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Performance Examination

Private Care for Public Patients

**A Follow-on Examination of the
Joondalup Health Campus Contract**

Report No. 4 June 2000



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**THE SPEAKER
LEGISLATIVE ASSEMBLY**

**THE PRESIDENT
LEGISLATIVE COUNCIL**

PERFORMANCE EXAMINATION: Private Care for Public Patients – A Follow-on Examination of the Joondalup Health Campus Contract

This report has been prepared consequent to an examination conducted under section 80 of the *Financial Administration and Audit Act 1985* for submission to Parliament under the provisions of section 95 of the Act.

The report is a follow-on examination to the 1997 report '*Private Care for Public Patients – Examination of the Joondalup Health Campus Contract*'. Follow-on examinations have a wider scope to follow-up examinations in that they evaluate aspects of performance not covered in the initial examination. In this report, comment is made on the management of the Joondalup Health Campus (JHC) contract by the Health Department and the performance of the JHC; matters not dealt with in the initial examination for reason that JHC had not at the time been commissioned.

This approach of progressive evaluation of key areas of agency performance will, I am sure, assist Parliamentary decision-making to the benefit of all Western Australians.

A handwritten signature in blue ink, appearing to read 'D D R Pearson'.

D D R PEARSON
AUDITOR GENERAL
June 21, 2000

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Overview

- ◆ *Hospital funding to the JHC/Wanneroo site has tripled in the last four years, and is likely to continue to grow at a steady rate under the Department's new metropolitan health plan – 'Health 2020'.*
- ◆ *Cost and quality of services delivered by JHC are generally comparable to metropolitan public hospitals. However, some opportunity exists under the contract to negotiate a lower cost for emergency department services.*
- ◆ *Opportunity exists to relieve some of the pressure on teaching hospitals particularly Sir Charles Gairdner Hospital through increased patient transfers to JHC and higher acuity profiles in the JHC emergency department.*
- ◆ *Structural and procedural arrangements for managing the contract are good and the risks associated with the contract are satisfactorily managed overall.*
- ◆ *Private hospital arrangements entered into by the Department subsequent to the JHC contract provide an opportunity for future comparative analysis of the different models.*

Background

In 1996, the Joondalup Health Service Agreement was signed with Health Care of Australia (HCoA), a division of Mayne Nickless Limited. Under the contract, HCoA took control of the 84 bed Wanneroo Public Hospital and financed, designed, built and now operates an upgraded 335 bed hospital comprising 265 public beds and 70 private beds. Hand over of the old Wanneroo Hospital took place on June 1, 1996 and the new hospital came into commission on January 12, 1998. The new hospital became the Joondalup Health Campus (JHC).

The contract was the outcome of a government policy to encourage greater involvement of the private sector in the provision of hospital services and followed a 1993 review which found need for additional hospital services for Joondalup residents.

The contract provides for the State to purchase public patient services from HCoA through annually negotiated service agreements. Payment to the operator for the capital cost of the hospital is made via two instalments a year over 20 years at the end of which control reverts to the State. At the end of 40 years, the private component of the hospital transfers to the State at no cost.



*Net present
value is over
\$1 billion.*

The net present value of the contract when signed in April 1996 was estimated to exceed \$700 million, about 90 per cent of which relates to the purchase of services. Current estimate of the net present value of the contract is \$1.06 billion.

In 1997, a performance examination was undertaken of the planning and management of the JHC contract. The main findings were:

- ◆ The Health Department of Western Australia (the Department) managed a competitive selection process, though the scope was limited to two models of private sector involvement with the model involving the provision of both services and facilities by the private sector being preferred.
- ◆ There was no reliable information to establish that the contract would provide net tangible benefits relative to a public sector alternative.
- ◆ The extent to which the contract delivers lower cost of services depends critically upon whether the Department succeeds in minimising risks and negotiating each year substantial quantities of additional services at competitive prices.
- ◆ Other potential benefits included:
 - ▲ the impact of competition on the efficiency of public sector hospitals; and
 - ▲ stimulus for reform of the planning of hospital services across the metropolitan area and the delineation of roles for each hospital.

Follow-on examination and approach

The 1997 examination of the JHC contract focused on the planning and tendering processes for the awarding of the contract as well as the inherent risks in the contract. However, assessment was not made of how well services were delivered as JHC was not commissioned until after the tabling of the report.

Follow-on examinations are usually undertaken two to three years after the initial examination. This follow-on examination to the 1997 report provides an assessment of the performance of JHC since commissioning in January 1998 and of the Department's management of the contract.

Findings

Capital Cost

Final capital cost is \$42.1 million.

As forecast in the 1997 report, the final capital cost to the State of the JHC was \$42.1 million. The cost of the project rose from the operator's original proposal of \$27 million to \$39 million when the contract was signed in April 1996. The increase was due to changes in the Department's specifications and modifications to address shortcomings in the operator's proposal. Subsequent scope change to provide facilities for mental health, restorative and community health services added \$3.1 million to the project.

The total capital cost of the public component of the hospital forms the basis of an Availability Charge that the State pays to HCoA. Payment of the Availability Charge is via 40 six-monthly instalments that commenced in December 1998 and will end in January 2018.

Early completion resulted in additional cost.

Additional capital costs of \$522 000 were also incurred as a result of the commissioning of JHC ahead of schedule though the State benefited from the early commencement of services. Commissioning was planned for June 1998 but instead occurred in January 1998. This event was not foreseen in the contract. Payment to HCoA was based on the additional interest cost it would incur from drawing down funds from its financier in advance of the planned cashflow. An alternate option of bringing forward the first payment of the Availability Charge from December 1998 to July 1998 was considered but advice from the Western Australian Treasury Corporation (WATC) was that this would involve a significantly greater cost (\$1.2 million) to the State.

