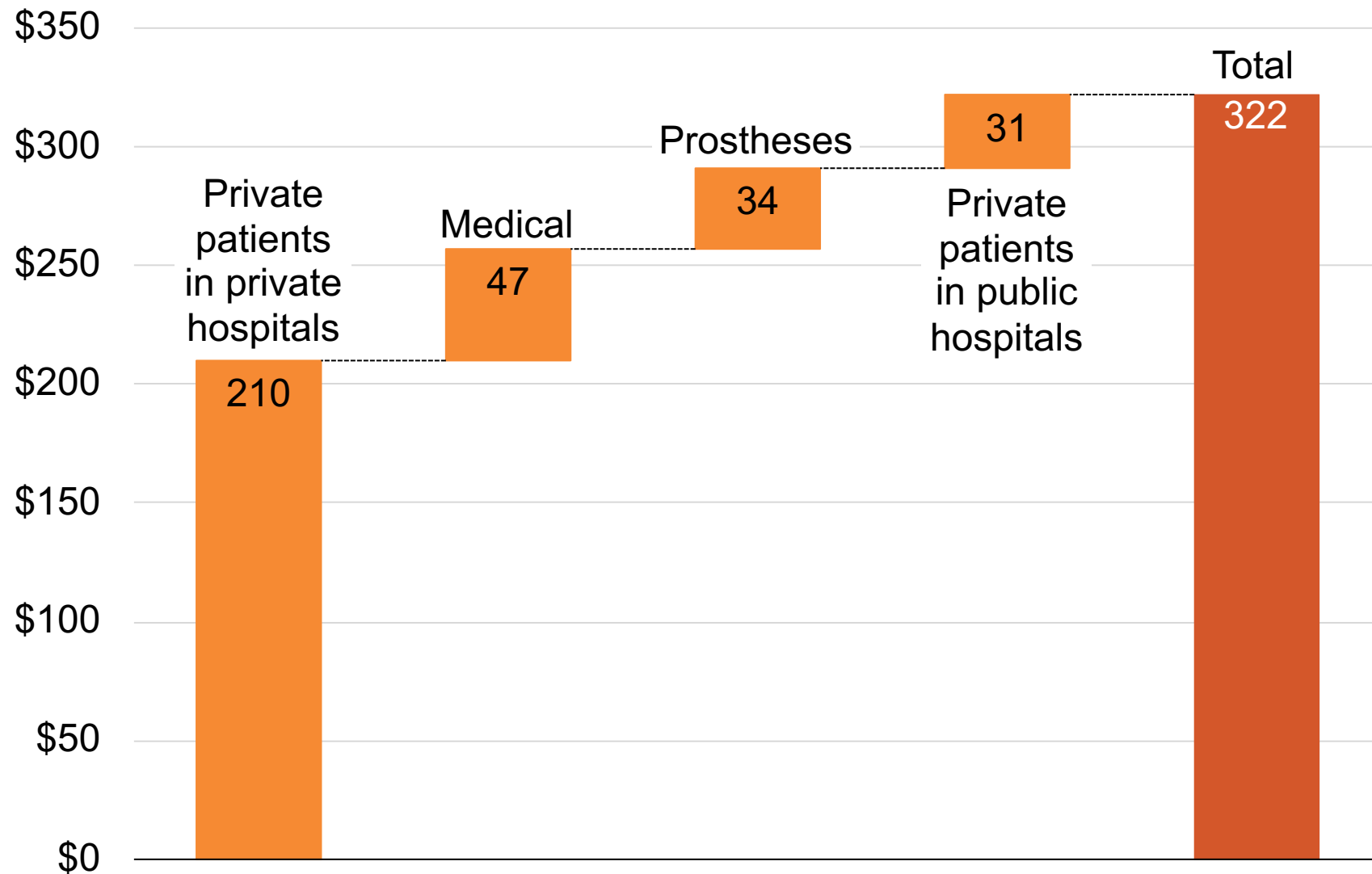# Saving private health 1: reining in hospital costs
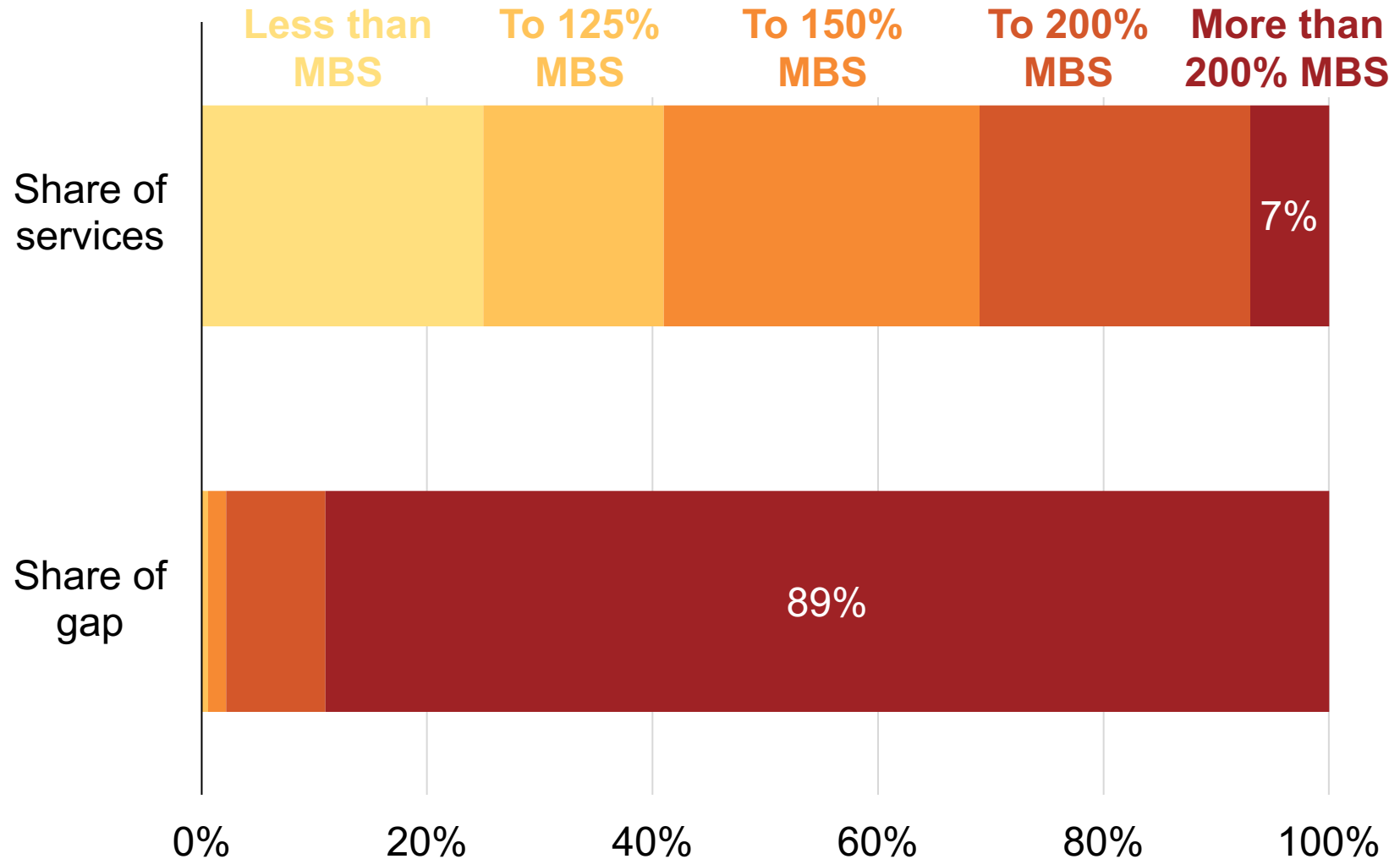
Chart pack

