

**Interim Report of the
Review of the Private
Hospitals and Day
Procedure Centres Act 1988**

MAY 2002



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EXECUTIVE SUMMARY

Introduction

The Private Hospitals and Day Procedure Centres Act 1988 requires the licensing of private hospitals and day procedure centres in NSW.

The Department has prepared the Interim Report to assist in further consultation with stakeholders. In addition to a discussion of the issues that arose during the review the Interim Report makes a number of preliminary recommendations and provides further discussion of options for regulatory reform.

Further comment is sought from stakeholders on the preliminary recommendations and additional matters for consideration in the Interim Report. Following consideration of stakeholder views the Department will produce a Final Report containing recommendations for consideration by the Minister for Health and the NSW Government.

The operation of the Private Hospitals and Day Procedure Centres Act 1988

The Act requires the operators of private health facilities to be licensed. The Private Hospitals Regulation 1996 and the Day Procedure Centres Regulation 1996 prescribe a range of licensing standards.

The Director-General's functions in respect of the licensing and inspection of private hospitals and day procedure centres are undertaken by the Department of Health's Private Health Care Branch.

The market for private health facilities

For the 1999/00 financial year NSW hospitals (both public and private) and day procedure centres recorded 1,838,740 separations. Of these 972,495 (52.9%) involved overnight stay and 866,245 (47.1%) were day procedures. As at 10 September 2001 in NSW there were 91 licensed day procedure centres and 85 private hospitals with 6,305 licensed beds in use.

Objectives

It is proposed that the Act should include a statement of its objectives. Such a statement should reflect that the objectives of the Act are the regulation of private health care facilities in the interests of maintaining high standards of care in the interests of the health and safety of patients.

Recommendation 1

The objectives of the Act be the licensing and regulation of private health care facilities for the purpose of maintaining standards of health care and professional practice within those facilities.

Regulatory options

As required by the Competition Principles Agreement the review has considered alternatives to the current regulatory regime for private hospitals and day procedure centres. The Issues Paper raised for discussion five separate regulatory options, one of which is the current licensing system.

The Department of Health is of the view that regulatory legislation with the objective of maintaining standards of health care in private facilities will deliver substantial public benefits. It is recommended that the Department of Health continue to license private health facilities. It is also recommended that the current regulatory system be updated to reflect recent developments in both the market and regulatory approaches.

Recommendation 2

That NSW Health continue to license private health facilities.

Distinctions between private hospitals and day procedure centres

The Private Hospitals and Day Procedure Centres Act draws a distinction between private hospitals and day procedure centres with each being separately defined and subjected to different licensing standards.

The licensing standards for private hospitals and day procedure centres are to a large extent comparable, and are in many cases identical. Similarly licensing procedures for facilities of all types is parallel and where it varies that variation is in large part due to the different requirements under the licensing standards.

The primary rationale for the distinction between private hospitals and day procedure centres appears to be the overnight accommodation of patients in private hospitals. It is not immediately apparent that the distinction retains any utility.

Discussion Point 1

Should the licensing of private hospitals and day procedure centres be amalgamated with all facilities being licensed as private health care facilities?

If amalgamation of licensing is supported should facilities be licensed in separate classes based on the type and complexity of procedure performed and if so what classes should be developed? Should any classification based on the type of procedure performed incorporate consideration of the type or degree of anaesthesia used?

Discussion Point 2

Should the licensing standards be based on minimum prescribed inputs or outcome standards or a mixture of the two?

Is it appropriate to adopt by regulation the published guidelines of the learned colleges as an element of the licensing standards?

Should licensing standards include the prescribing of minimum patient throughput for particular procedures and if so which procedures and what level of throughput is appropriate?

Discussion Point 3

Is there a need for licensing to extend to office based surgery carried out by medical practitioners?

Is there a need for licensing to extend to office based surgery carried out by dentists?

Restrictions on Patient Capacity

Section 9(3)(d) of the Private Hospitals and Day Procedure Centres Act provides that an application for a private hospital licence may be refused if approval would result in an increase in the total number of patients who may be accommodated overnight at private hospitals in New South Wales. This restriction is commonly known as the ‘bed cap’.

No similar restriction exists in respect of day only facilities whether they be stand alone or contained within a private hospital.

It has not been demonstrated that the bed cap delivers, or in fact can deliver, any of the objectives that are claimed for it nor has it been demonstrated that those objectives are appropriate for legislative intervention.

Therefore the Department of Health considers that the bed cap should be removed as it does not appear to meet its objectives and there is no evidence that it delivers a net benefit to the community.

Recommendation 3

That the restriction on private hospital patient capacity be removed.

Discussion Point 4

Should the restriction on private hospital patient capacity be replaced with a regional hospital capacity planning mechanism?

Submissions advocating a regional planning mechanism should demonstrate that the public interest requires such a mechanism, including demonstrating that government planning will deliver benefits in excess of those that can be delivered by the market, and describe the type of planning controls envisaged.