Interest rate set for second 10 years.

At the time of the 1997 report, payment of the Availability Charge was at an interest rate of 10.04 per cent fixed for the first 10 years of the 20 year term. The interest rate for the second 10 years remained to be set. However, in early 1999, the Department with the agreement of the WATC chose to lock in a rate of 8.575 per cent on the \$39.1 million principal and a rate of 8.02 per cent on the additional three million dollars for the second ten year period. WATC concluded that this arrangement is "...financially neutral and the principal amount involved will not materially impact on the State's existing debt maturity profile".



Service Delivery

Many factors affect whether the State benefits from the contract including whether:

- ◆ the purchase and delivery of appropriate services is at a competitive price and to a good quality; and
- ◆ management of the contract protects the interests of the State.

These matters comprise the focus of this report.

Purchase of services

The Department functions as a single integrated purchaser of health services for the Western Australian public. Its role as purchaser is to assess the health needs of the State and whilst considering government policy and direction, to purchase services from health providers.

Providers of public health services in the metropolitan area are the Metropolitan Health Service Board (MHSB) and private sector providers such as HCoA through the JHC. The MHSB was established in mid 1997 by the amalgamation of the ten Boards of Management of the metropolitan public hospitals and health services. Its goals are to improve the efficiency and effectiveness of metropolitan public health service by eliminating duplication in service provision, moving services closer to where people live and through the adoption of system wide coordination and clinical best practice.

*JHC receives
five per cent
of metro
health service
funding.*

The MHSB is the primary public health service in the metropolitan region, receiving approximately 93 per cent of Departmental funding of metropolitan health services. By comparison, the \$50.8 million contract for JHC services in 1999/2000 represented about five per cent of metropolitan health service funding by the Department. Nevertheless, JHC is becoming an increasingly important provider of metropolitan hospital services and therefore competitor to the MHSB for available funding. The Department's original intention was for the JHC contract to be managed by the MHSB. However, the MHSB considered that such a relationship would be a conflict of interest and instead it was agreed that the contract would be managed by the Department.

Findings

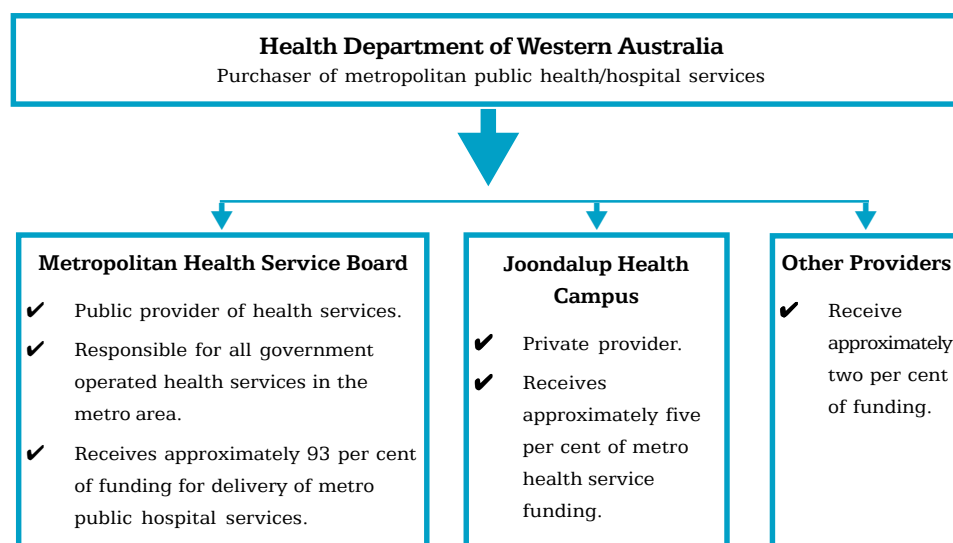


Figure 1. Public health/hospital service delivery in the metropolitan area.

JHC is an important provider and therefore competitor to the MHSB for metropolitan hospital funding.

Source: Health Department and OAG

Under the JHC contract the Department sets the quantity of each type of service it wishes to purchase in the forthcoming year. Although the Department can gradually reduce the quantities involved, the contract effectively guarantees to purchase a minimum quantity (volume and type) of services each year, partially protecting the operator from any adverse impacts of future changes in government policy. This represents a risk to the State, albeit that the risk is small given the quantity of services purchased since commissioning has well exceeded the minimum quantity required under the contract and can be expected to remain so under the Department's new metropolitan health plan, 'Health 2020'.

Table 1 shows how the quantities purchased and the maximum payment amount (MPA) has grown since 1996/97. The MPA is the maximum budget available to meet all operational commitments under the contract for that year.



	Unit of Measure	1996/97 (Note 1)	1997/98 (Note 1)	1998/99	1999/2000
Value					
Maximum Payment Amount (MPA)	\$ million	15.4	26.0	38.6	50.8
MPA – in Constant 1996/97 prices.	\$ million	15.4	25.5	35.9	41.4
Activity					
Admitted patients (weighted) (Note 2)	DRGs (Note 3)	7 101 (unweighted)	7 581 (weighted)	10 639 (weighted)	12 439 (weighted)
Dept Veterans Affairs. (DVA) (Note 4)	DRGs	100	87	105	1 000
Emergency Department	Attendance	20 000	27 200	35 750	35 286
Non admitted patients	Attendance	20 540	23 450	25 047	26 227
Mental Health, palliative care, aged care	Bed-days	N/A	6 298	14 783	16 608
<p>Note 1 The values relate to Wanneroo Hospital until January 1998.</p> <p>Note 2 Each service is given a weighting to reflect the level of acuity (difficulty) which in turn affects cost. No comparison should be made between weighted and unweighted figures.</p> <p>Note 3 Diagnostic related group, that is, related types of medical and surgical services.</p> <p>Note 4 From 1999/2000, DVA services are contracted direct with the Commonwealth and are therefore outside the MPA.</p>					

Table 1: Growth in volume and value of services provided.

