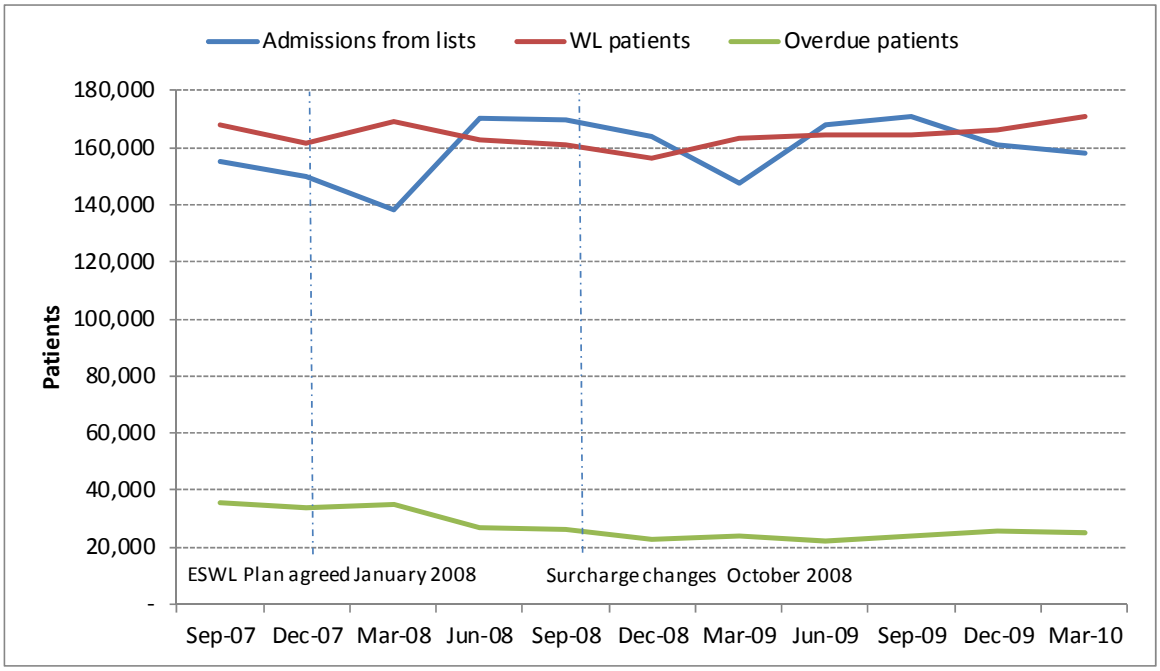
Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09)

1.8 In 2008-09, there was a 3.2 per cent increase in the number of public patient separations, from the previous year. During the same the period, there was an 8.3 per cent increase in the number of privately treated patients in public hospitals and a 3.3 per cent increase in private patient activity in private hospitals (Table 1, page 11). The higher growth in private patient activity relative to public activity is counter to what would be expected were the Surcharge to have resulted in a transfer of activity from privately to publicly treated patients.

Impact on public hospital operating costs

1.9 The absence of a discernible impact on public hospital activity rates suggests there has been no significant impact on public hospital operating costs. Rather, the growth in private patients treated in public hospitals suggests increased revenue contribution from private patients to public hospital operating expenditure, independently of the Surcharge changes.

Figure 2: National elective surgery admissions, patients waiting and patients overdue at the end of the quarter, September 2007 to March 2010



Source: RP-ESWL (2010)

1.10 Stage one of the Elective Surgery Waiting List (ESWL) Reduction Plan resulted in an injection of $150 million into the public hospital system in 2008 to provide a national blitz to improve access to elective surgery (Section 3.5, page 6). Stage two (2009) provided a further $150 million targeted to system and infrastructure improvements to improve elective surgery performance in the long term. Stage one funding resulted in an immediate and marked increase in admissions from the elective surgery waiting list and a reduction in both the number of patients waiting for surgery and those waiting longer than the clinically recommended time for surgery. This is apparent in Figure 2.

1.11 Though there has been a marginal increase in waiting lists and overdue patients in 2009, this is more likely a result in the slowing of direct expenditure on elective surgery and a re-emergence of longer-term demand trends rather than a result of the implementation of changes to the Surcharge.

Summary of key findings

1.12 Trends in relation to the number of public and private hospital separations remain unchanged since the introduction of the Surcharge.

1.13 The rate of growth in privately treated patients within public hospitals was higher than for public activity. This is the reverse of what would be expected were the Surcharge to have resulted in increased demand on the public hospital system.

1.14 There was no indication in the mix of activity within public hospitals suggesting a shift in the types of cases treated following changes to the Surcharge.

1.15 In that there is no discernible impact of changes to the Surcharge on public hospital activity, it can be concluded that the Surcharge has not impacted on public hospital operating costs.

Indeed, the finding of increasing private patient utilisation of public hospitals would suggest an increasing proportion of public hospital operating costs are being met through private patient payments.

1.16 ESWL Reduction Plan funds appear to have been the principal factor driving increases in elective surgery admissions and reductions in waiting times.

1.17 Though there has been a recent upturn in waiting times, this is more likely to be a resumption of historical trends as the immediate impact of the national blitz funded through the ESWL Reduction Plan diminishes, rather than as a result of changes to the Surcharge.

1.18 As no discernible impacts on public hospital activity were found, private hospital insurance data were not undertaken for this report.

Chapter 1 – Background to the review

2. 1 This chapter provides a background to the review, articulates the purpose of the review and outlines the structure of the report.

2. 2 On 31 October 2008, legislation commenced lifting the Surcharge income threshold for single people from $50,000 to $70,000 per year and from $100,000 to $140,000 per year for couples and families. As with the previous Surcharge threshold, the new threshold increases by $1,500 for the second and each subsequent dependent child. The new thresholds are indexed annually to full-time adult average weekly ordinary time earnings (AWOTE)[1]. These changes to the threshold are enacted through the *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008* (*the Act*).

2. 3 Section 4 of the Act requires an independent review of its operation to be undertaken every year for a period of three years:

> *4. Review of operation of the Act*
>
> *(1) The Minister for Health and Ageing must cause an independent review of the operation of this Act to be undertaken as soon as possible after each anniversary of the commencement of this Act, for a period of three consecutive years.*
>
> *(2) The review is to consider and report on the impact on public hospitals of the amendments made by this Act, including the number of episodes of care, the impact on operating costs and the impact on elective surgery waiting lists.*
>
> *(3) The person undertaking this review must give the Minister a written report of the review, and the Minister must cause a copy of the report to be tabled in each House of the Parliament within 15 sitting days of receiving the report.*

2. 4 *Review Report 1* was tabled in Parliament on 22 June 2010. For *Review Report 1*, only waiting list data and private health insurance participation data were available for a period post implementation of changes to the Surcharge. *Review Report 1* identified an increase in admissions from the elective surgery waiting list and a reduction in the number of patients waiting longer than the clinically recommended time for elective surgery in the period subsequent to the Surcharge changes. This was counter to what would have been expected were the Surcharge changes to have resulted in a shift from privately to publicly treated patient activity.