Private hospital costs are the biggest driver of increases in private health insurance benefit payments

Real change in benefits per member, 2008-09 to 2018-19

Source: Grattan Institute analysis of Australian Prudential Regulation Authority (APRA) private health insurance statistics.

Seven per cent of inpatient medical services account for 89 per cent of all medical gaps

Share of total gap and total services in each fee bracket relative to the MBS schedule fee

| | Less than MBS | To 125% MBS | To 150% MBS | To 200% MBS | More than 200% MBS |

Share of services — 7%

Share of gap — 89%

0%　20%　40%　60%　80%　100%

*Source: APRA Medical Gap Statistics for the 2018-19 financial year*

Out-of-pocket costs vary significantly between doctors

Average gap per service, where there was a gap, by speciality, and speciality share of total gap for financial year
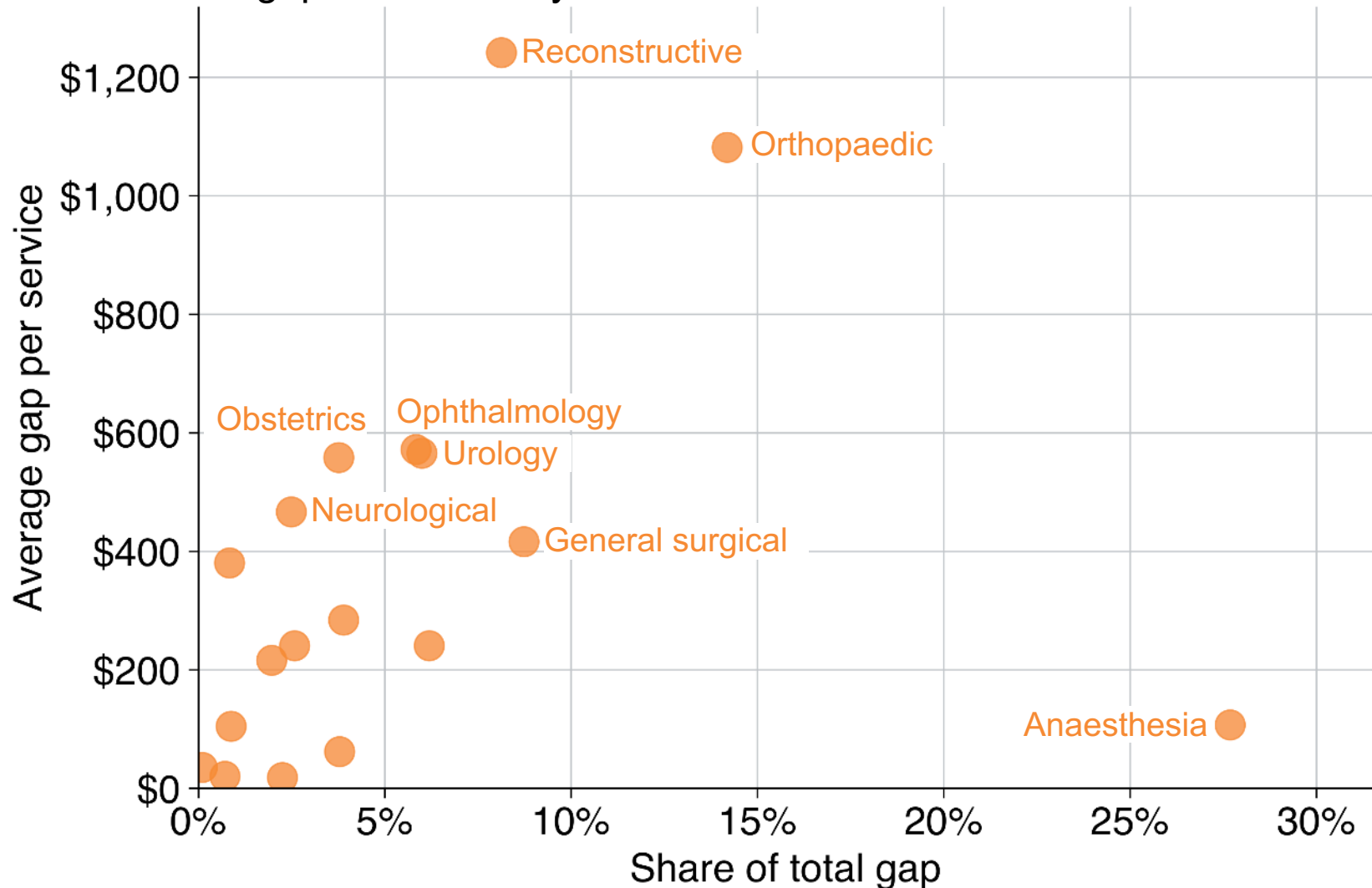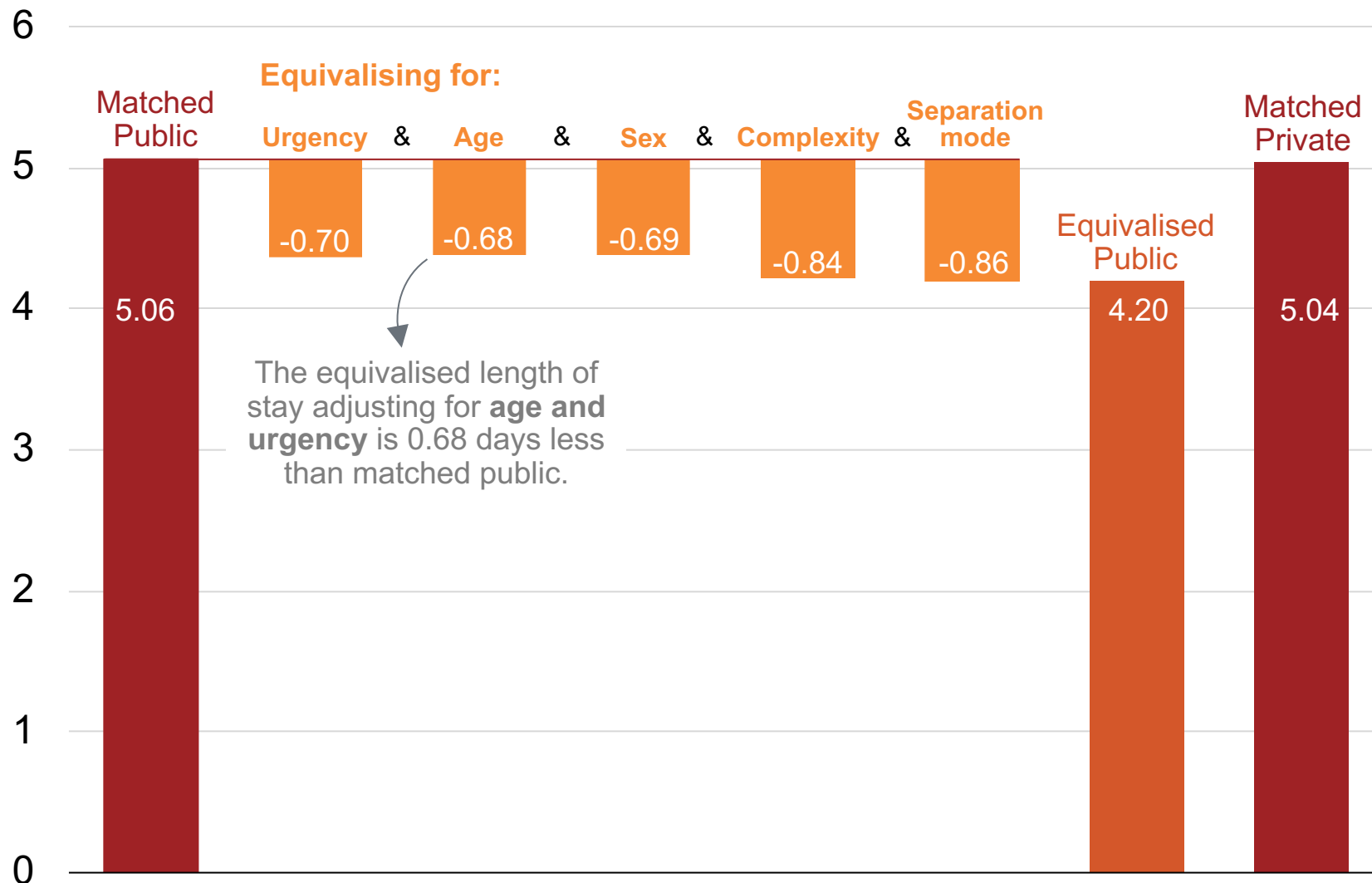
The out-of-pocket costs for women with breast cancer are significant