The volume and value of services provided has grown significantly since 1996/97.

Source: Health Department

The need for health services varies according to demographic factors such as age, sex, income and ethnicity. These factors along with the preference of patients and referral practices of doctors affect demand for services at new hospitals such as JHC.

Since commissioning, HCoA have consistently sought to increase the volume of services and the MPA offered by the Department, arguing that volumes and the MPA were being determined unduly by budget limitations rather than other contractual requirements such as demographics and changing need for services.

Findings

Departmental documentation confirms that the volumes purchased have been limited by financial constraints. However, the range and volume of services purchased is also based upon:

- ◆ The forecast population increase within the North Metropolitan locality of which JHC is part, but which also includes Sir Charles Gairdner Hospital, Osborne Park Hospital and Princess Margaret and King Edward Hospitals.
- ◆ Patterns of morbidity, mortality and hospitalisation within the metropolitan area. The Department advised that variations across metropolitan localities are slight.
- ◆ Maintaining current role delineation between teaching hospitals and public non-teaching hospitals. Teaching hospitals would continue to have responsibility for tertiary admissions. The Department has no plans for JHC to be elevated to teaching hospital status.
- ◆ Government policy of delivering services closer to home.

Analysis of the 1999/2000 profile found that the overall value of services delivered to the end of December 1999 was within two per cent of the contracted value of services on a year to date basis. However, amongst the 28 medical specialities, it is likely that there will be significant under and over purchasing of many major service types. In 1998/99, variations in services delivered from the purchased case mix profile ranged from 132 per cent over to 85 per cent under, with 16 of the 28 medical specialities varying from the purchased profile by 20 per cent or more.

Opportunity to improve activity profiling.

Part of the reason for the likely variance in medical specialities in 1999/2000 is a 16 per cent increase in emergency attendances above the forecast level on a year to date basis. Under the contract, JHC must treat all emergency attendances but also must stay within the MPA. This is achieved by reducing other services, which is the normal operational requirement of both public and privately operated health services. In February 2000, JHC advised the Department that it expected to deliver 400 fewer weighted DRG services for the year than was contracted. As at the beginning of April, the Department had not yet agreed on the nature of the reduction in services.

The start up nature of JHC along with changing medical treatment and health outcomes and varying seasonal factors makes it difficult to accurately predict service requirements. Nevertheless, greater accuracy in setting activity profiles is required if the Department is to have any real capacity to manage the types of services performed by JHC as is provided under the contract.



*Better ICU/CCU
services
introduced by
HCoA.*

An important change that occurred in purchased services has been the provision of a higher acuity level Intensive Care/Coronary Care unit (ICU/CCU)¹ than is required under the contract. This higher service level which is more comparable to a teaching hospital was introduced in early 1998 by HCoA without reference to the Department. The Department had no intermediate plans to introduce the higher ICU/CCU service level to JHC and initially refused to fund the service.

In late 1998, HCoA advised that it would revert to the lower service level unless additional funding was provided. After several months of discussions, the Department concluded that the potential benefits of the higher ICU/CCU level such as reduced transfers of critical condition patients to Sir Charles Gairdner or Royal Perth Hospitals warranted a trial period. Negotiations led to a retrospective payment of \$300 000 for part of 1998/99 and agreement to fund the higher service in 1999/2000 at a cost of \$1.9 million. This amount reflects the actual cost of providing the higher level service. The Department has used the first six months of 1999/2000 to conduct an acuity analysis of attendances at the emergency department, the outcome of which has been a decision to continue at the higher level service in 2000/2001.

The MHSB welcomed the higher level service at JHC as being important to reducing the flow of persons living in the Joondalup catchment area to its teaching hospitals. For the period 1996/97 to 1998/99, patients from the Joondalup catchment area attending the emergency department (ED) of Sir Charles Gairdner Hospital (SCGH), the main alternative public hospital for Joondalup residents, declined 30.5 per cent.

Upward changes to the profile of patients attending the JHC emergency department will also reduce the burden on SCGH as high acuity patients usually attend teaching hospitals. In 1998/99 the proportion of patients in the important triage two and three codes increased significantly though thereafter only code two is forecast to increase whilst code three is expected to decline (Table 2). The Department advised that acuity levels can not be strictly managed as the hospital must treat all patients that attend the ED. On this basis, a higher acuity profile may depend upon increasing public knowledge about JHC.

¹ Raised to a level 5 service from a level 2/3, meaning increased medical and nursing staff levels and available specialist doctors.

Findings

Triage Code (Acuity)	Service Description	Volume 1997/98 (Actual)		Volume 1998/99 (Actual)		Volume 1999/00 (Projected)		Volume 2000/01 (Purchased)	
1	Resuscitation	90	0.3%	172	0.5%	219	0.5%	200	0.5%
2	Emergency	335	1.1%	1 473	4.1%	2 518	6.3%	2 804	6.8%
3	Urgent	3 331	11.2%	11 607	32.3%	12 422	30.9%	13 110	31.7%
4	Semi urgent	19 603	66.0%	20 313	56.4%	23 296	57.9%	23 410	56.6%
5	Non urgent	6 326	21.4%	2 405	6.7%	1 773	4.4%	1 818	4.4%
	Total	29 685	100.00%	35 970	100.00%	40 228	100.00%	41 342	100.00%

Table 2. Acuity level of patients attending the JHC emergency department.