2. 5 This report (*Review Report 2*) builds upon the background analysis compiled in Year 1 and utilises data released to December 2010.

2. 6 The final report, *Review Report 3* will be submitted as the next year's data becomes available.

[1] Indexation is linked to the December AWOTE which comes out in the following February.

Chapter 2 – Methodology for the review

3.1 This chapter details the hypotheses to be tested, the approach, the data utilised in the review and the stakeholders consulted. It also presents the conceptual link between the Surcharge and hospital use, operating through the media of choices about hospital insurance and private or public treatment in hospitals. This conceptual link underpinned the development of the review methodology.

Hypotheses to be tested

3.2 The data utilised in this and the final report will be used to address one or both of the following hypotheses:

(i) The rate of public and private hospital utilisation and public hospital waiting lists is not significantly different in the months subsequent to changes to the Surcharge with that expected, based on the earlier trends. Indicators of change include:

- increased level of public hospital utilisation
- reduced rate of private patients in public hospitals
- reduced rate of private hospital utilisation relative to public hospitals
- increases in waiting time for elective surgery.

(ii) Should hypothesis (i) prove false, supplementary analysis will be undertaken to ascertain whether there is sufficient evidence to attribute this to changes to the Surcharge.

3.3 Underlying these hypotheses is the assumption that any impact on public hospital demand, arising due to the Surcharge changes, will act through the influence of the Surcharge on choices regarding private hospital insurance and consequent choices regarding public or private hospital treatment. In particular, as a policy mechanism, the Surcharge is meant to influence the level of private hospital insurance coverage in the Australian population.

Commonwealth Elective Surgery Waiting List Reduction Plan

3.4 In addition to hypothetical impacts of the Surcharge on public hospital activity and particularly on volume and waiting times for elective surgical activity from waiting lists, other policies may also affect this activity. A key influence in this respect is the Commonwealth Elective Surgery Waiting List Reduction Plan, the timing of which has coincided with the introduction and operation of the Surcharge changes.

3.5 Through the ESWL Reduction Plan, the Commonwealth has committed $600 million to reduce the backlog of patients waiting longer than the clinically recommended time for elective surgery in all states and territories and to implement strategies to provide long-term improvements in elective surgery and waiting times.

- Under Stage 1, the Commonwealth allocated $150 million for an immediate national blitz to improve access to elective surgery in 2008.
- Under Stage 2, the Commonwealth provided $150 million between 2008 and July 2009 to make systematic improvements in the hospital system to improve elective surgery throughput in the longer term, including construction of additional day surgery units.

- Stage 3 is currently being developed and provides $300 million in dividend payments to states and territories that dramatically increase the number of elective surgeries completed within the clinically recommended time by the end of the four-year plan.
- As a component of the plan, each state and territory is required to report elective surgery and waiting time performance. Reports on the Australian Government's ESWL Reduction Plan were utilised for this report.

Factors influencing private health insurance coverage and public hospital utilisation

3.6 There are a range of factors that influence the rate of private health insurance membership and mix of public and private hospital utilisation. Each of these factors may interact with changes to the Surcharge to moderate or exacerbate any impacts of the changes on both rates of insurance coverage and consequent patterns of public hospital use. These factors include:

- The potential that any decision to opt in or out of private health insurance will be delayed until after a tax return is lodged. This and the fact that the impact on the health system will not be felt until the person requires hospital care could stagger the effect over a number of years.
- Strategies by public hospitals to maximise the rates at which privately insured patients elect to be treated as private patients may lead to an increase in the number of private patients treated in public hospitals. A number of jurisdictions are implementing 'no gap' arrangements for private patients treated in public hospitals. This may lead to some patients choosing private treatment in a public hospital instead of treatment in a private hospital.
- Commonwealth health reform initiatives are increasing the focus on casemix based funding, better service coordination and options to improve efficiency across jurisdictions, making public hospitals a more attractive option to private hospitals.
- Changes in waiting list policies and practices in states and territories and provision of additional funding to reduce elective surgery waiting lists will affect rates of treatment in public hospitals for elective surgery.
- Gap payments or out of pocket expenses for treatment in private hospitals for individuals with private health insurance may also influence the decision to be treated in a public hospital or the decision to take out private hospital insurance.
- Declining rates of Department of Veterans' Affairs (DVA) coverage in the ageing population will reduce the proportion of compensable patients in the older age groups and increase apparent rates of public patient treatment in those age groups.
- The impact of Lifetime Health Cover on people from the age of 31, which is a powerful and robust driver of private health insurance membership in the 30 to 40 years age group.
- The wavering of community confidence in the public hospital system due to regular adverse publicity affecting public perceptions of the adequacy of the public hospital system to meet future health needs (Australian Government National Health and Hospital Reform Commission 2009).
- Health insurance fund premium increases and the overall perception of health insurance product value for money by consumers.
- The impact of further changes to private health insurance policy generally and to the Surcharge specifically, announced in the 2009 Federal Budget.

Overview of approach

3.7 Overall, the review has three key stages:

(i) scoping and data collection

(ii) analysis and testing of results

(iii) reporting.

Data utilised in the review

3.8 The review utilises data from the following primary data sources to test hypothesis (i) (page 6):

- Australian Hospital Statistics (AHS) reporting of hospital episode data
- AHS-ESWL data reporting of elective surgery activity
- RP-ESWL reporting of key elective surgery indicators.

3.9 Secondary data sources were also available to further test the impact of the Surcharge on public hospital activity, operating costs and elective surgery waiting lists. Supplementary analysis utilising these sources was not to be undertaken unless a discernible impact was identified in the primary data sources. This included Australian Tax Office (ATO) data reporting income and health insurance status, Private Health Insurance Administrative Council (PHIAC) private health insurance membership and benefit data, Australian Bureau of Statistics (ABS) population estimates and ABS National Health Survey (NHS) data.