Median out-of-pocket costs, $, and interquartile range, 25th to 75th percentile, for women diagnosed with breast cancer

*Source: Adapted from Deloitte Access Economics (2016, Chart 5.1).*
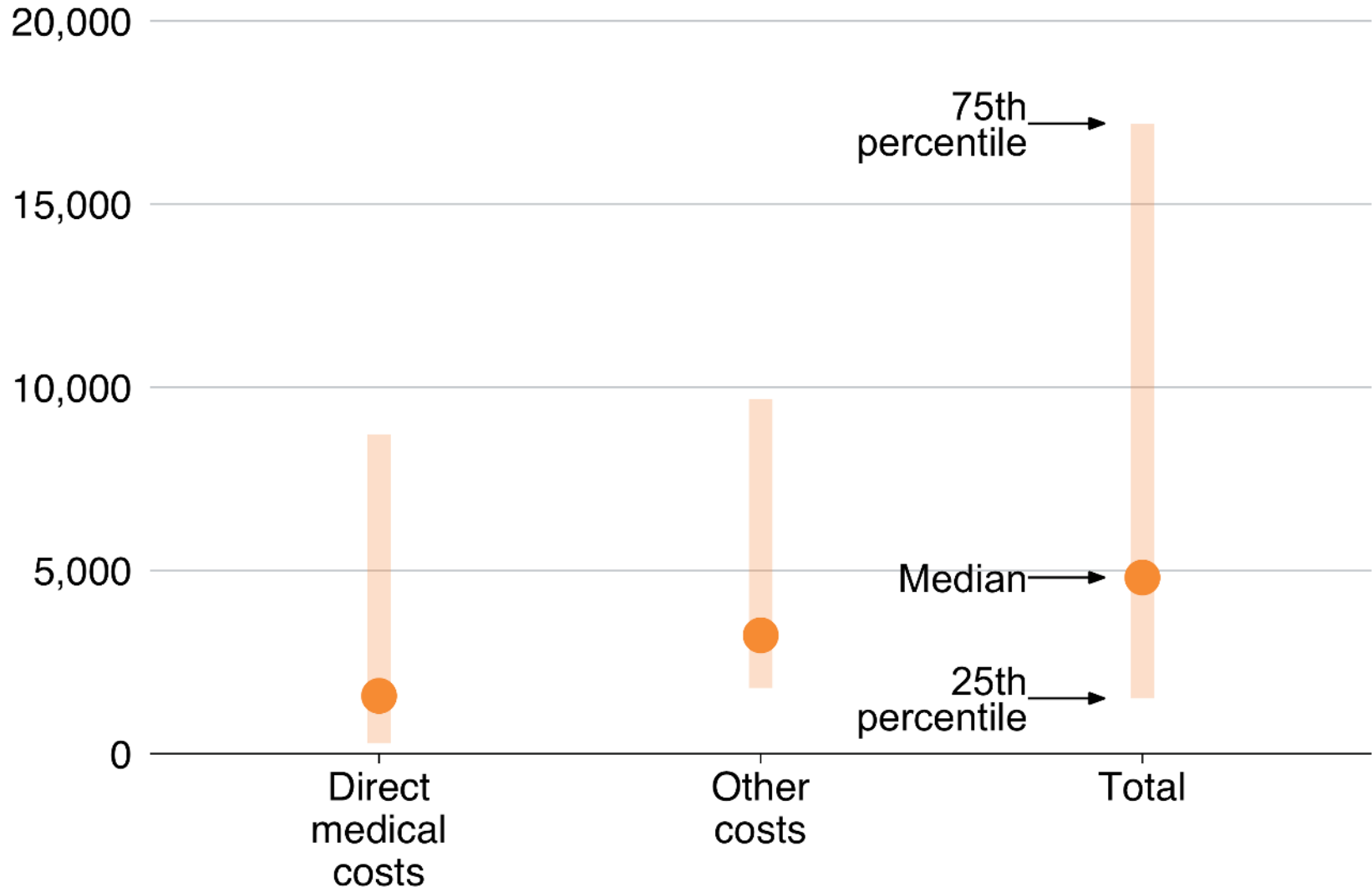
Public hospital hip replacement patients have a shorter length of stay once patient attributes are considered