The acuity profile of patients attending JHC increased significantly in 1998/99 but thereafter is not forecast to change greatly.

Source: Health Department

Future Services

In February this year, the Department released its '2020 Health Plan' for metropolitan Perth. The plan forecasts that by 2021, two thirds of Perth's population would be living in outer metropolitan suburbs. The population of the North-West region (Wanneroo/Joondalup) would grow from 207 000 to 415 000. These trends make it essential to redistribute hospital treatment patterns from the situation that existed in 1997/98, whereby 75 per cent of inpatient services in publicly funded metropolitan hospitals² were undertaken by inner city teaching hospitals.

The 2020 Plan forecasts a range of measures to reduce delivery of secondary hospital services by inner city hospitals whilst satisfying community demand for services closer to home. The key to the plan is to increase the number and range of services delivered at selected secondary hospitals such as JHC as well as facilitating greater use of ambulatory care centres³ as an efficient way of managing the burgeoning growth in day services. Distribution of inpatient services is expected to shift to a ratio of 40:35:25 across the inner hospitals, outer hospitals and ambulatory care centres by 2009/2010. Delivery of high speciality, high cost tertiary services would continue to be focused at the inner city teaching hospitals.

The 2020 Plan also forecasts an integrated system of health care whereby clinical services are delivered across a seamless health system rather than the current system in which clinicians in the main operate within the boundaries of particular hospitals and health services. The integrated clinical services (ICS) would involve groups of clinicians from a number of related or complementary services or activities organised into geographically focused networks working together to provide services to a community. The ICS would be grouped to reflect the way people use services and would span the continuum of care through the health system (Figure 2).

² Based on unweighted separations

³ Day surgery facilities

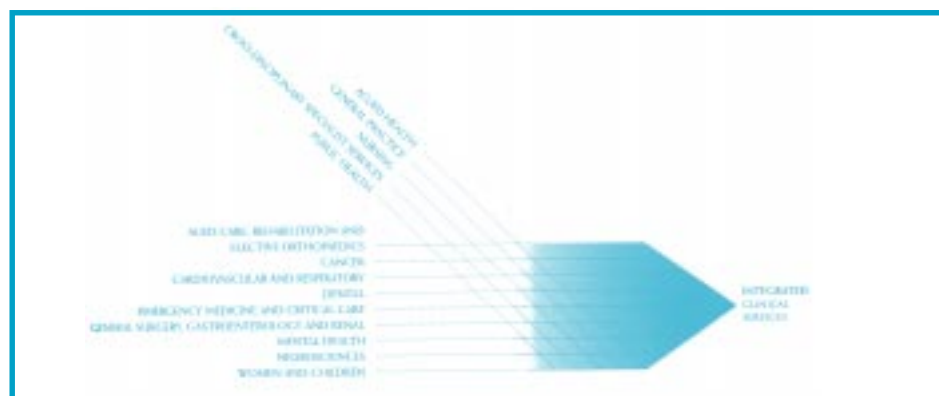


Figure 2. An example of integrated clinical streaming.

Integrated clinical services involve geographical networking of related or complementary services to provide a continuum of patient care through the health system.

Source: Health Department

Implementation of 2020 Plan in JHC will require agreement of HCoA.

To be effective, clinical integration would require the cooperation of private providers of public health services such as JHC. The 1997 report identified future changes to public policy as a risk of the JHC contract in that negotiations over desired changes to arrangements would occur without the benefits of competitive processes. If agreement with HCoA cannot be reached, the desired changes would not occur and the Department would have to look at less desirable alternatives.

The 2020 Plan forecasts the need for the cooperation of providers such as JHC. The Department advised that implementation of the 2020 Plan has not yet begun and any negotiations with JHC on ICS are some way off.

Cost of services

Unit service cost can be reduced.

Reducing the cost of hospital services to the State was seen as an objective of the JHC arrangement. The contract provides potential to reduce both the average availability charge per unit of service as well as the average unit service cost. Inherent to both opportunities is the capacity of JHC to deliver services in excess of the contracted baseload (indicative) quantities. This spare capacity exists. For instance, approximately 220 beds are available for acute inpatient care but the baseload quantity corresponds to approximately 135 beds.

Availability charge

As mentioned, the availability charge is paid to HCoA via twice-yearly fixed instalments for 20 years. The availability charge in 1999/2000 totals \$4 170 946.

Increasing the volume of service above the baseload quantity effectively creates a productivity gain to the State by reducing the average availability charge per unit of service (Figure 3).

Findings

A decline in the average availability charge per unit of service will occur in 1999/2000, though estimating the size of this productivity gain is difficult. As an indication however, the biggest service items purchased in 1999/2000, namely inpatients, emergency medicine and mental health services exceed the baseload service levels by between 17 and 108 per cent.