Approvals in Principle

When an application for a licence is made the Director-General can either grant an approval in principle (AIP) or refuse the application. The applicant must address the licensing standards and probity requirements of the legislation in order to obtain an AIP. An AIP expires after one year unless it is extended by the Director-General.

The Department of Health considers that the AIP process has substantial utility for both the Department and for the developers of private health facilities. It is, however, clear that the utility of the process, from the Department's perspective, is somewhat compromised by the length of time that many developments take to complete and the resultant lengthy extensions that are granted.

Discussion Point 5

What role does the approval in principle process serve? How should the process be modified, if at all, to ensure that it fulfils that role?

Should an annual fee be charged for the retention of an approval in principle and should holders of approvals in principle be required to periodically provide the Department of Health with specific information about their corporate structure, ownership, management and development progress?

Building Development

As the Issues Paper noted the Private Hospitals and Day Procedure Centres Act provides for the regulations to include design and construction standards for facilities. The Act also provides that a facility may not be altered or extended unless the Director-General of Health has given approval.

Class 9a of the Building Code of Australia contains detailed design and construction standards for hospitals. Given the existence of those standards it is questionable whether the officers of the Department of Health can effectively add value at the general design and construction stage of private health care facilities.

However, a compelling case can be made for the Department to continue to be involved in approval of the design and equipping of clinical facilities, such as intensive care and emergency units, theatres and treatment rooms.

Recommendation 4

That the legislation continue to prescribe minimum standards for clinical areas within private health facilities but that in all other respects approval, design and construction of facilities be regulated by local government or the Planning NSW as the case may be.

Discussion Point 6

Which clinical areas should the legislation set standards for? What should those standards encompass? How should regulation be effected?

Staffing

Section 41 of the Private Hospitals and Day Procedure Centres Act prohibits the conduct of a private hospital or day procedure centre unless there is a person appointed to carry out the duties of chief nurse. The chief nurse is required to be a registered nurse who holds such additional qualifications as are prescribed. In addition, section 43 requires that there is to be a registered nurse on duty in the private hospital or day procedure centre at all times when the establishment is being conducted.

The Department is of the view that the title ‘Chief Nurse’ should be replaced with the title ‘Director of Nursing’.

The Department is of the view that there should be a registered nurse on duty at all times when a facility providing hospital type services is in operation it does not necessarily follow that this should be extended to facilities which only provide office type surgery.

It is also the Department’s view that a director of nursing should be required in all facilities providing hospital type services.

The question of whether each facility requires a dedicated director of nursing warrants further consideration.

Recommendation 5

That the requirement for each private health care facility providing hospital type services to appoint a chief nurse be retained with a change in title to Director of Nursing (with additional consideration to be given to whether each facility requires a dedicated DON).

The requirement that each private health care facility providing hospital type services have at least one registered nurse on duty at all times whilst the facility is being conducted be retained.

Discussion Point 7

Does each individual private health facility require a dedicated Director of Nursing or is it possible for a Director of Nursing to be responsible for more than one facility? If it is possible for a Director of Nursing to take responsibility for more than one facility in what circumstances should this be permitted?

Discussion Point 8

If facilities providing office type surgery only are able to become licensed what sort of staffing requirements should apply? Submissions should detail the type of staffing arrangements considered appropriate and consider the impact of those arrangement on patient safety and amenity.

Enforcement

The Act provides that authorised persons may enter and inspect licensed premises and those premises the subject of an approval in principle. Authorised officers are also entitled to inspect the records maintained in a licensed facility. However, difficulties arise when

complaints are received about unlicensed premises to which authorised officers have no right of access.

The Department is of the view that the carrying out of complex procedures of the type that should be performed in a hospital or licensed day procedure centre raises significant public safety concerns. Given that the Act is designed to minimise the risk of harm to patients through the maintenance of high clinical standards in private health care facilities the inability of the Department of Health to effectively police illegal practices in unlicensed facilities is a major impediment to successful achievement of the Act's objectives.

Therefore it is recommended that authorised officers have a power of entry to both licensed facilities and to unlicensed facilities where there are reasonable grounds for believing that a breach of the Act is occurring.

Recommendation 6

That officers who hold a certificate of authorisation from the Director-General of Health be empowered to enter unlicensed premises if they have reasonable grounds on which to believe that a breach of the Act is occurring.

Recommendation 7

That a prosecution under the Act is to take place within two years of the alleged commission of the offence.

Recommendation 8

That SEINS be adopted for minor breaches of the Act and regulations.

Discussion Point 9

Should a Provisional Improvement Notice system be adopted in the legislation? If so what type of matters should it apply to and what type of penalties (eg fines or cancellation/suspension of a licence) and remedies should apply for failure to comply with a notice?

Other Matters

On 29 June 2001 the New South Wales Parliament passed the Health Care Liability Act 2001.¹ The Act, with the exception of Part 3 of the Act (relating to professional indemnity insurance), received the Governor's Assent on 5 July 2001 and commenced operation.