3.10 The timing of data availability and associated limitations are reported with respect to each data collection.

AHS data

3.11 The Department obtains episode level public hospital data within the National Minimum Data Set (NMDS) from states and territories on an annual basis. The data is provided for each financial year (July to June). This data provides the main source of information about the profiles and patterns in use by hospitals (public and private) by insured and not insured patients, before and after the changes to the Surcharge.

3.12 The data utilised in this report is the aggregated NMDS prepared and released by the Australian Institute of Health and Welfare (AIHW) in published AHS reports. The timetable for release of data is 12 months after the end of the relevant financial year. Data to 2008-09 was available for this report. Data to 2009-10 will be available for the *Review Report 3*. Appendix 2 details the variables provided within the AHS extract used for this report.

3.13 AHS data was obtained with a view to determining:

- Trends in public hospital utilisation (separations, length of stay, undiscounted cost weighted separations) in combination with same day and overnight status, acute flag (acute, mental health, sub acute and non-acute), episode type (medical/surgical and procedural), admission status and payment status.
- Trends in private hospital utilisation (separations, length of stay, undiscounted cost weighted separations) in combination with same day and overnight status, acute flag (acute, mental health, sub acute and non-acute), episode type (medical/surgical and procedural).

- Depending upon the results of analyses of impacts on public hospital activity, correlations and relationships between the above and rates of private health insurance (membership and new members), with a focus on changes post October 2008.

AHS-ESWL data

3.14 The AHS also reports the number of admissions from the elective surgery list per 1,000 people and average waiting time in days for the 50th percentile (median), 90th percentile of patients and per cent of patients who waited more than 365 days between the date of addition to and removal from the waiting list. The reported admission rate is a crude rate based on the Australian estimated resident population. The 50th percentile represents the number of days within which 50 per cent of patients were admitted for the awaited procedure. The 90th percentile represents the number of days within which 90 per cent of patients were admitted. Unlike the ESWL Reduction Plan reports, the AIHW data does not report overdue patients based on clinical urgency and recommended waiting time.

3.15 Through accessing current and historical AHS reports, the AIHW data provides a trend in the rate of admission from the waiting list and average waiting times over a period of years. For this report, data from 1 July 2000 to 30 June 2009 is used. Data for 2000-01 to 2004-05 was extracted from the AHS 2004-05 and data for 2005-06 to 2009-10 was extracted from the AHS 2009-10.

RP-ESWL data

3.16 The report utilises reports on the Australian Government's ESWL Reduction Plan.

3.17 The Australian Government has funded the ESWL Reduction Plan for the period 2008-2011. Each State and Territory receives funding intended to improve access to, and waiting times for, elective surgery. Under this plan, states and territories are required to report quarterly data on trends in throughput for public hospital elective surgical waiting lists. Cleared quarterly, reports to the Australian Health Ministers' Conference (AHMC) are available on the Department website. The most recent report (March 2010) was used to compare trends in key indicators since the baseline quarter of September 2007.

3.18 It should be noted that the ESWL Reduction Plan, while generating data useful to this review, also presents a confounding influence in the event of this review showing hypothesis (i) to be incorrect and need to test hypothesis (ii) (see page 6). Anecdotally, more rapid access to elective surgical services in the private sector has been an incentive for people to take or hold private health insurance and also to use that insurance when choosing private or public hospital treatment. If the plan is successful in significantly improving access to elective surgery in the public sector then this may lead to a reduction in the incentive for insured people to choose private treatment and hold private insurance. Under this scenario, a reduction in private surgical activity would be expected.

3.19 In contrast, the changes to the Surcharge, should they have any impact on public hospital waiting lists, would be expected to increase pressure on those lists and so increase waiting times and potentially the length of the lists.

3.20 Waiting list initiatives implemented by states and territories further confound assessment of the impact of changes to the Surcharge on waiting lists. Periodically, state and territory governments provide additional funding, or other resources, on either an ongoing or one off basis to achieve a general reduction in the waiting list, reduce the number or percentage of patients waiting beyond benchmark waiting times, or provide an increase in the volume of particular types of surgery (Queensland Government 2008; Victorian Government 2009; NSW Government 2009).

3.21 As a result, the extent to which changes in waiting list indicators will be able to be firstly detected, and secondly attributed, to changes to the Surcharge is limited. Nonetheless, significant deterioration in waiting times or in rates of throughput over the period of the review, in light of these

other initiatives, would be unexpected. This would be an indicator that further investigation might be warranted. As such, the analyses of the waiting list data have focused on waiting times and throughputs from the lists.

Stakeholder consultations

3.22 The key stakeholders for this review comprise states and territories, private health insurers and private hospitals (Appendix 1). Key stakeholders were consulted in both the Year 1 and Year 2 Reviews. The consultations informed the analysis in this report.

Chapter 3 – Key findings

Public hospital activity

Hospital Episode Data

4. 1 The Department provided AHS data for all public and private hospitals in Australia, for the years 2006-07, 2007-08 and 2008-09. This data was analysed to identify changes in the pattern of hospital utilisation by public and private patients that may correlate with changes to the Surcharge.

4. 2 Table 1 shows year on year change in hospital episodes by the public or private status of the patient[2] and the hospital choice (public or private hospital). This table excludes episodes where the patient's public or private status was other, such as compensable patients, DVA patients and patients from correctional facilities.

4. 3 Table 1 shows that private treatment has grown more substantially than public treatment since 2006-07[3]. However, it also shows that there was a larger increase in public separations for 2008-09, relative to the previous year's growth, while private growth was lower than for the previous year.

Table 1: Separations by public or private status[2] and hospital setting

Year	All public patients	Private patients in public hospitals	Private patients in private hospitals	All private patients
2006-07	4,072,266	435,470	2,609,812	3,045,282
2007-08	4,157,338	470,684	2,765,071	3,235,755
Change from previous year	+2.1%	+8.1%	+5.9%	+6.3%
2008-09	4,289,120	509,817	2,857,214	3,367,031
Change from previous year	+3.2%	+8.3%	+3.3%	+4.1%

Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

4. 4 Figure 3 explores this finding in terms of patient's treatment choices, as defined by their public or private status and type of hospital chosen for treatment. It presents the underlying trend in separations by treatment choice, with each treatment choice expressed as an index relative to the

[2] Public and private status, for the purposes of this table, are defined using the following definitions, which is consistent with that used in the AIHW's Australian Hospital Statistics publications. Public patients comprise those patients:

- with a funding source of the Australian Health Care Agreements or of reciprocal health care agreements with other countries; or
- who elect to be treated publicly and for whom the funding source is contracted care through another hospital or public (health) authority; or
- with a funding source showing no charge raised and who were treated in a public acute hospital or a public psychiatric hospital.