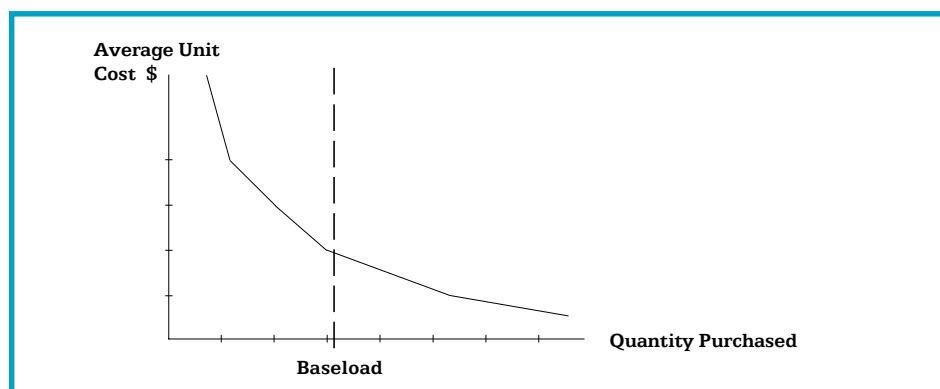


Figure 3: Effect of increased throughput on the average availability charge per unit of service.

The purchase of increased quantities of service will reduce the availability charge per unit of service.

Source: OAG

Service charge

The contract states that increases in public patient throughput above the baseload quantity should be met at a cost lower than at benchmark hospitals. Although this objective is set out in the contract, the wording is such that there is doubt that it is contractually binding.

The price of services delivered by JHC is determined through a costing and activity model calculated from the cost of providing equivalent services at benchmark hospitals. For the majority of services the benchmark hospitals comprise all the metropolitan non-teaching hospitals. For mental health services the benchmark hospitals are Graylands, Fremantle and Bentley. The Department also pays HCoA for the actual cost of depreciation, superannuation and payroll tax incurred for JHC.

Inpatient services represent the largest cost component of the MPA. For these services, the Department pays on a weighted basis that reflects the fact that inpatient conditions vary widely in terms of complexity and severity and therefore of the resources required for treatment.



Other services are purchased by occasions of services and attendance such as physiotherapy. This is consistent with the contract, though the contract also forecasts that such non DRG services should in due course be purchased on the basis of weighted activity measures.

In 1999/2000, the Department agreed to purchase inpatient and mental health services above the indicative contract level on the proviso that a "*credible marginal price was offered... so that the benefits (of the contract) are demonstrated*". The outcome was a five per cent reduction in the price for inpatient services and mental health bed days above the baseload quantity and a ten per cent reduction for waitlist work. Subsequently, other public hospitals have also been paid at this discount rate for waitlist work thereby neutralising the discount effect to JHC.

Price for some services are discounted...

...but not emergency medicine.

Of the other service types listed in the indicative profile⁴, only service levels for emergency medicine have exceeded the indicative level. No discount has been negotiated for emergency medicine despite purchased quantities being more than double the indicative level. Nevertheless, the price paid for ED attendance at JHC is favourable to the State as the rate is based on costs at benchmark hospitals that overall have a slightly lower acuity profile than JHC.

Savings have occurred.

Service cost savings to the State from delivering services under the JHC contract compared to delivery through an appropriate public hospital in the 1999/2000 year are estimated at between \$0.3 and \$0.4 million⁵.

Quality of services

The contract contains a range of measures that seek to ensure an acceptable standard of service quality. These include:

- ◆ Requirement for JHC to obtain accreditation from the Australian Council of Healthcare Standards. This was achieved in August 1999.
- ◆ Reporting of a large range of clinical indicators quarterly to the Department and publicly through JHC's annual report.

The 1997 report concluded that most health measures used in Australia to focus on clinical procedures and misadventures were of limited value because they usually relied on judgement and most did not contain thresholds for assessing performance⁶. This situation is gradually improving. Some indicators used by the Department across the public health system do enable the quality of JHC's service delivery to be considered against both thresholds and the comparative performance of benchmark hospitals and teaching hospitals⁷. A range of these key indicators are listed below.

⁴ JHC is now also delivering service types that are not listed in the indicative profile.

⁵ Excludes any savings or loss on capital cost components of the contract as well as costs of managing the agreement with JHC versus those with the benchmark hospitals.

⁶ Refer also to Auditor General's report '*Getting Better All the Time*' tabled in Parliament in June 1999.

⁷ JHC indicators were audited by the Department.

Findings

Waiting Times in Emergency Departments

Waiting times in emergency departments is an important indicator of hospital practices and/or level of resourcing. When patients enter an ED they are allocated a triage code that indicates their level of urgency. For each triage code, the Australian College of Emergency Medicine (ACEM) has recommended a maximum waiting time, with code one patients requiring immediate treatment, whilst code five patients are non-urgent but should be seen within 120 minutes.

Waiting times incorrectly recorded by JHC.

Attempts to compare JHC with other metropolitan hospitals were prevented by incorrect measurement techniques at JHC that came to light as a result of this review. This is a concern for the management and the transparency of the contract particularly as some evidence indicates that waiting times for code two (emergency) and code three (urgent) patients increased in 1998/99 compared to the previous year. The Department has advised that it has now arranged for JHC to provide weekly reports on ED waiting times until problems are rectified.

Readmission to hospital for same or related condition

Rate of readmission to hospital is low.

Low instances of readmission to hospital for same or related condition are an indicator of good clinical practice. For non-teaching hospitals such as JHC and its benchmark hospitals, satisfactory performance is judged to fall within or below a threshold of 2.6 per cent to 3.8 per cent of patients readmitted to hospital for the same or a related condition⁸. Figure 4 shows that the JHC is well below the threshold.