¹ The Act is available from the Department of Health Website:
www.health.nsw.gov.au/csd/lisb/legislation/HealthCareLiabilityAct2001.pdf

Discussion Point 10

Should all licensed private health care facilities be required to hold indemnity insurance?

What type and level of indemnity insurance, if any, should private health facilities be required to hold? Should the level of cover required depend on the type of procedure a facility is licensed to undertake?

Part 2 of the Private Hospitals and Day Procedure Centres Act provides for the establishment of the Private Hospitals and Day Procedure Centres Advisory Committee.

Discussion Point 11

Is there a need for the Private Hospitals and Day Procedure Centres Advisory Committee to be retained? If the Committee is to be retained should its composition be reformed?

The licensing standards under both the Private Hospitals Regulation 1996 and the Day Procedure Centres Regulation 1996 require licensed facilities to establish medical advisory committees. Committees must comprise at least five persons each of whom is a medical practitioner or dentist and may include additional people, for example psychologists or nurses, as determined by each facility.

Discussion Point 12

Should there be reforms to the nature and structure of medical advisory committees? If so what should those reforms be?

Part 6 of Schedule 1 of both the Private Hospitals Regulation and the Day Procedure Centres Regulation contain detailed provisions with respect to the creation and keeping of clinical records and patient access to those records.

Recommendation 9

That access to health records kept in private health care facilities be governed by the proposed Health Records Information Privacy Act.

1. INTRODUCTION

1.1 Background to the review

The Private Hospitals and Day Procedure Centres Act (the Act) was enacted in 1988. The Act requires the licensing of private hospitals and day procedure centres in NSW, including both those facilities that are conducted on a for profit basis and those that are conducted on a not for profit basis. The Act was introduced as part of a package of legislation along with the Nursing Homes Act 1988 and repealed the Private Health Establishments Act 1982 which, as the name suggests, regulated a range of private health facilities in NSW including nursing homes and private hospitals. Prior to 1982 private facilities were regulated under the Private Hospitals Act 1908-1965.

The review of the Act has arisen from the Competition Principles Agreement and changes within the private health care landscape since the introduction of the Act in 1988. Amongst the most important changes are:

- the rapid growth over the last few years in the portion of the community with private health insurance and its impact on the demand for private hospital services;
- technological changes within health care including developments in anaesthesia and sedation techniques, the development of less invasive surgical techniques, and the growth of 23 hour care;
- proposed Commonwealth changes in the classification of day surgery; and
- the rapid growth in the number of procedures that can be performed as day only surgery and the associated growth in the number of day procedure centres.

1.2 The Competition Principles Agreement and the Public Interest Test

In April 1995 the Council of Australian Governments (COAG) agreed to the Competition Principles Agreement. The Agreement commits Commonwealth, State and Territory governments to consider, review and, where appropriate, reform the potentially anti-competitive effects of all legislation.

It is clear that the Act has an impact on business and competition in the private health care industry. The Act restricts entry to the market via the licensing system and imposes certain minimum standards on market participants. Those minimum standards will of necessity involve service providers incurring some expense and may potentially reduce competition, efficiency and profitability within the industry.

However, it is essential to recognise at the outset that the Competition Principles Agreement includes a robust public interest test which is applied when investigating reforms to the statutory regulation of various industries and sectors of the economy. The public interest test is incorporated in section 1 paragraph 3 of the Agreement. That paragraph provides:

- 3) *Without limiting the matters to be taken into account, where this Agreement calls;*
 - (a) *for the benefits of a particular policy or course of action to be balanced against the costs of the policy or course of action; or*
 - (b) *for the merits or appropriateness of a particular policy or course of action to be determined; or*

- (c) *for an assessment of the most effective means of achieving a policy objective;*
- the following matters shall, where relevant, be taken into account:*
- (d) *government legislation and policies relating to ecologically sustainable development;*
 - (e) *social welfare and equity considerations, including community service obligations;*
 - (f) *government legislation and policies relating to matters such as occupational health and safety, industrial relations and access and equity;*
 - (g) *economic and regional development, including employment and investment growth;*
 - (h) *the interests of consumers generally or a class of consumers*
 - (i) *the competitiveness of Australian businesses; and*
 - (j) *the efficient allocation of resources.*

It is therefore apparent that while the Government is obliged to review the Act and consider its impact on competition and efficiency in the industry, the Competition Principles Agreement does not per se require the removal of existing regulation or preclude the introduction of additional regulation where that regulation can be demonstrated to be in the public interest. Indeed the National Competition Council, the body responsible for the overall administration of the Agreement, has stated in its publication *Considering the Public Interest under the National Competition Policy* (November 1996):

“The CPA states that these factors [those listed in paragraph 1(3) of the Agreement] (and any others) may be considered in balancing the benefits of a particular policy or course of action against the costs, to determine the appropriateness or most effective means of achieving a policy objective. ... The inclusion of the subclause in the CPA reflects the desire of governments to make clear their view that competition policy is not about maximising competition per se, but about using competition to improve the community’s living standards and employment opportunities.”²