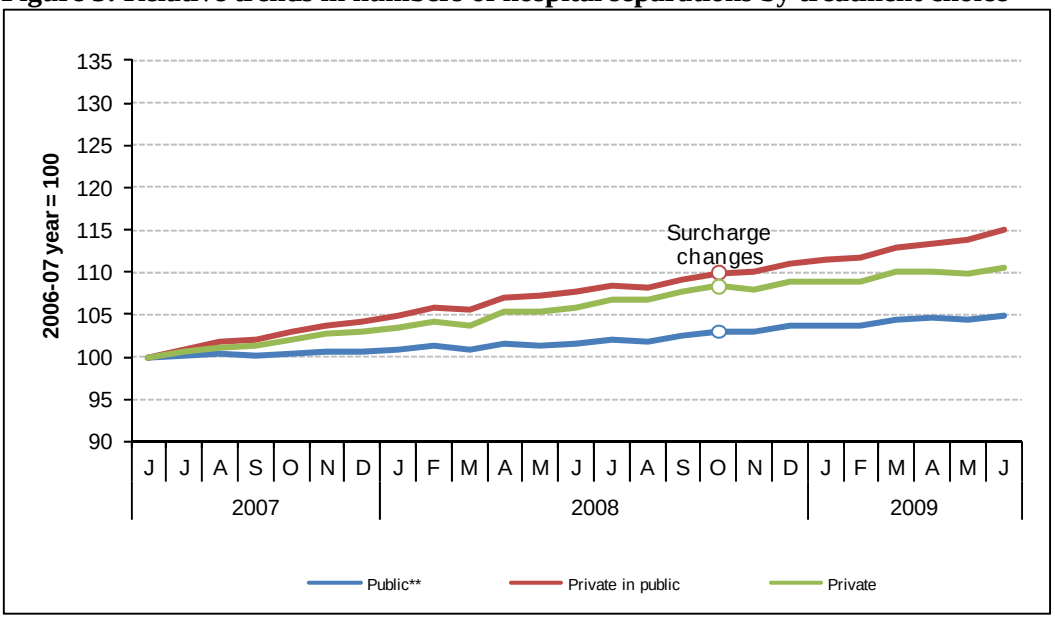
Private patients are those patients with a funding source of private health insurance or self-funded.
All remaining patients are classified as Other. This Other group principally comprises DVA patients, compensable patients, Department of Defence patients and patients from correctional facilities.

[3] Changes in hospital classification reporting arrangements in 2006-07 may account for a component of growth activity reported for public and private hospitals.

2006-07 year. As hospital separations are very seasonal in nature, Figure 3 is based on 12-month moving totals of episode numbers.

4. 5 From Figure 3, it can be seen that the trend in the annual number of public separations was flat for the months leading up to January 2008. This trend then turned slowly upwards from around May 2008. This timing precedes the onset of the Surcharge changes by five months, with those changes coming into effect at the end of October 2008.

Figure 3: Relative trends in numbers of hospital separations by treatment choice



Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

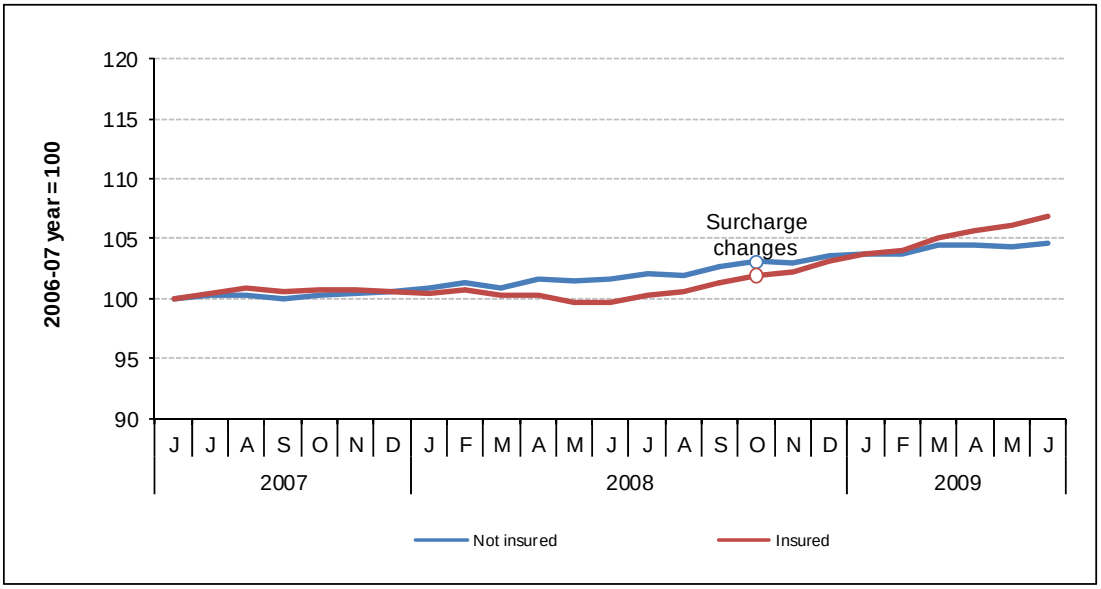
4. 6 To test whether this change in trend is related to the impact of the Surcharge changes on hospital insurance coverage in the Australian population, we compared the trends in public patient separations for insured and non-insured patients. Figure 4 clearly shows that the change is due to a change in treatment choices for insured patients rather than for non-insured patients. This finding is the reverse of what would be expected should the Surcharge changes have led to an immediate increase in public hospital usage caused by the dropping of hospital insurance.

4. 7 In considering what might have contributed to this trend, other than the Surcharge changes, we analysed the patterns of planned surgical activity in Australian hospitals. This component of the analysis used the Urgency category of the episode to determine whether it was planned (elective) or not and the diagnosis related group (DRG)[4] partition to determine whether the episode was surgical, medical or other (such as investigative or diagnostic) in nature.

4. 8 Results using this method will not match exactly the elective surgery waiting list data presented later in this report, but nonetheless should be consistent with those results.

[4] Australian Refined Diagnosis Related Group Version 5.1

Figure 4: Relative trends in numbers of public patient separations by insurance status



Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

4. 9 Figure 5 clearly shows the substantial increase in planned, surgical separations experienced for patients electing to be treated as public patients in a public hospital. Moreover, it shows this growth to have far exceeded that for patients electing to be treated privately in either a public or a private hospital. The April 2008 timing of the rapid increase in public planned, surgical separations precedes the earlier noted upward trend in total public separations by several months.