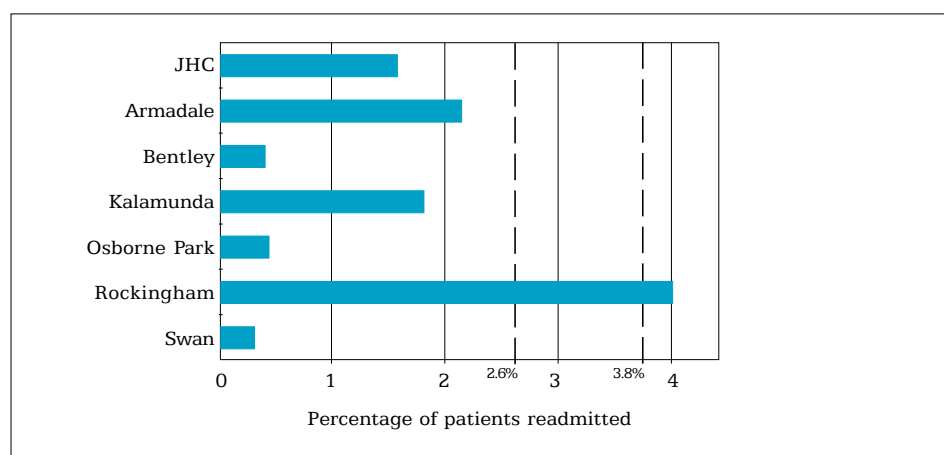


Figure 4: Readmission to hospital for same or related condition – 1998/99.

The percentage of patients readmitted for the same or related condition at JHC is low.⁹

Source: Health Department and JHC

⁸ Developed by the Australian College of Health Care Standards and the Royal College of Medical Administrators.

⁹ MHSB has reported that the results for Rockingham indicate a need to review the data collection mechanism.



Child birth – well managed labour

In 1998/99, 1728 babies were born at JHC making it second only to King Edward Hospital in total number of deliveries in the State. A well managed labour will normally result in the birth of a minimally distressed infant. The level of well-being is measured five minutes after the delivery by a numerical scoring system that assesses the heart rate, respiratory effort, muscle tone, reflex irritability and skin pallor. Scores of four or more are regarded as good. Figure 5 indicates that JHC performs well in comparison to most other metropolitan hospitals with well under one per cent of births with scores below four¹⁰.

Births are generally well managed.

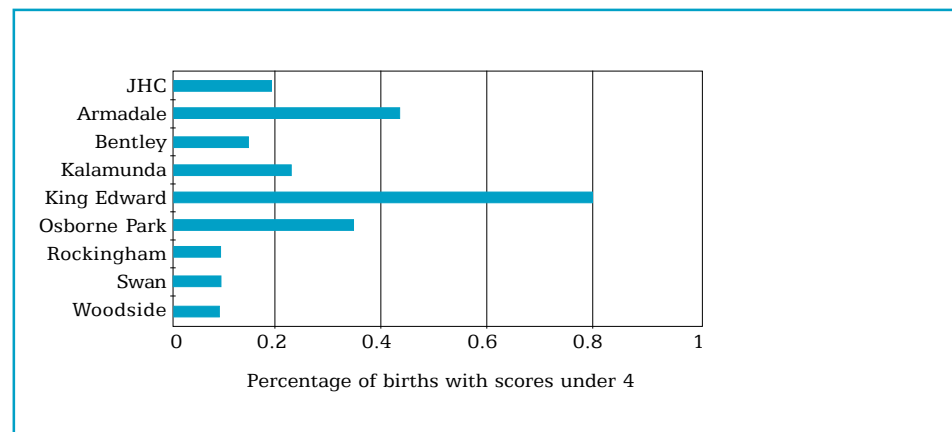


Figure 5: Indicator of Infant Condition at Birth – 1998/99.

The percentage of infants born in distress at JHC is very low. (Note – Woodside is part of Fremantle Hospital and Health Service.)

Source: Health Department and JHC

Patient satisfaction

For many years patient satisfaction surveys have been undertaken at WA public hospitals. In 1998/99, JHC patients were surveyed by the Department for the first time. Listed below are the survey results of JHC, the benchmark hospitals and the four teaching hospitals. The results are based on dozens of questions supporting eight major groupings.

The results whilst showing some differences in satisfaction were not statistically significant. Inquiries into the largest variance – *'Availability of Hospital Staff When Needed'* – found that JHC had complied with minimum required nursing staff levels when an inspection was carried out in June 1999 by the Department's Private Sector Licensing Unit.

Results at JHC were similar to other hospitals.

¹⁰ King Edward Hospital specialises in managing 'at risk' births and hence its performance is not considered to be directly comparable to other metropolitan hospitals.

Findings

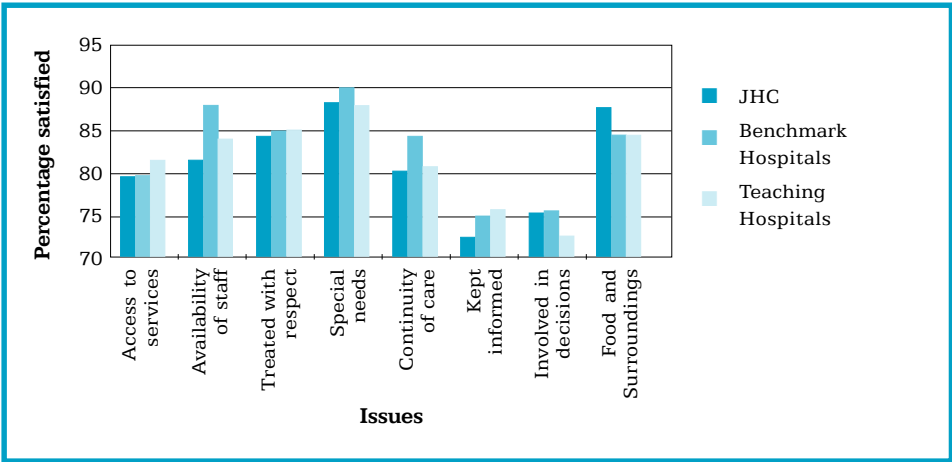


Figure 6: Patient satisfaction ratings – 1998/99.

