Public v Private – Similarities and Differences

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What is a Private Hospital?

A private Hospital is a ‘privately owned and operated institution catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners’ (AIHW 2014a).
Who owns Private Hospitals?

- Private acute and psychiatric hospitals operating on a For profit basis accounted for over half of the patient separations and patient days reported in 2013-14 at 56.8% and 56.4% respectively. Religious or charitable Not for profit hospitals accounted for 37.2% of separations and 36.4% of the patient days, with Other Not for profit hospitals accounting for the balance. (Source: ABS Private Hospitals Australia 2013-14)
Hospital Landscape

Figure 1: Proportion of beds by hospital type, public hospitals (2012–13) and private hospitals (2011–12)

Hospital beds – Australian Institute of Health and Welfare 2012-13
Funding of Private and Public Hospitals

(Australian Institute of Health and Welfare, 2015)
Private Health Insurance take up in Australia

By 2011-12 57.1% of Australian adults held private health insurance (7.2% had ancillary coverage only).

Levels of private health insurance membership varied by age, with people aged 55-64 having the highest coverage (67.5%).

Source: Australian Bureau of Statistics.
The most commonly cited reason for having private health insurance is “Security/protection/peace of mind” with 52% of policy holders identifying this as a reason.

(ABS 2011/12)
The most commonly cited reason for having not private health insurance is the cost with 58% of non-policy holders identifying this as a reason.

(ABS 2011/12)
Things you may not know about private hospitals

- Nearly half of Australian hospitals (44%) are private (Australian Institute Health Welfare 2011-12, ABS 2013)
- In 2012-13, 41% of all patient admissions were treated in private hospitals (Australian Institute Health Welfare 2014)
- 1 in 3 hospital beds are private (Australian Institute Health Welfare 2011-12, ABS 2013)
- 66% of elective surgeries are performed in private hospitals and day surgeries. (AIHW 2011-12)
- From January 2013, all public and private hospitals were required to be accredited against a nationally consistent and uniform set of measures known as National Safety and Quality Health Service Standards developed by Australian Commission on Safety and Quality in Health Care. (My Hospitals 2014)
Some key Differences to Public Health

- Private Revenue is derived primarily from Private Health Insurers (PHI), with some MBS, DVA, and self-funded patients.
- Cabrini has its own agreements with PHI which differ by each Insurer.
- At Cabrini any profits are re-invested into staff and facilities, and used for altruistic purpose.
- No financial reporting to DHHS.
- EBA rates are generally aligned with those in the public sector. There are no mandated nursing bed ratios requirements in the Private Sector.
- Specialists are generally not directly employed by the hospital.
- Organisational Structure is largely campus based.
How do we work differently in finance?

• Budgeting
• Analysis & Reporting
Budgeting

Key differences between public and private

• Public – Largely budgets based on “what we have”, costs are budgeted in silos (e.g. Specialist Clinics, Medical Salaries, Theatre, Wards), and there can be a lack of connectivity between sections of the “production line”, generally budgets are adjusted in “steps” when there are clear changes in the level of service.

• Private – Budgets are based on “what will we do”, and changes to base year will flow onto budgets throughout the organisation from both a revenue and cost perspective. There is less of an assumption that costs are fixed.
Budgeting

Budgeting is based on expected clinical output – what do we expect to do this year?

Acute revenue budget is built based on expected activity at a SRG and DRG level. (Separations x Length of Stay x Revenue per bed day).

Required activity level is distributed to wards based on SRG’s, then checked to ensure wards are within capacity.

Total bed days assumption by ward leads to expected labour costs. (Bed Days x Nursing Hours per Bed Day x Labour cost per Nursing Hour). Same logic is linked to consumables, and used as a basis for phasing diagnostics, food, linen activity.
Budgeting

Advantages:

• There is a link between revenue and cost, when there are variances in one, you expect to see corresponding variances in the other.

• The assumptions flow through the patient journey, an increase in theatre activity is linked with ward activity, diagnostics, food and linen.

• The output of different specialties are highly visible.

• It is easy to determine whether variances exist due to throughput, patient mix, or health fund mix.
Analysis & Reporting

By budgeting revenue at SRG level we are able to analyse results at the same level:
Activity data is aligned with financial reports. Key ratios including staff cost per hour and hours per bed day are used to measure workforce efficiency.

A brief snapshot of variances by SRG’s draws into focus those performing or not performing and leads to conversations on why.
Analysis & Reporting

Key indicators include (acute):

• Revenue
  • Bed day volume
  • Separations
  • Revenue per bed day
  • Theatre Separations
  • Emergency Presentations

• Salaries
  • FTE (Establishment and Productive)
  • Labour cost per hour
  • Nursing staff mix
  • Nursing hours per bed day

• Operational Expenditure
  • Food cost per bed day
  • Linen cost per bed day
  • Medical supplies per bed day
In Summary

• Budgeting and analysis is able to be enhanced through use of unit level drivers for both revenue and cost.
• Visible indicators of price and volume allow targeting and management of case mix, case volume, and staff mix, and staff numbers. This gives a measure of efficiency.
Thank you for your attention, any questions?

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