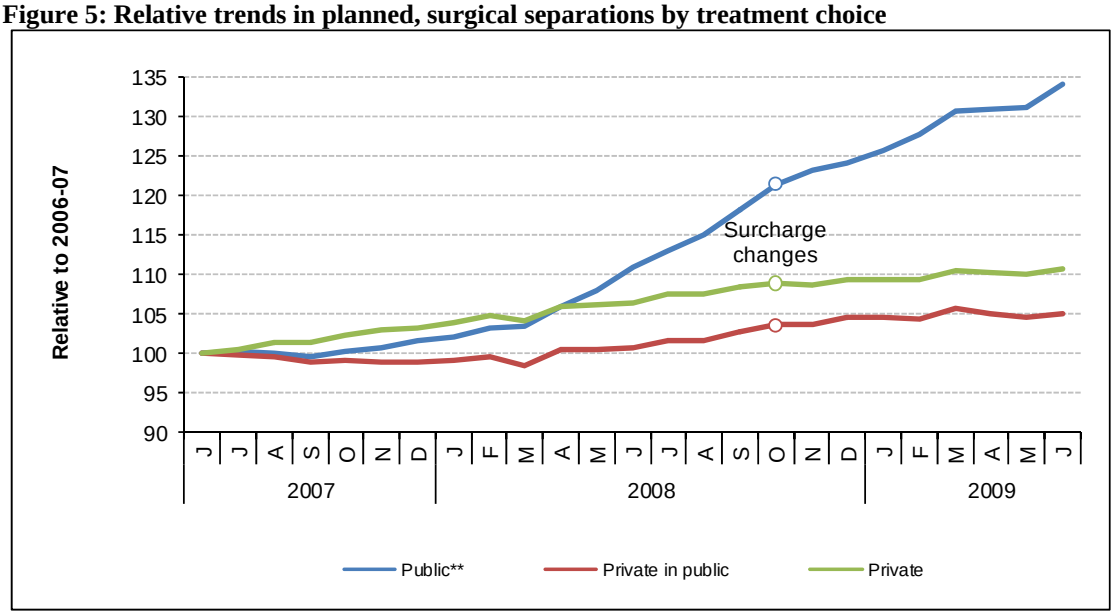
4. 10 While there has been growth in the public treatment component of planned, surgical activity, the proportion of all planned, surgical separations attributable to patients with hospital insurance has remained stable, ranging between 66.7 per cent and 67.1 per cent from October 2007 to June 2009[5]. This suggests the observed increase in public activity is not related to hospital insurance coverage.

4. 11 Closer examination of the trends in planned, surgical separations from public hospitals show distinctly different trends for different age groups (Figure 6). The growth has been stronger for older age groups (65 and over, and 50 to 64) and lowest for the age groups 30 to 49 and 20 to 29.

4. 12 This pattern is consistent with more general patterns of hospital usage, with older age groups generally having higher rates of hospital treatment. It is also consistent with the trends observed elsewhere in this report, relating to elective surgery waiting list data.

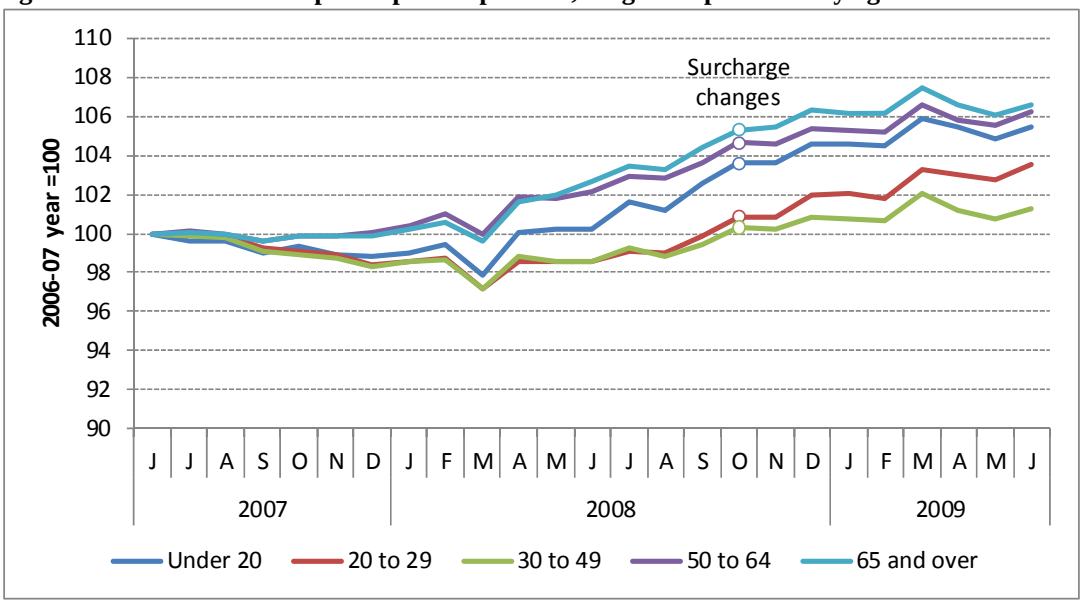
[5] Derived from AHS reported elective surgery separations by treatment choice, excluding Other category.

Figure 5: Relative trends in planned, surgical separations by treatment choice



Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

Figure 6: Relative trends in public patient planned, surgical separations by age and month