Incremental impact of adjusting for various factors on length of stay, days, 2016-17

Equivalising for:

Matched Public — 5.06

Urgency -0.70 & Age -0.68 & Sex -0.69 & Complexity -0.84 & Separation mode -0.86

The equivalised length of stay adjusting for **age and urgency** is 0.68 days less than matched public.

Equivalised Public — 4.20

Matched Private — 5.04

Source: Grattan analysis of dataset obtained from AIHW. See Appendix B.

Public hospitals have a shorter length of stay once complexity is taken into account

Length of stay for matched patients (days)

Source: Grattan analysis of dataset obtained from AIHW. See Appendix B.
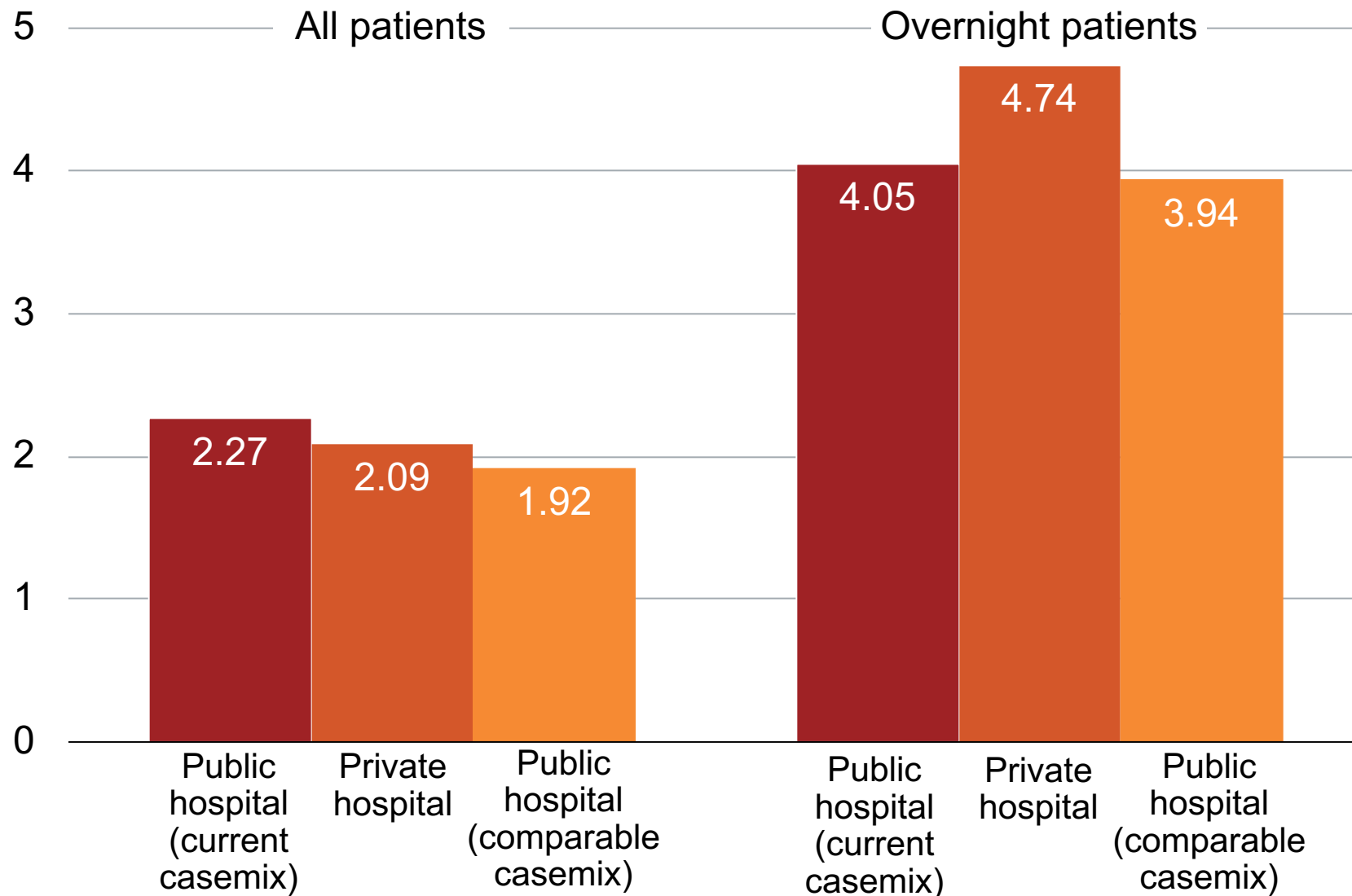
Three steps to one bundled bill