A robust application of the public interest test to the private health industry is supported by the Report of the Royal Commission into Deep Sleep Therapy

“A hospital is far from just a business. It is not like a restaurant, a hotel, a department store or a bank. It is an institution established to care for people who are sick and for people who cannot adequately care for themselves temporarily or permanently, and to provide medical and nursing care and other services for those people. The overriding consideration in the conduct of a private hospitals (and one might add a public hospital) is the welfare of the patients. Special skills, special experience and qualifications are necessary to conduct such an institution.”³

² Cited in Competition Policy: Friend or Foe. Economic Surplus, Social Deficit? An Interim Report of the Senate Select Committee on the Socio-Economic Consequences of the National Competition Policy. (Canberra, August 1999), Paragraph 7.17.

³ Volume 7, page 49.

1.3 The current review

To facilitate the review process, the Department prepared an Issues Paper⁴ which was released for public comment in December 2000. The Terms of Reference for the review are detailed in **Appendix A**.

As part of the review and in order to assist the development of the Issues Paper the Department of Health engaged PriceWaterhouseCoopers Economic Studies and Strategies Unit (the consultants) to undertake an independent economic assessment of the licensing system and the current restrictions on private hospital capacity (the bed cap). The consultants provided their report to the Department on 7 June 2000. The consultant's report is **annexure 1** to this Interim Report.

The views of consumers and consumer organisations, government bodies, health care professionals and their professional associations, industry bodies, service providers and other interested parties were sought on the Competition Principles Agreement issues and other possible changes to the Act. Twenty-eight submissions were received by the Department in response to the Issues Paper and a list of those submissions is provided as **Appendix B**.

1.4 This Interim Report

The Department has prepared this Interim Report to assist in further consultation with stakeholders. In addition to a discussion of the issues that arose during the review the Interim Report makes a number of preliminary recommendations and provides further discussion of options for regulatory reform.

Further comment is sought from stakeholders on the preliminary recommendations and additional matters for consideration in the Interim Report. Following consideration of stakeholder views the Department will produce a Final Report containing recommendations for consideration by the Minister for Health and the NSW Government.

Copies of the Private Hospitals and Day Procedure Centres Act 1988, the Private Hospitals Regulation 1996 and the Day Procedure Centres Regulation 1996 are available from the NSW Government Information Service (tel: (02) 9743 7200) and on the Internet site of the Australian Legal Information Institute (www.austlii.edu.au).

All submissions received will be considered by the Department of Health during preparation of the Final Report to the Government. Submissions taking issue with any of the Interim Report's recommendations and any of the views expressed are welcome.

The Private Hospitals Regulation and the Day Procedures Centres Regulation were remade in 1996 in accordance with the requirements of the Subordinate Legislation Act 1987 and the Competition Principles Agreement. An opportunity to further review these regulations will arise following completion of the current review of the Act.

⁴ The Issues paper is available from the Department of Health Internet site, (<http://www.health.nsw.gov.au/csd/lisb/privhosp/privatehospitalsissuespaper.pdf>)

Submissions should be made to:

Legal and Legislative Services - Legal Branch
NSW Department of Health
Locked Bag No. 961
NORTH SYDNEY NSW 2059
Fax: 02 9391 9604
Ph: 02 9391 9606
e-mail – legal@doh.health.nsw.gov.au

The closing date for submissions is Friday 2 August 2002.

2. THE OPERATION OF THE PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES ACT 1988

2.1 Background

The Act was enacted in 1988 and, with the exception of section 37, commenced on 1 September 1990. Section 37 of the Act, which makes it an offence to conduct an unlicensed day procedure centre, commenced on 1 January 1993.

The Act does not contain an objects clause, nonetheless it is apparent, from the contents of the Act and Regulations and from the then Minister for Health's second reading speech, that the purposes of the Act are:

- the regulation of private health facilities in the interests of the health and safety of consumers; and
- to support the effective and efficient planning of health services by allowing the Director-General of Health to control the number, size and location of hospital facilities in the State.

The Act requires the operators of private health facilities to obtain a licence to operate from the Director-General of the NSW Department of Health and prescribes certain operating standards. The Act also provides that regulations may be made on operational matters including design and construction standards, facilities and equipment, staffing, administration and support services and clinical records including patient access to records. Both the Private Hospitals Regulation 1996 and the Day Procedure Centres Regulation 1996 prescribe standards in a number of these areas.