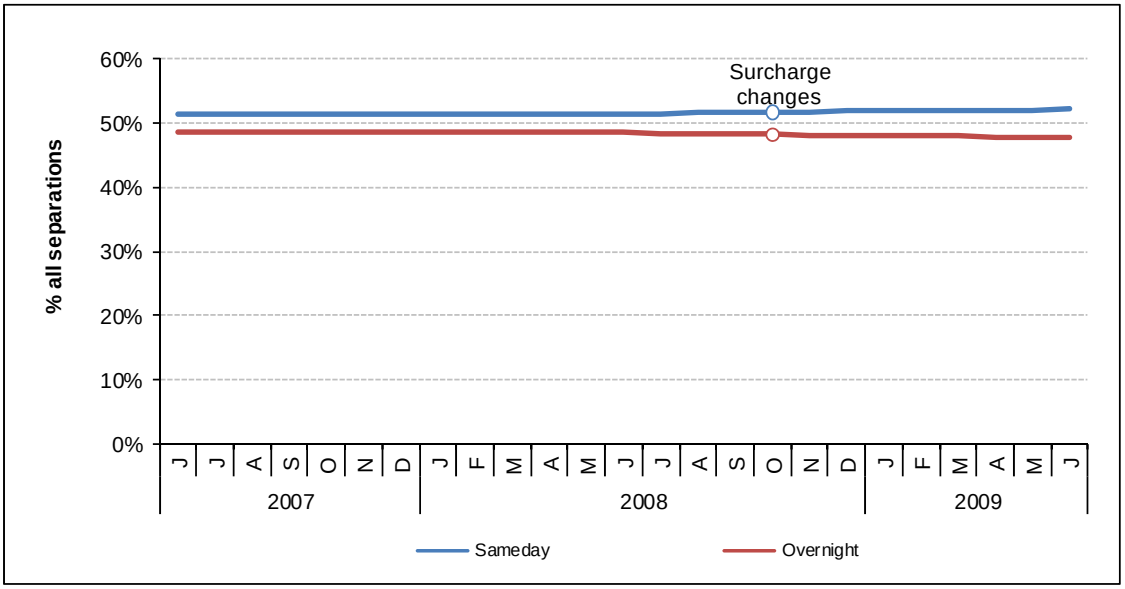


Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

4. 13 The analysis also considered rates of same day and overnight activity, as well as medical, surgical and other types of activity to assess the possibility that high growth in same day activity in the private hospitals may be masking a shift of more complex overnight activity to the public sector.

4. 14 Since 2006-07, the proportion of public hospital separations treated on a same day or overnight basis has remained relatively steady, with a very slight increase in same day activity relative to decreasing overnight activity (Figure 7). There was no detectable change as a result of changes to the Surcharge.

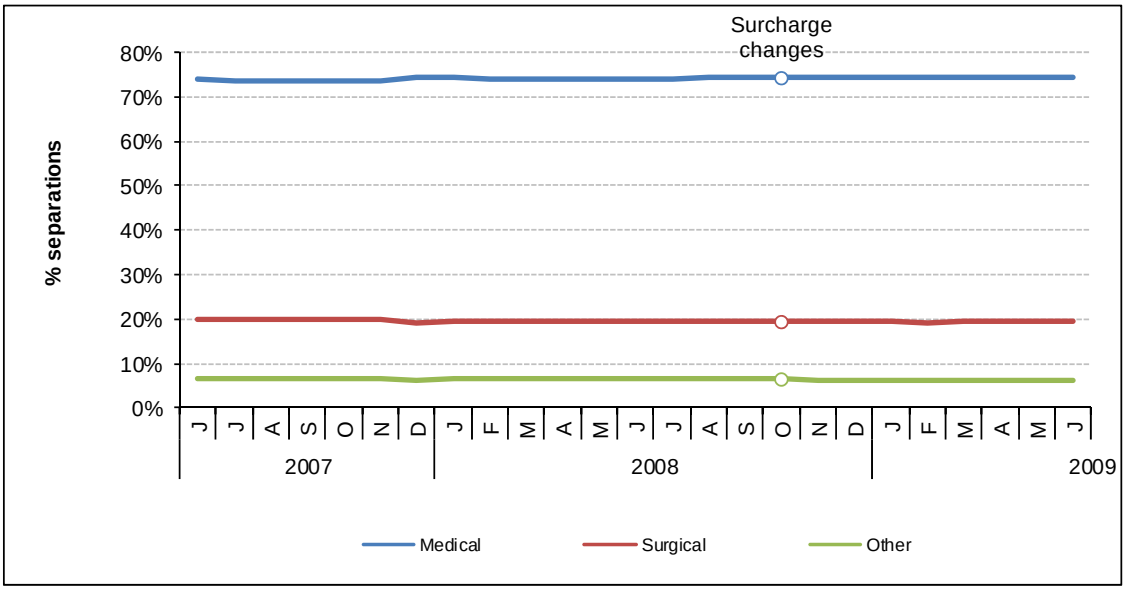
Figure 7: Proportion of public separations by same day or overnight status



Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

4. 15 There has also been little change in the relative mix of medical, surgical and other separations within public hospital activity (Figure 8).

Figure 8: Proportion of public separations by medical, surgical and other partition



Source: AHS data for all hospitals (2006-07, 2007-08 and 2008-09).

4. 16 The results in this section are consistent with there having been no substantive impact on public hospital activity nor on the relative rates of private and public hospital utilisation due to the 2008 changes to the Surcharge. That is, the first parts of hypothesis (i) are supported (see page 6). This finding is based on the analysis of data to the end of June 2009, providing eight months of data following the changes coming into effect. The indicators analysed in this report will be revisited in the third year of the review, to test whether this finding continues to be supported when more than 12 months of post implementation data will be available for analysis.

4. 17 The final part of hypothesis (i), relating to waiting lists, is discussed below.

Public hospital operating costs

4. 18 The review found that there was no discernible change in public hospital activity attributable to changes to the Surcharge.

4. 19 As a component of the activity, there was no discernible change in public hospital trends in same day and overnight admissions subsequent to the Surcharge changes. Nor was there a discernible change in the proportion of separations classified as medical, surgical or other.

4. 20 Given that the trends in these activity based drivers of operating costs showed no discernible change over the review period, it can be concluded that the Surcharge changes have had no significant impact (if any) on public hospital operating costs.