July 2021
- Bundle all hospital costs including days of stay, theatre costs, diagnostic costs (such as pathology, radiology), and medication costs
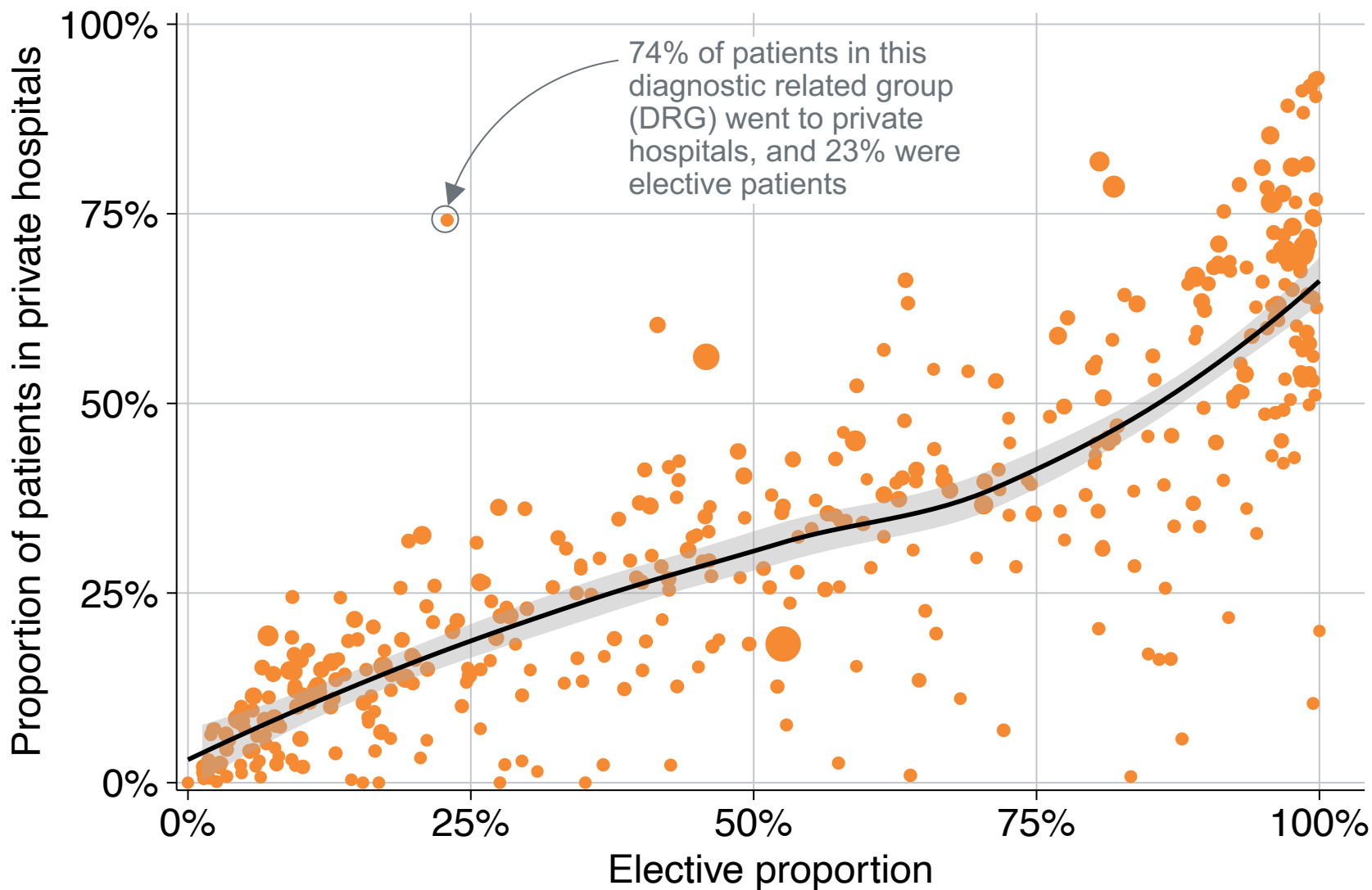
Feb 2022
- Add prosthesis costs to the bundle

July 2022
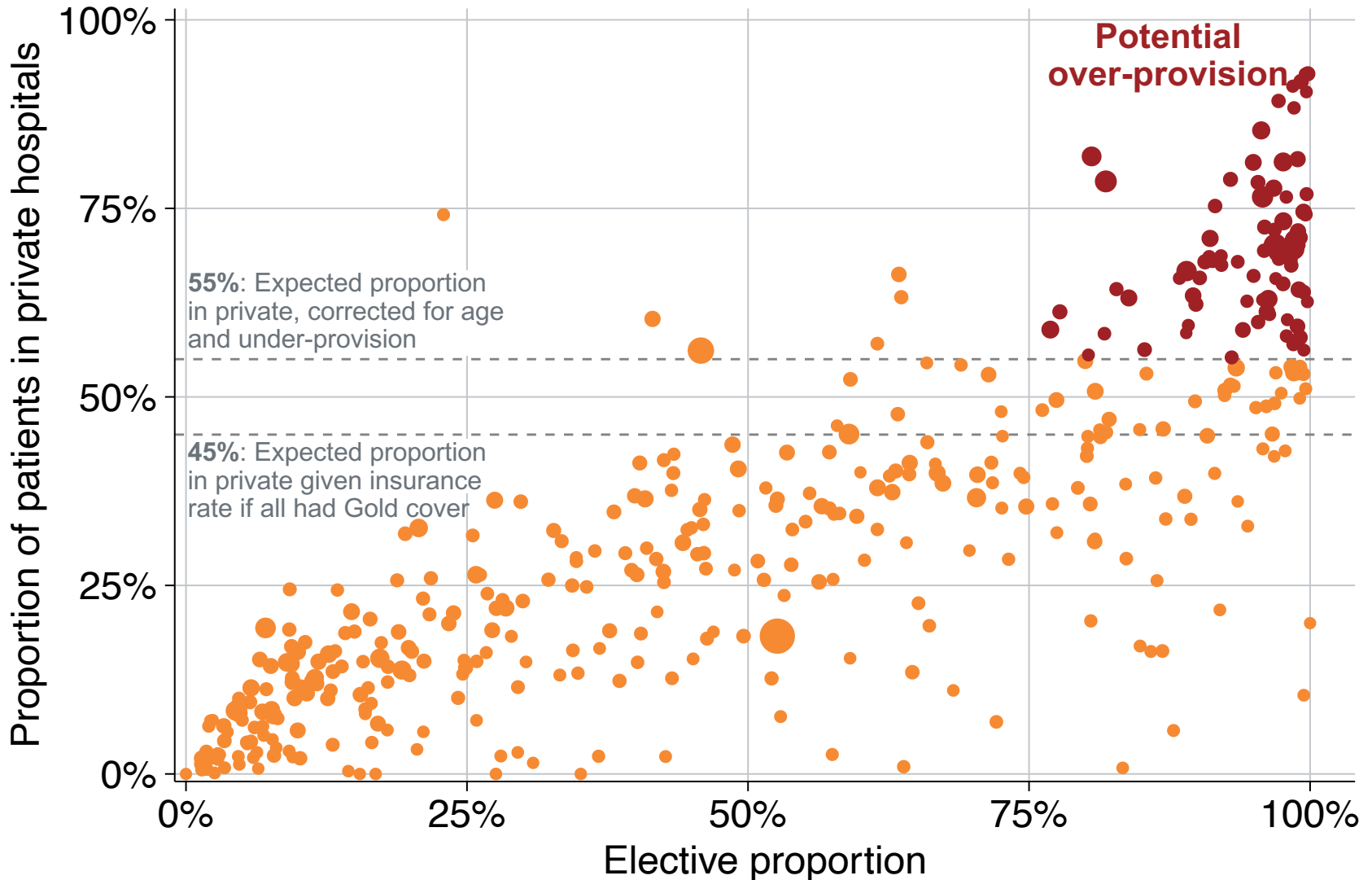- Add all medical costs to the bundle