2.2 Application

The Act requires that private hospitals be licensed. Section 3 of the Act defines a private hospital as:

premises at which any patient is provided with medical, surgical or other treatment, and with ancillary nursing care, for fee, gain or reward, but does not include:

- (a) an institution conducted by or on behalf of the State, or*
- (b) a hospital or health service under the control of a public health organisation within the meaning of the Health Services Act 1997, or*
- (c) (Repealed)*
- (d) a nursing home within the meaning of the Nursing Homes Act 1988, or*
- (e) a residential rehabilitation establishment licensed under the Drug and Alcohol Rehabilitation Establishments Act 1987. [This Act was repealed in 1990]*

The Act also requires that day procedure centres be licensed. A day procedure centre is defined as:

premises at which any patient is admitted and discharged on the same day for such medical, surgical or other treatment, and in such circumstances, as maybe prescribed by the regulations, but does not include:

- (a) any such premises conducted by or on behalf of the State, or*

- (b) *a public hospital or health service under the control of a public health organisation within the meaning of the Health Services Act 1997, or*
- (c) *(Repealed)*
- (d) *a private hospital licensed under this Act, or*
- (e) *a nursing home within the meaning of the Nursing Homes Act 1988, or*
- (f) *a residential rehabilitation establishment licensed under the Drug and Alcohol Rehabilitation Establishments Act 1987. [This Act was repealed in 1990]*

Clause 3 of the Day Procedure Centres Regulation provides:

For the purposes of the definition of "day procedure centre" in section 3 (1) of the Act, the prescribed treatment and circumstances are as follows:

- (a) *surgical treatment that involves the administration of a general, spinal, epidural or major regional block anaesthetic or intravenous sedative otherwise than for the purpose of simple sedation,*
- (b) *endoscopic treatment that involves the administration of a general anaesthetic or intravenous sedative otherwise than for the purpose of simple sedation,*
- (c) *treatment that involves dialysis, haemofiltration or haemoperfusion,*
- (d) *treatment that involves prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent,*
- (e) *treatment that involves cardiac catheterisation,*
- (f) *multidisciplinary care and treatment of children who are less than 5 years of age for early childhood conditions relating to developmental, behavioural, feeding or sleeping disorders.*

(3) *However, the prescribed treatment and circumstances do not include the following:*

- (a) *emergency treatment provided by a medical practitioner in circumstances that render impracticable the transfer of the patient to a hospital or day procedure centre,*
- (b) *dental treatment provided by a dentist in the course of the practice of dentistry.*

4. *Definitions*

(1) *In this Regulation:*

...

"simple sedation" means a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out in such a manner:

- (a) *that verbal contact with the patient can be maintained throughout the period of sedation, and*
- (b) *that the drugs and techniques used have a margin of safety wide enough to render unintended loss of consciousness unlikely.*

In effect a private hospital is a facility in which a patient is accommodated and provided with medical, surgical or other health treatments and ancillary nursing care for fee gain or reward. A day procedure centre is a facility which a person is admitted to and discharged from on the same calendar day for medical, surgical or endoscopic treatment involving anaesthesia greater

than simple sedation; dialysis, haemofiltration or haemoperfusion; intravenous infusion of cytotoxic agents; multidisciplinary treatment involving the management and assessment of early childhood (less than 5 years) disorders; and cardiac catheterisation.

2.3 Administration

The Director-General's functions in respect of the licensing and inspection of private hospitals and day procedure centres are undertaken by the Department of Health's Private Health Care Branch (PHCB).

2.3.1 Licensing

Initial application

On receipt of a completed application, including the \$615 application fee, PHCB advises the applicant that assessment of the application will take up to 60 days. Assessment of the application involves:

- advertising of the application; and
- fitness and probity testing which includes:
 - (a) criminal records checks of all applicants or directors of applicant companies,
 - (b) a check with the Australian Securities and Investments Commission, and
 - (c) a check with the Health Care Complaints Commission to determine if any of the applicants have been or are subject to complaints.

The licensing process can be divided into 4 stages:

- 1) Assessment for approval in principle (AIP).
- 2) Issue of an AIP outlining the conditions of approval, (eg. compliance with relevant building codes and standards, compliance with licensing standards, appointment of a Chief Nurse, establishment of a medical advisory committee).
- 3) A review of the plans and specifications for the facility.
- 4) Commissioning inspection and the issue of a licence on completion of the project in accordance with approved plans and to the satisfaction of the local government authority.

Transfer of licence

On receipt of a completed application for transfer of a licence, including the \$615 application fee, PHCB advises the applicant that assessment of the application will take up to 60 days. Assessment of the application involves:

- Advertising of the application; and
- Fitness and probity testing which includes:
 - (a) criminal records checks of all applicants or directors of applicant companies;
 - (b) a check with the Australian Securities and Investments Commission;
 - (c) a check with the Health Care Complaints Commission to determine if any of the applicants have been or are subject to complaints.

The licence transfer process can be divided into 3 stages:

- 1) Assessment for approval in principle (AIP).

- 2) Issue of an AIP with a request for advice as to the date of settlement of the transaction.
- 3) Issue of a new licence when fitness and probity checks are complete and advice has been received from both parties confirming settlement.