Patient satisfaction levels at JHC were not significantly different statistically from those of other metropolitan public hospitals.

Source: Health Department

Qualitative and other measures

To supplement the above measures, comments on the quality of health services delivered by JHC were sought from a range of government, professional and community groups. These included the Health Consumer Council of Western Australia, the Office of Health Review, the Central Waitlist Bureau (adjunct of the Health Department), the Australian Medical Association, the Community Board of Advice to the JHC and the Department itself. Key comments are listed below.

Board of Advice considers JHC is operating well...

- Community Board of Advice – in accordance with the contract, this Board was established under HCoA By-Laws for the management of the hospital. The role of the Board is to make recommendations to HCoA concerning the range, quality and accessibility of services to the public. However, the Board meets only four times per year and has no authority. Board membership is comprised of community representatives including the Chairman who is a Professor of Medicine as well as representatives from the Health Department and HCoA including the Chief Executive of JHC. The Chairman of the Community Board of Advice advised this Office that "...the Board regularly reviewed the JHC performance from a consumer's point of view, including key activity indicators, quality indicators, clinical indicators, patient satisfaction surveys (and) the top 20 diagnostic related groups (and) ... that it is the Board's perception that JHC has functioned exceedingly efficiently and has provided a high quality of patient care".



*...though
complaints
about JHC
appear
high.*

- ◆ The Office of Health Review (OHR) reported on the number of complaints lodged by public patients in regard to medical services from July 1998 to January 2000 against JHC and also for the six benchmark hospitals. In this period, JHC was subject to 39 complaints, of which 15 were upheld. The total number of complaints lodged against JHC is more than one and a half times as many as the combined six benchmark hospitals on a pro rata weighted DRG basis (55 complaints) with only five complaints against the benchmark hospitals being upheld. However, OHR indicated that caution needs to be exercised in interpreting the significance of the raw numbers for reasons such as differences in age cohorts. It should also be remembered that these complaints represent only a minute fraction of the number of services provided at JHC during this period. Nevertheless, these figures need ongoing monitoring by the Department.
- ◆ The Department advised that the health benefits of JHC centred mostly around services being delivered closer to home and include:
 - ▲ delivery of a comprehensive range of new services to the Joondalup area such as renal dialysis and chemotherapy that were previously only provided in teaching hospitals;
 - ▲ reduction in the need to transfer local patients to central Perth hospitals; and
 - ▲ high level ICU/CCU services underpinning an emergency department that is now second only to Royal Perth Hospital in number of attendances.

Contract management

The contract establishes a legally binding relationship between the State as purchaser and HCoA as the provider of services and facilities. Changes to the contract can only occur by mutual agreement.

Protecting the interests of the State requires rigorous contract management to ensure that services are delivered in accordance with the requirements as well as the spirit of the contract. Effective contract management is also required to manage issues that are not specifically dealt with in the contract. For instance, payment responsibility for non-coronial post mortems was not covered by the contract but has been resolved through negotiation.

Findings

Arrangements for managing the contract are good.

Management arrangements

The Department has established appropriate structural and procedural arrangements to manage the contract. Under the contract, a named individual is assigned the role of the Department's Contract Manager. This person is supported by a small team and reports to a Contract Management Steering Committee comprising representatives from the General Health Purchasing, Mental Health, Finance and Resource Management divisions of the Department.

To assist in the management of the contract, the Department has prepared a procedural manual for purpose of guiding its performance monitoring and management strategies. The Department has also adopted a recommendation from the 1997 report by preparing a detailed Risk Management Analysis Plan.

For the most part, the Department was found to be actively managing the identified risks. Some risks of an unlikely nature but significant consequence were not being monitored though since this audit review the Department has taken steps to address these risks.

An important part of the contract management process includes monthly contract meetings between the Department and senior executives of HCoA Joondalup. This review found that issues are properly raised and professionally dealt with by the Department and HCoA.

Service delivery risks

A number of service delivery aspects of the contract require careful monitoring by the Department to ensure that the treatment of patients is delivered at an efficient price to the State and in an equitable manner to the public. These are:

- ◆ **Preventing selective admittance and transfer of inpatients in order to increase the proportion of more profitable treatments.** The Department has a number of procedures in place to manage this risk including, the capping of some elective surgery procedures and denial of payment unless certain clinical conditions are met and monitoring of treatment, transfer and discharge patterns. However, ensuring appropriate transfer of patients is difficult.

Under the contract JHC is paid at 40 per cent of the DRG price for transfers from JHC to another hospital and 30 per cent for transfers to JHC. Advice obtained from Sir Charles Gairdner Hospital, the most common destination of transfers from JHC, was that whilst there have been instances of inappropriate transfers, the problem is not significant. However, problems do exist for transfers from other hospitals to JHC with JHC not required under the contract to accept transfers.



Patient
transfers to
JHC are a
concern...

...but a
resolution
is in sight.

Services in
1998/99
were
delivered
unevenly...

The MHSB advised that its understanding of the role of JHC was that it "...was intended to deliver secondary level services and by so doing reduce the demand on the tertiary (teaching) hospitals for secondary services"... but that... "JHC would frequently not accept 'step down' patients ostensibly due to the payment arrangements in place. This results in bed blocking in the inner city hospitals and cancellation of elective surgery".