Elective patients are more likely to be treated in private hospitals

Proportion of admissions treated in private hospitals, by adjacent DRG (sizes proportional to total number of admissions), 2016-17
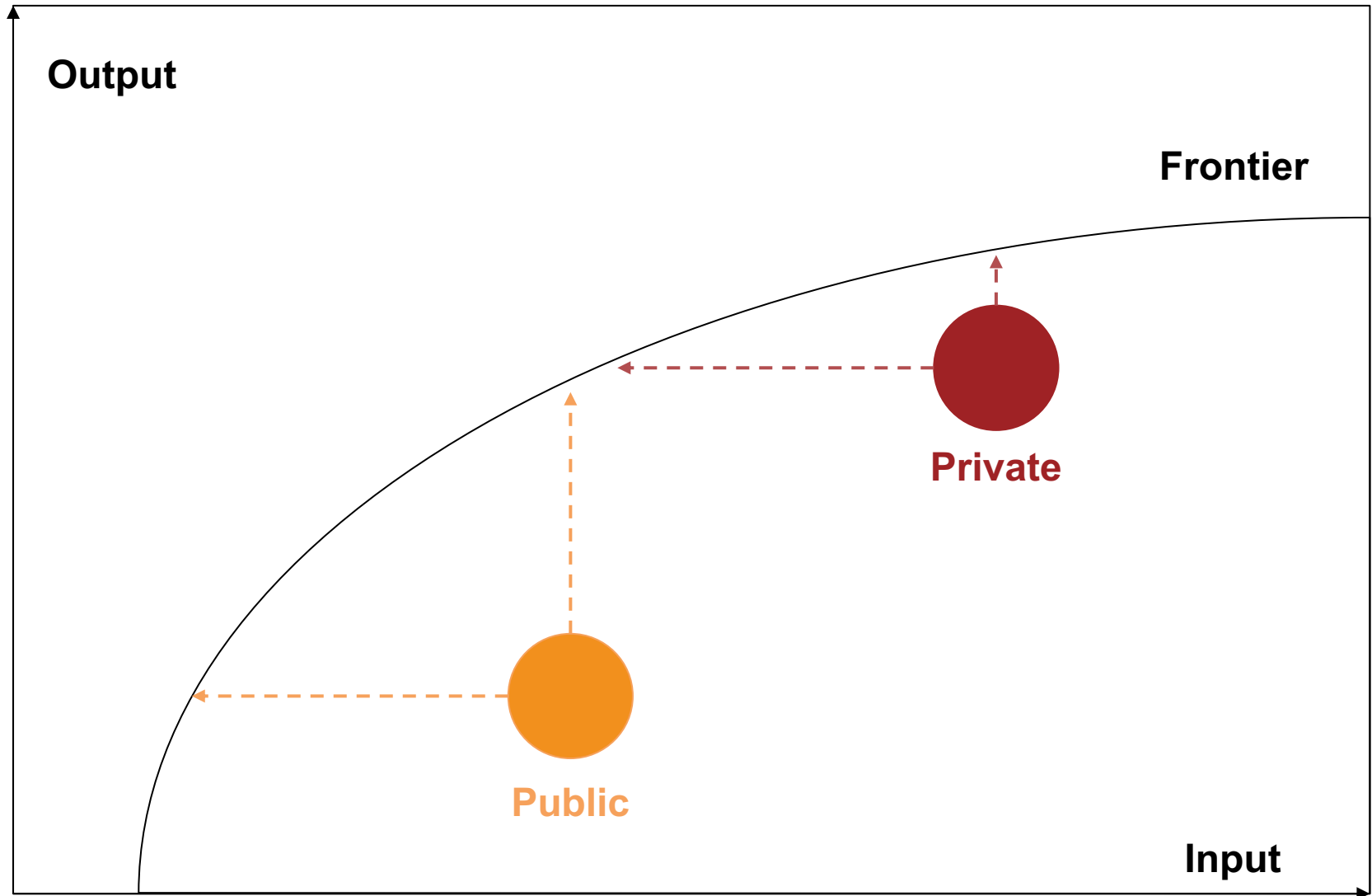

74% of patients in this diagnostic related group (DRG) went to private hospitals, and 23% were elective patients

Source: Grattan analysis of dataset obtained from AIHW. See Appendix B.