Elective surgery waiting lists

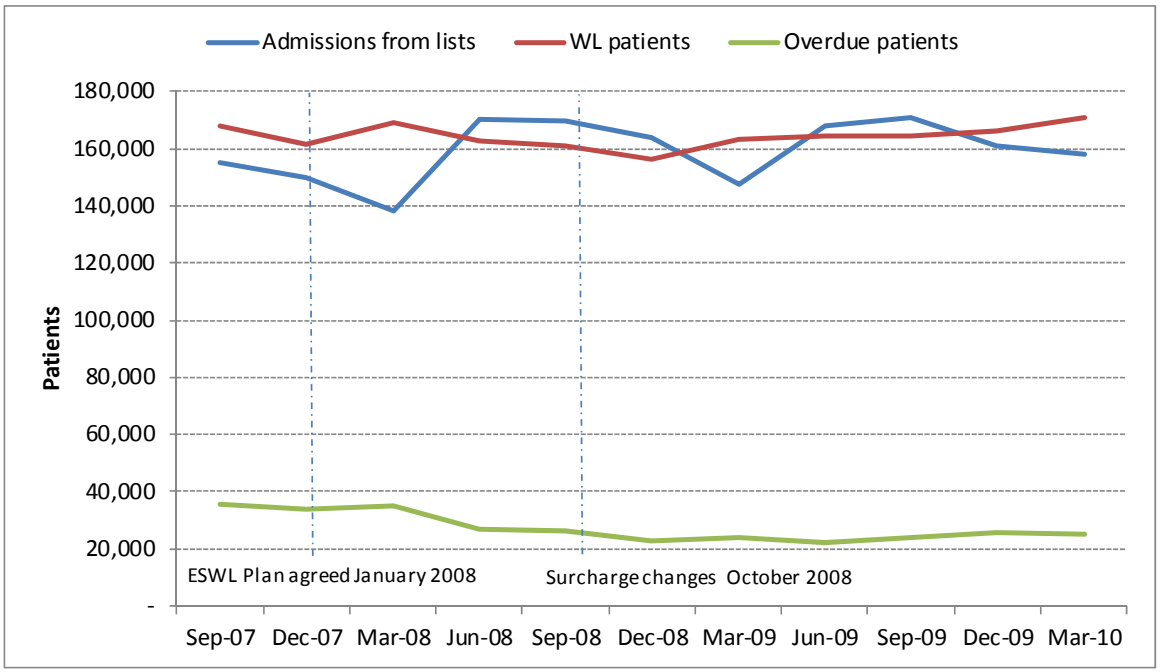
4. 21 ESWL Reduction Plan Progress Reports for March 2010 report the number of admissions to hospital from the elective surgery waiting list, the number of patients still waiting and the number of overdue patients[6] at the end of the reporting period for each quarter between September 2007 and March 2010. Figure 9 presents quarter on quarter comparison of these key indicators.

4. 22 Apparent in the RP-ESWL data is a marked decline in the number of overdue patients subsequent to the introduction of the ESWL Reduction Plan. These improvements have been maintained despite a slight increase in the December 2009 and March 2010 reported number of overdue patients relative to the corresponding 2008 and 2009 quarters.

4. 23 The impact of the ESWL Reduction Plan on admissions from the waiting list and total number of patients on the list has not been as pronounced. There has been an increase in the number of admissions from the list, and these have been subject to seasonal fluctuations. However, the number of patients remaining on the waiting list has been increasing steadily since the December 2008 quarter and now exceeds the number of patients on the list in September 2007.

[6] Overdue patients are those patients waiting longer than the clinically recommended time based on urgency category.

Figure 9: National elective surgery admissions, patients waiting and patients overdue at the end of the quarter, September 2007 to March 2010[7]



Source: RP-ESWL (2010)

4. 24 On initial examination, the flattening of the downward trend in overdue patients and the increasing number of patients on the waiting list subsequent to the introduction of the Surcharge changes appear to suggest that the Surcharge may have had a dampening effect on the impact of the ESWL Reduction Plan on elective surgery waiting lists. However, this interpretation is likely to be incorrect for several reasons:

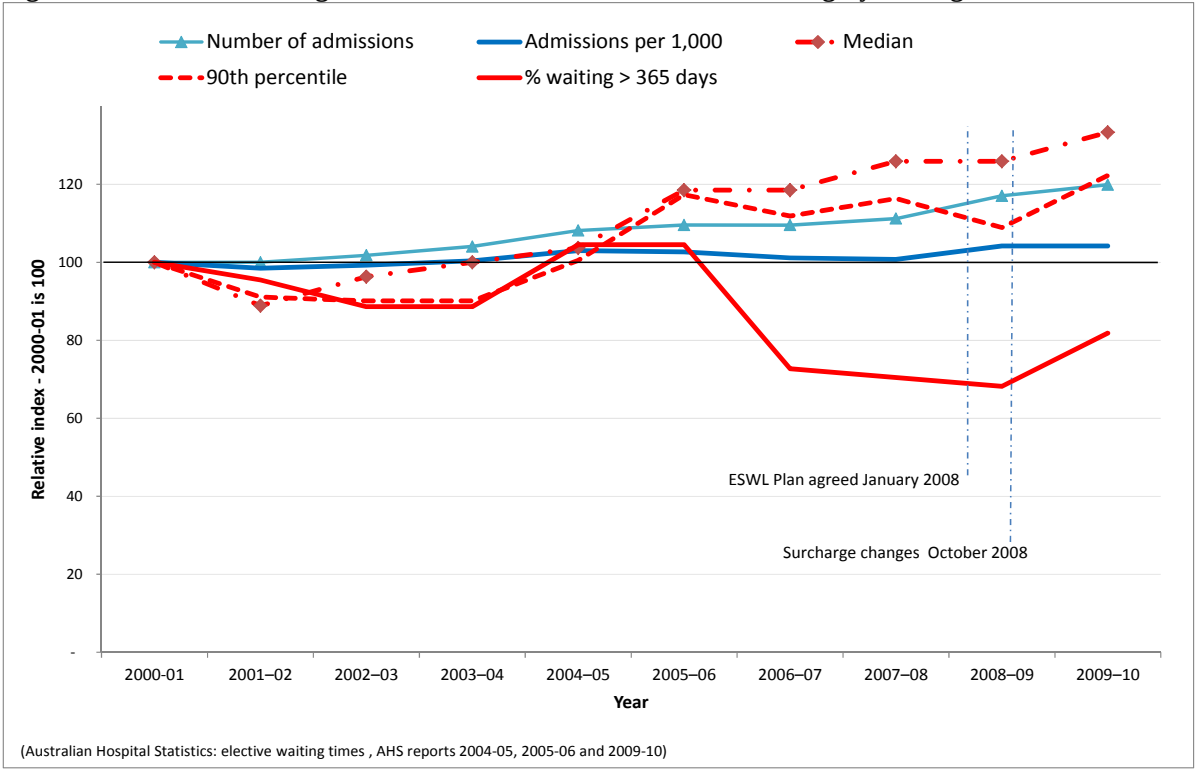
- The time period subsequent to Surcharge changes is such that general seasonal fluctuations are likely to affect activity in the time period observed.
- Increases in the waiting list relative to the overall increase in admissions from the list are usually observed when throughput is increased. The commonly accepted explanation for this relationship is that as clinicians are provided with increased theatre time, they accept more patients onto their waiting lists.
- The decrease in the number of patients who have been waiting an excessively long time suggests waiting times have also reduced. Increased throughput of elective surgery cases is known to generate increased admissions, as doctors and patients become aware that waiting times in the public sector are decreasing, reducing the incentive for the patient to choose private treatment.
- The hospital activity trends reported earlier are counter to what would be expected were the Surcharge to have resulted in a shift from private to public patient activity.