Annual licence renewals

Licence fees are due at the end of each calendar year and are paid prospectively. The annual fee for a private hospital is determined on a sliding scale depending on the number of licensed beds and ranges between \$1,130 and \$4,270 (as at 31 December 2000). The annual fee for day procedure centre is \$1,130 (as at 31 December 2000). Licence fees are paid into consolidated revenue and may not be refunded. Along with the renewal fee licensees must submit an annual return which includes information relating to corporate and management structures and details of the chief nurse's current authority to practise.

Conditions of licence

As part of the licensing process the Director-General may impose conditions on a licence. Common conditions include:

- limiting the accommodation of certain classes of patients (eg psychiatric) to a particular ward or wing; and
- matters to do with the admission and accommodation of child patients.

Appeal rights

There is provision for appeal to be made to the Minister for Health against licensing decisions made by the Director-General. The decisions which may be appealed against in this way are:

- a decision to refuse an application for a new licence or transfer of an existing licence;
- a decision to make a licence subject to a condition;
- a decision to issue a notice requiring specified repairs, maintenance, alterations, extensions or improvements to be carried out; and
- a decision to amend a licence otherwise than in accordance with an application by the licensee.

2.3.2 Monitoring

Monitoring is undertaken to enforce compliance with licensing standards. Private Health Care Branch aims to visit each facility at least once every two years, however where there are concerns about a particular facility those visits occur on a far more frequent basis. During the inspection process officers of PHCB endeavour to work with the licensees, chief executive officers and staff of facilities with the aim of improving the standards of safety, care and services provided for patients. The licensee is advised of the outcome of the monitoring inspections and where deficits are identified requested to take remedial action.

Inspections are generally undertaken on a cyclical basis with the facility notified prior to the inspection. However, where an adverse event or a reportable incident has occurred at a facility an immediate inspection is undertaken to monitor the actions implemented by the facility to ensure continued patient safety. These visits may also be undertaken in cooperation with other expert teams such as a Public Health Unit, depending on the nature of the incident that has occurred.

The quality improvement approach is considered to be effective and to lead to improved outcomes for patients. However, prosecution is used if there is major breach of the legislation or compromise in the safety or care of patients and the licensee is unwilling to take the appropriate action to remedy identified deficits.

2.3.3 Complaints

The PHCB investigates any matter concerning standards of care, risks to patient wellbeing, or any obvious or potential breach of the legislation. Complaints about private hospitals and day procedure centres are received from a wide range of sources including patients and their relatives, visitors, staff members, other health professionals and members of the public. A breakdown of the complaints received for the last three years is provided in **Appendix C**.

All complaints are assessed for appropriateness for investigation by PHCB according to the relevant legislation. If a complaint is outside the PHCB's jurisdiction the complaint is referred to another agency, such as the Health Care Complaints Commission.

The PHCB has an indicative time frame for completion of an investigation of 6 weeks from date of receipt.

3. THE MARKET FOR PRIVATE HEALTH FACILITIES

3.1 Market theory

Market theory holds that in a properly operating distortion free market consumers are free to choose a service provider who provides the service that best meets their needs at the best price. Purchasing decisions are made based on an individual combination of considerations including quality, price and convenience. In theory purchasers are free to move between providers as service levels or prices change and providers are free to enter the market to fill any unmet demand including a demand for better services or lower prices. The theory holds that markets are therefore dynamic and encourage competition, innovation and efficiency.

3.2 Size of the market

For the 1999/00 financial year NSW hospitals (both public and private) and day procedure centres recorded 1,838,740 separations. Of these 972,495 (52.9%) involved overnight stay and 866,245 (47.1%) were day procedures. Of the procedures performed 57.1% were performed on public patients, 42.8% were performed on private patients and the status of the patient was either nursing home patient or unrecorded in 0.1% of cases⁵.

Procedures involving overnight stay⁶

- 972,495 procedures involving overnight stay were performed.
- 729,339 (75%) took place in public hospitals⁷.
- 243,156 (25%) took place in private hospitals.
- 611,547 separations (62.9%) were for public patients.
- 341,927 separations (36.9%) were for private patients⁸.
- 98% of the public patients were treated in public hospitals.
- 2% of public patients were treated under contract in private hospitals.
- 35.7% of private patients were treated in public hospitals.
- 64.3% of private patients were treated in private hospitals.

Day only procedures⁹

- 866,245 day only procedures were performed.
- 507,069 (58.5%) were performed in public hospitals.
- 230,187 (26.6%) were performed in private hospitals.

⁵ Hospital Statistics for the State of New South Wales 1999-00. To be published in the NSW Department of Health Annual Report 2000-2001.

⁶ *ibid.*

⁷ Public hospitals is defined in section 15 of the *Health Services Act 1997* (NSW) as

- (a) a hospital controlled by an area health service, or
- (b) a hospital controlled by a statutory health corporation, or
- (c) a hospital that is a recognised establishment of an affiliated health organisation, or
- (d) a hospital controlled by the Crown (including the Minister or the Health Administration Corporation).