About $2 billion could be saved each year by recouping over-provision

Proportion of admissions treated in private hospitals, by adjacent DRG (sizes proportional to total number of admissions), 2016-17


Potential over-provision

55%: Expected proportion in private, corrected for age and under-provision

45%: Expected proportion in private given insurance rate if all had Gold cover

Proportion of patients in private hospitals

Elective proportion

Source: Grattan analysis of dataset obtained from AIHW. See Appendix B.

Conceptual visualisation of technical efficiency

There is a strong relationship between cost and length of stay

Cost per admission
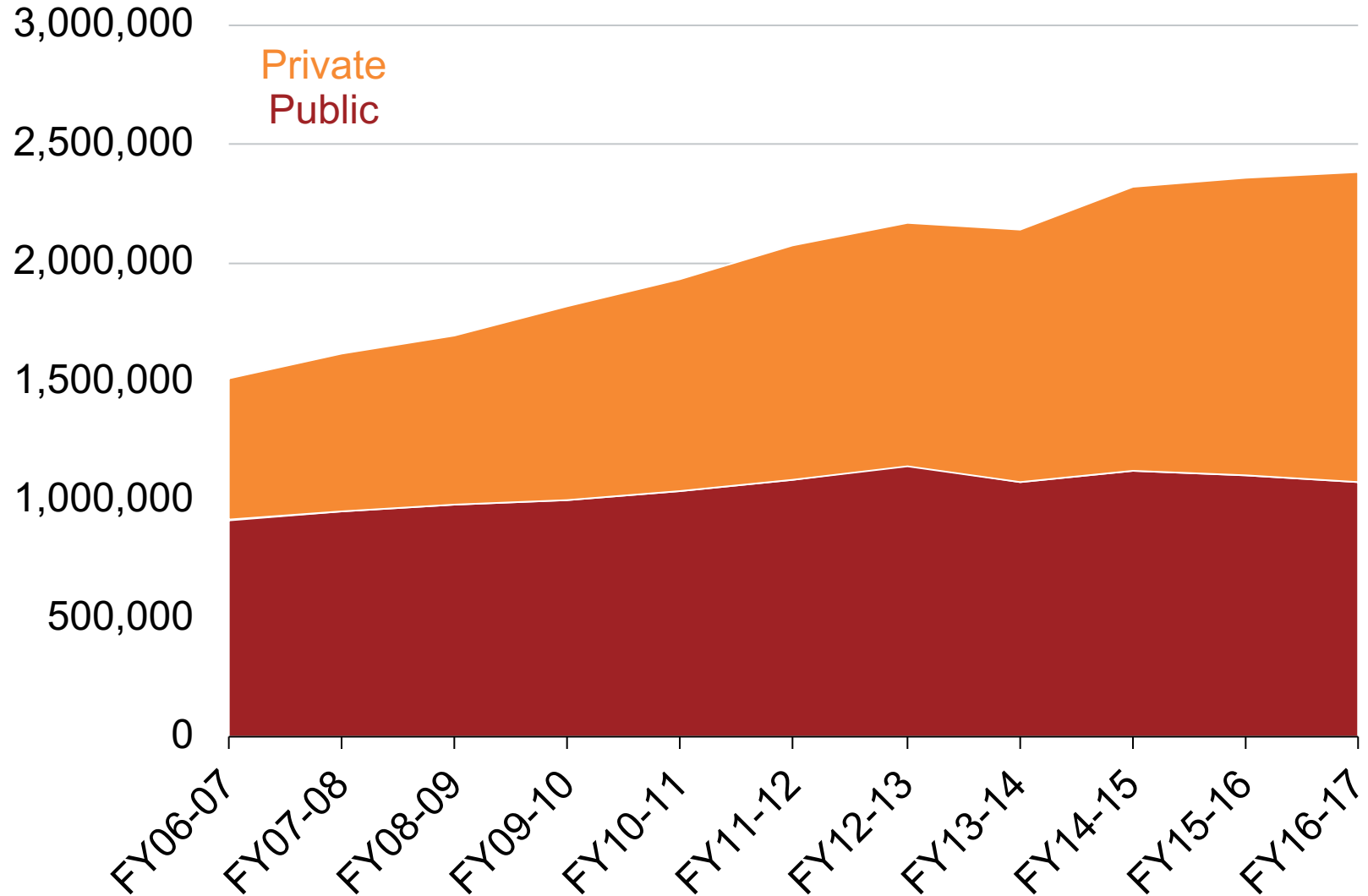

Length of stay (days)