4. 25 To more closely test the relationship between the Surcharge and elective surgery waiting lists, AHS-ESWL data was examined to provide a longer timeframe for elective surgery waiting list indicators. Figure 10 shows the long-term trends in admissions to hospital from the waiting list, the

[7] Elective Surgery Waiting List Reduction Plan. March 2010 Quarterly National Progress Report to the Australian Health Ministers' Conference – Chart 1.

rate of admissions per 1,000 population and median and 90th percentile waiting time relative to baseline 2000-01 data.

Figure 10: Trends in waiting times and rates of admission to elective surgery waiting lists



Source: AHS-ESWL (2010), AHS-ESWL (2007) and AHS-ESWL (2006)

4. 26 From Figure 10, it is apparent that, though the number of admissions from the list has increased steadily over the 10-year period, the rate of admission per 1,000 population has changed very little. In other words, the rate of increase in admissions largely has kept track with the increasing population. The three per cent increase in the rate of admissions between 2007-08 and 2008-09 as a result of the ESWL Reduction Plan returned the admission rate to a level marginally higher than that reported in 2005-06.

4. 27 Between 2008-09 and 2009-10, the median waiting time increased by six per cent from 34 to 36 days. During the same period, the 90th percentile waiting time increased by 12 per cent from 220 to 247 days and the proportion of patients waiting more than 365 days increased by 20 per cent from 3.0 to 3.6 per cent of patients.

4. 28 The increase in the median waiting times appears to continue a steadily increasing trend in median waiting times extending back to 2001-02. The decline in the rate of growth in the 90th percentile waiting times and percentage of patients waiting more than 365 days is reflective of successive strategies to decrease the number of patients experiencing long waits. However, the overall upward trend in 90th percentile waiting times since 2003-04 and the most recent year's increase in the percentage of patients waiting more than 365 days suggests that, with the exception of removal of long waits (greater than 365 days), these gains may be short lived.

4. 29 From the data, it is apparent that since 2003-04, the waiting times for most patients have been steadily increasing, despite real increases in the number of admissions. At best, increases in median waiting times have been held constant for periods of one financial year (in 2006-07 and in

2008-09) and single year improvements in 90th percentile waits achieved in the same years. However, the percentage of patients waiting more than 365 days, though increasing in the past year, remains lower than in any period between 2000-01 and 2005-06.

4. 30 The increase in waiting times relative to increasing volumes of activity and a reasonably stable admission rate suggests that waiting times are a product of an increasing proportion of the population entering the waiting list. This is a result of a combination of factors including supply driven demand, the ageing of the population, changing models of care (for example providing more procedures to a greater range of patients), patient expectations for care (more patients requesting elective surgery) and an increasing shift to the public sector for elective surgery (potentially influenced by a declining proportion of DVA eligible patients in the older population groups[8]). It is highly likely that these factors have exerted greater influence on elective surgery waiting lists than has changes to the Surcharge.

[8] AIHW (2010) has reported a fall in DVA funding between 2004-05 and 2008-09, both in real terms and as a proportion of public hospital expenditure.

Chapter 4 – Findings

5. 1 Trends in relation to the number of public and private hospital separations remain unchanged since the introduction of the Surcharge.

5. 2 The rate of growth in privately treated patients' episodes was higher than for public activity. This is the reverse of what would be expected were the Surcharge to have resulted in increased demand on the public hospital system.

5. 3 There was no indication in the mix of activity within public hospitals suggesting a shift in the types of cases treated following changes to the Surcharge.

5. 4 In that there is no discernible impact of changes to the Surcharge on public hospital activity, it can be concluded that the Surcharge has not impacted on public hospital operating costs. Indeed, the finding of increasing private patient utilisation of public hospitals would suggest an increasing proportion of public hospital operating costs are being met through private patient payments.

5. 5 ESWL Reduction Plan funds have formed the principal factor driving increases in elective surgery admissions and reduction in waiting times.

5. 6 Though there has been a recent upturn in waiting times, this is more likely to be a resumption of historical trends as the immediate impact of the national blitz funded through the ESWL Reduction Plan diminishes, rather than as a result of changes to the Surcharge.

5. 7 As no discernible impacts on public hospital activity were found, analysis of private hospital insurance data was not undertaken for this report.

Appendix 1 – Stakeholder consultations

Appendix 1a: Consultation with health jurisdictions

As a component of the Year 1 Review, the KPMG and Department of Health and Ageing project team met with representatives of each state and territory health department to discuss the review, seek comment on the approach and perceptions in respect to the likely impact of the Surcharge changes on public hospital activity, public hospital operating costs and elective surgery waiting lists.

Appendix 1b: Consultation with private health insurers and hospitals

As a component of the Year 1 Review, invitations to a workshop to discuss the impact of changes to the Surcharge and this review were forwarded to all private health insurers and private hospital representatives. Representatives of the below organisations attended a workshop held in Sydney on 28th October 2009.

Copies of the Year 1 Report were forwarded to all participants and invitations issued to provide feedback and comment to the Year 2 Review. A copy of the Year 1 Review was also forwarded to and discussed with the Australian Health Service Alliance.

Consultation with private health insurers

- Australian Health Insurance Association
- Health Insurance Restricted Membership Association of Australia (HIRMAA), representing 17 private health insurers. The following members of the HIRMAA also attended the workshop:
  - Reserve Bank Health Society
  - Railways and Transport Health Fund
  - Phoenix Health Fund
  - CBHS Health Fund
- Medibank Private
- NIB Health Fund
- Towers Perrin (Towers Watson)

Consultation with private hospitals

- Catholic Health Association
- Australian Private Hospitals Association

Appendix 2 – Variables within the AHS data set

The following table details the data items analysed for this review.

Table 2: Variables included in AHS data set

Variable Name	Description
MonthOfSeparation	Month of separation
YearOfSeparation	Year of separation
StateOfHospital	State of hospital
EstablishmentType	Establishment type
CareType	Care type. Separations for which the care type was reported as Newborn with no qualified days, and records for Hospital boarders and Posthumous organ procurement have been excluded.
PsychiatricCareDays	Psychiatric care days
SamedayFlag	Same day flag
Age	Age of patient in years
Sex	Gender
DRGv51	AR-DRG v5.1
BedDays1	Bed days - Total bed days excluding leave days. For same day separations bed days = 1.
BedDays2	Bed days - Total bed days without excluding leave days. For same day separations bed days = 1.
DRGPartition	DRG partition
ElectionStatus	Admitted patient election status
InsuranceStatus	Hospital insurance status
ModeOfAdmission	Mode of admission
FundingSource	Funding source for hospital patient
UrgencyOfAdmission	Urgency of admission

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