MHSB's concerns have some validity, with only 59 transfers made from teaching hospitals to JHC in 1998/99. By comparison, 1 198 transfers were made to the benchmark hospitals or approximately 30 times as often on a pro rata weighted DRG basis.

The Department acknowledges that the payment of only 30 per cent of the DRG price for patients transferred to JHC has affected the number of transfers, though it rejected the idea that JHC is intended to be a 'step down' facility from the teaching hospitals. To the contrary, the Department advised that a reconfiguration of the capacity of JHC has enabled it to take on services such as hip replacements that previously were only undertaken at teaching hospitals, thereby reducing the need for transfers.

Possible resolution of the transfer problem is in sight. Negotiations to change the basis of payment for transfers are currently underway between the Department and HCoA for the 2000/2001 contract year.

- ◆ **Incorrect coding of medical services on invoices issued to the Department in order to attract the highest possible prices.** To counter this risk, the Department engaged a private accounting firm to undertake annual auditing of inpatient and outpatient invoices. The Department's auditors found some instances of incorrect coding of invoiced amounts, but overall considered that JHC systems and procedures were "...efficient, accurate and timely". Nevertheless, as the JHC invoicing is affected by the accuracy of medical treatment records and is therefore subject to human error, it is essential that JHC invoicing continues to be closely monitored.
- ◆ **Uneven delivery of contracted services throughout the year and the maintenance of the overall cost of services within the MPA for the contract year.** In 1998/99 the management of inpatient services was not delivered evenly, with total services to the end of January 1999 running at 16 per cent above the target level. Departmental records show that a combination of factors led to this situation including:

Findings

- ▲ Attendances at the emergency department were about 3 000 above the level forecast for the year with consequent partial flow-through to inpatient services;
- ▲ HCoA's incorrect assumption of a major Christmas drop-off in inpatient services. This assumption was based on the workload trends of the benchmark hospitals.
- ▲ The undertaking by JHC of non-priority inpatient activity during the first six months of the year.

To correct the situation, the Department in March 1999 agreed to:

- ▲ Redirect \$1 million from projected underspending on Restorative Services to purchase additional inpatient services. The total MPA did not change.
- ▲ Temporarily cancel some non-urgent elective surgery and reduce available medical beds from 60 to 45 for the final months of the 1998/99 year.

JHC for its part performed more inpatient services than that for which it was contracted. Departmental documents show the value of this additional activity to be about \$1.27 million and to have been met by HCoA as per the contract.

...requiring adjustment to available services in late 98/99.

Other Subsequent Private Hospital Arrangements

When planning for the JHC, the Department considered two models for involving the private sector. These were:

- ◆ The model that was eventually selected (the preferred model).
- ◆ A model whereby the facility was constructed by the private sector but the public component was managed by the public sector.

The 1997 report was critical of the fact that only two models were considered. Since the signing of the JHC contract in April 1996, the State has entered into two other contract arrangements with private hospital operators and is at an advanced stage of negotiations on a third. Each of these new arrangements are different to the JHC model and as such will provide a basis for comparative analysis of the different public-private hospital models:

- ◆ **Peel Health Campus at Mandurah** – under a 20 year contract signed in June 1997 with Health Solutions of Western Australia (HSWA), the existing Mandurah Hospital was expanded to 110 beds and a 20 bed co-located private hospital was constructed. Both the public and private components of the

New public/private health sector models at...

Mandurah – owned by the State but privately operated.



Health Campus are owned by the State but are leased to and operated by HSWA. The State pays HSWA a management fee to operate the public hospital. At the end of 20 years the health facility reverts to State control.

Government estimated net present value savings on inpatient usage over the term of the contract (net present value of about \$170m in 1996) is \$3.2 million, representing a saving of 1.8 per cent over 20 years. Like the Joondalup arrangement, services are paid at a rate that is linked to average costs for similar services at benchmark hospitals.

*Bunbury -
co-located
and
independently
owned and
operated.*

- ◆ **South West Health Campus at Bunbury (SWHC)** – commenced operation in March 1999 under a 50 year contract with St John of God Health Care Inc (SJOG). The SWHC was formed from a relocation onto one site of the aging Bunbury Regional Hospital and the privately managed St John of God Hospital of Bunbury. Government assistance was provided to encourage SJOG to relocate to the new site.

Under the arrangement, each hospital remains independently owned and operated. Benefits expected are improved quality of services and savings from reduced duplication and cost sharing of common services, though no information is available concerning the extent of savings to the State.

*Armadale –
co-located
private
hospital built
by the State.*

- ◆ **Armadale Health Service (AHS)** – in January 1999, the Government announced that it would build and operate a new 190 bed hospital at a cost of \$48 million. In June 1999, the Cabinet agreed to seek the co-location of a private hospital of approximately 60 beds on the AHS site.

Under the proposed arrangement, the Government would build and lease the private hospital to a private operator. The arrangement would involve a 20 year lease agreement and shared services agreement with a private hospital operator. Lease payments would consist of a fully capitalised 'up-front' payment equal to the Government cost to construct the private hospital, a portion of the costs attributable to shared spaces and infrastructure and all additional external costs incurred by Government in connection with the project. Each hospital would be independently operated. Opening of the new Campus is planned for July 2001.

Recommendations

The Department should:

- ◆ in its next contract year negotiate with HCoA a discounted price for emergency department services above the indicative profile level and increased transfers from teaching hospitals; and
- ◆ schedule a future review of the comparative benefits of the different private hospital arrangements in which it is engaged.