Surgical
Non-surgical
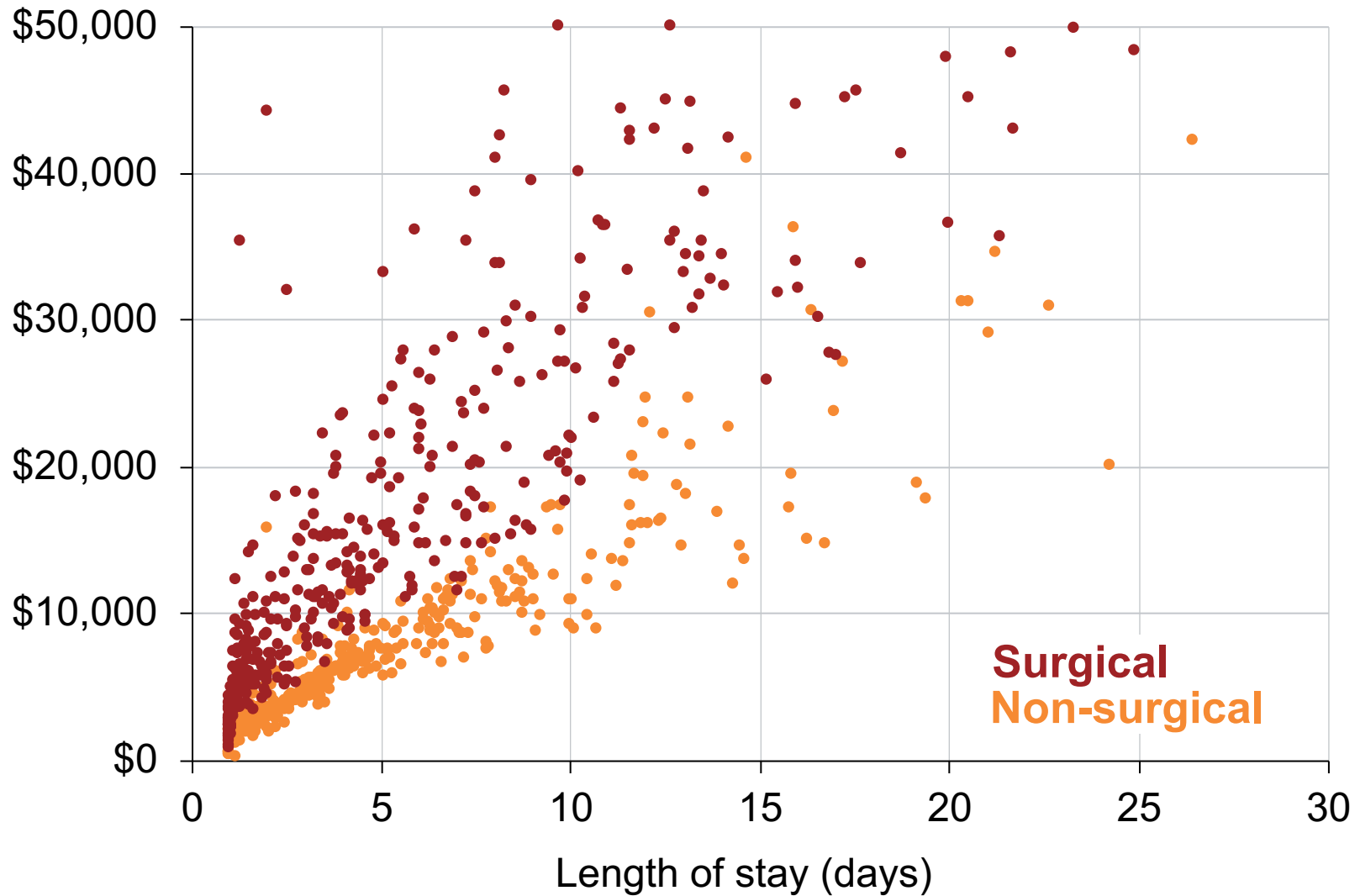
Remote patients are less likely to visit a private hospital

Proportion of admissions that are elective, by DRG (sizes proportional to total number of admissions)
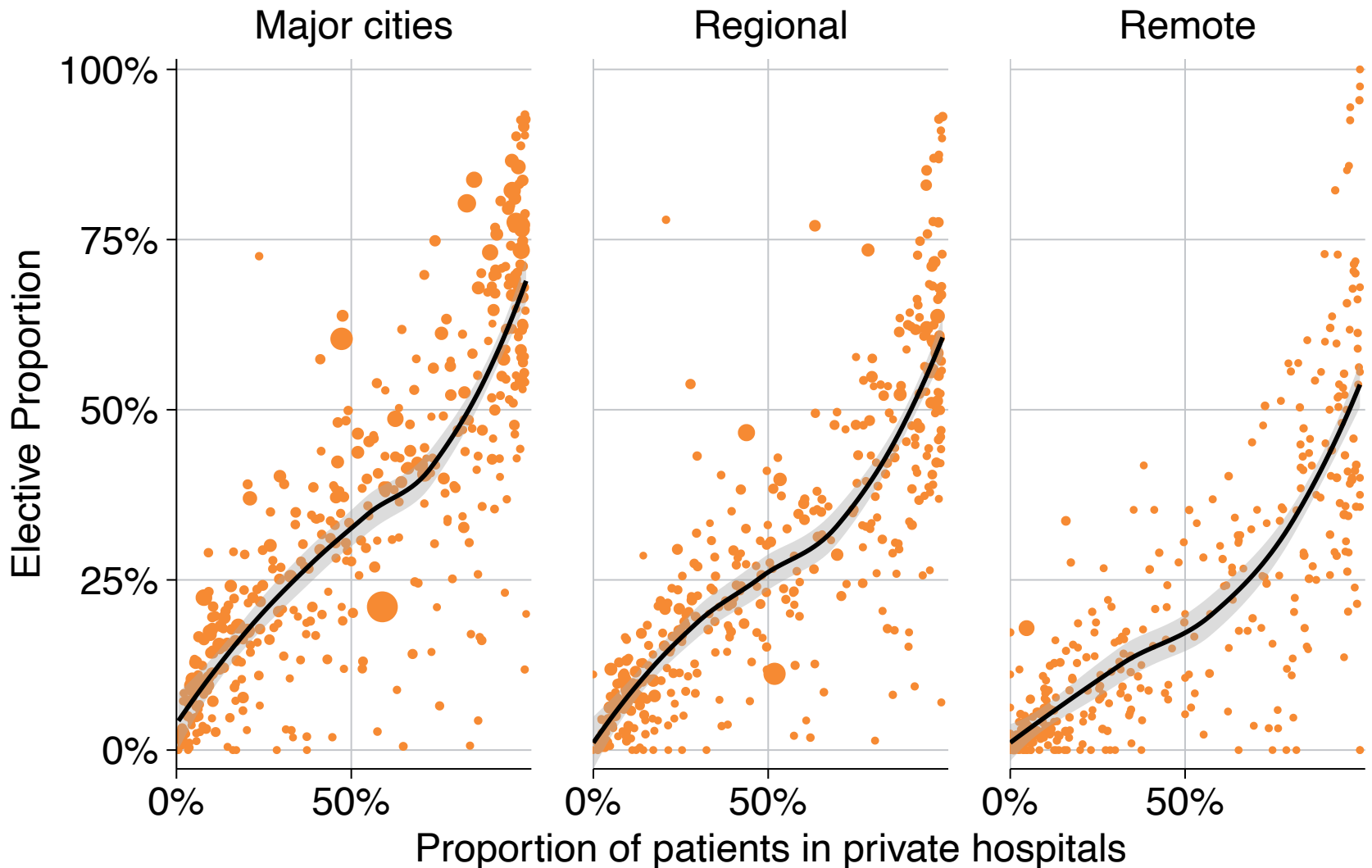
Almost all the growth in rehabilitation days in the past decade has been in private hospitals

Number of inpatient rehabilitation days, 2006-07 to 2016-17

There is a higher incidence of low-value care in private hospitals than public hospitals

Sources: Private rates: Chalmers et al (2019); Public rates: Badgery-Parker et al (2019).