⁸ For present purposes the term private patient includes privately insured patients, compensable patients, patients whose care is funded by third parties such as the Department of Veteran's Affairs, and patients who are Medicare ineligible (such as overseas visitors).

⁹ Hospital Statistics for the State of New South Wales 1999-00. To be published in the NSW Department of Health Annual Report 2000-2001.

- 128,989 (14.9%) were performed in licensed day procedure centres.
- 437,711 (50.5%) procedures were performed on public patients.
- 428,505 (49.5%) procedures were performed on private patients.
- 23 patients were nursing home type patients and the status of the patient is not known for the remaining 6 patients.
- 97.8% of public patients were treated in public hospitals.
- 1.2% of public patients were treated under contract in private hospitals.
- 1% of public patients were treated under contract in licensed day procedure centres.
- 18.5% of private patients were treated in public hospitals.
- 52.4% of private patients were treated in private hospitals.
- 29.1% of private patients were treated in licensed day procedure centres.

As at 10 September 2001 in NSW there were 91 licensed day procedure centres and 85 private hospitals with 6,305 licensed beds in use.

The bed occupancy rate in private facilities for the 1999/00 year was 73.8% which compares to a rate of 72% in 1998/9 and 71.1% for 1997/8.¹⁰

3.3 Market distortions

The term ‘market distortion’ is used to describe external factors that impacts on the operation of the free market and influences the actions of market participants. Market distortions include those actions of governments, such as the Medicare system and State Government licensing standards, that are designed to address market failures.

The figures above show that the market for private health services is substantial. Fluctuations in the number of facilities and the usage of those facilities, as well as developments in procedures and technology, demonstrate that the market is reasonably dynamic. However, there are a number of factors, structural and legislative, which distort the market by increasing consumer demand and reducing the capacity of the market to respond to that demand.

3.3.1 Demand side distortions

Demand distortions in the health services market are generally caused by third parties paying for care thereby sheltering both consumers and providers from concerns about the cost of care. These distortions generally operate to increase the demand for services. The most significant distortions are:

- the existence of the Medicare system; and
- the Commonwealth Government’s taxation and subsidy policies, including the 30% rebate on private health insurance, which encourage the take-up of private health insurance.

Medicare

The Medicare system is a system of universal health care provided by the Commonwealth Government and funded via a levy on each taxpayer’s annual taxable income (the levy). The levy is currently set at 1.5% of taxable income and is applied in addition to normal income

¹⁰ NSW Department of Health Annual Report 1999-2000, Appendix 6, http://internal.health.nsw.gov.au/health-public-affairs/ar9900/nswhealth_ar9900.pdf

tax. High income earners who do not hold approved private health insurance are also liable to pay a Medicare surcharge of 1% of their taxable income, while those on very low incomes and certain other exempt individuals (such as eligible war veterans) are exempt from the levy¹¹.

Under the Commonwealth/State Medicare Agreement all eligible patients must be given the option of being treated as public patients in the public system (including in contracted private hospitals). When a person is treated as a public patient there is no cost to the patient for the treatment and accommodation services provided. Clearly in a situation where there is no directly related financial cost to consumers, given that the Medicare levy is paid based on taxable income and not how much health care is consumed, there is little if any financial disincentive to consumption.

Private health insurance incentives

Private health insurance on the other hand would, in the absence of external factors, not distort the market as contributors to a particular scheme have paid for a particular level of cover which generally has an annual or bi-annual monetary limit. However, the private health insurance market is not free of external distortions. The most significant distortions in the health insurance market are the Commonwealth Government's incentives to encourage the increased take-up of insurance. These incentives include:

- the additional 1% Medicare levy on high income earners who do not have approved private insurance, effective from 1 July 1997;
- the 30% rebate on premiums, effective from 1 January 1999;
- the requirement for health insurers to offer *no gap* and *known gap* insurance products; and
- modifications to the community rating system to encourage people to take up insurance prior to their 31st birthday, otherwise known as lifetime health cover, effective from 1 July 2000.

These initiatives appear to have resulted in a substantial increase in the number of Australians with private health insurance. The following table provides some relevant figures and more detail can be obtained from the Private Health Insurance Administration Council website.¹²

Table 1: Private health insurance rates

	NSW	Australia
30/6/01	45.8%	44.9%
30/6/00	44.8%	43.0%
30/6/99	30.9%	30.6%
30/6/98	30.8%	30.5%
30/6/97	32.1%	31.9%

The substantial increase in private health insurance could be expected to result in an increase in the number of incidents of service in private hospitals and day procedure centres and this expectation is borne out by the Department of Health's inpatient statistics.¹³

¹¹ See the Australian Tax Office website for more information on the Medicare levy
http://www.ato.gov.au/content.asp?doc=/content/ormsboa/oi_ml.htm

¹² http://www.phiac.gov.au/phiac/fr_index.htm

¹³ NSW Department of Health Annual Report 1996/7, Appendix 6,

Table 2:

	1994/5	1995/6 *	1996/7	1997/8	1998/9	1999/00
Public hospitals overnight (all patients)	106.8	100	96.8	98.2	97.9	95.5
Public hospitals overnight (private patients)	116.0	100	92.8	84.9	81.0	80.1
Public hospitals day only (all patients)	91.8	100	104.3	109.9	111.2	109.2
Public hospitals day only (private patients)	102.5	100	98.3	93.5	88.1	87.4
Private hospitals overnight (all patients)	101.3	100	103.5	104.8	107.1	111.5
Private hospitals day only (all patients)	92.8	100	114.3	121.4	130.8	142.6
Day procedure centres (all patients)	93.5	100	106.9	117.6	115.5	122.9
Total State overnight	105.6	100	98.3	99.9	100.1	99.2
Total State day only	92.2	100	106.8	113.3	115.8	118.1

* Note base = 100.
1995/6 has been selected as the base year as it is the last complete reporting year before the election of the current Federal Government and the strategies designed to increase private health insurance were proposed and implemented.

The figures also demonstrate a very substantial decrease in the number of private patients treated overnight in public facilities and a lesser but nonetheless substantial decrease in the number of private day only patients treated in public hospitals. This decrease is in marked contrast to the growth in the number of overnight patients treated in private facilities and the very substantial growth in the number of day only patients treated in private facilities.

3.3.2 Supply side distortions

There are potentially a number of factors that can operate to distort the supply of services in private hospitals and day procedure centres. The most significant of these factors are:

- State Government licensing requirements;
- the restriction on the number of private hospital beds, or the ‘bed cap’;

- facility/health fund contracting;
- Commonwealth Government recognition of facilities for Medicare and insurance purposes;
- the licensing/registration of health professionals and non-statutory restrictions on the number of medical specialists; and
- local government building and development restrictions.

(a) State Government licensing requirements

The requirement that private facilities be licensed by the State Government quite clearly imposes restrictions on the supply of services in that not all potential service providers may be able or willing to meet the licensing requirements. Part of the inability or unwillingness of providers to meet those standards may be due to the costs of compliance and of applying for and renewing the licence each year.

(b) The ‘bed cap’

The bed cap is explicitly designed to restrict the supply of private hospital beds in NSW. The cap has arisen from section 9(3)(d) of the Act which allows the Director-General to refuse an application for a licence where approval would result in an increase in the number of patients that may be accommodated overnight in private hospitals in NSW. Section 14(d) of the Act is also relevant and requires that a licence for a private hospital is to specify the maximum number of patients that may be accommodated overnight in the facility.

The bed cap applies only in respect of private hospitals and there is no similar limitation on day procedure centres.

(c) Facility/health fund contracting

Health insurance funds are regulated by the Commonwealth Government under the National Health Act 1953 and the Health Insurance Act 1973. Recent legislative amendments at Commonwealth level, associated with the policy to increase private health insurance in the community, have allowed funds to contract with private facilities to provide ‘no gap’ coverage for fund members using those facilities. The Issues Paper noted that it is expected that health funds will limit the number of facilities that they contract with, and a number of submissions to this review have argued that the funds are beginning to utilise their bargaining power in this respect.

There is no evidence that contracting between health funds and private facilities has at this stage had any impact on the supply of private facilities although there is potential for such contracting arrangements to have an impact on ease of entry to the market.

(d) Commonwealth Government recognition of facilities

The Commonwealth Government recognises or ‘declares’ private facilities for the purposes of the National Health Act and the Health Insurance Act. Such recognition allows for the payment of Medicare and private insurance rebates for treatment provided in recognised facilities.

In essence the Commonwealth relies on State licensing in determining whether a private facility is recognised. There is no evidence that the need for Commonwealth recognition places any additional constraints on the supply of facilities although if State licensing were

removed the Commonwealth may be forced to introduce a new process for recognition of facilities which may impact on supply.

(e) Restrictions on health professionals

Legislation requiring the registration or licensing of health professionals and restricting certain potentially dangerous practices places nominal restrictions on the establishment and operation of health care facilities both private and public. In circumstances where licensing requirements oblige facilities to employ particular staff or to have certain staff on duty, for example registered nurses, an inability to attract the necessary number of appropriately qualified staff could prevent a facility from opening or force the closure of an existing facility.

Limitations on the carrying out of certain potentially dangerous health practices, such as delivering babies and prescribing powerful drugs, to particular registered health professionals may also place restrictions on the range of services that can be provided in particular facilities and therefore on the profitability and supply of those facilities.

Furthermore restrictions placed by training organisations and professional colleges on the number of practitioners, such as medical and dental specialists, they will train may also limit the procedures that can be undertaken in a facility that is unable to attract practitioners with the training to undertake those procedures. The restrictions on health practitioners may be felt most acutely in rural and regional areas and thereby further distort the distribution of facilities within the State.

(f) Building and development restrictions

In addition to the controls placed on building developments and alterations by the Private Hospitals and Day Procedure Centres Act and regulations, building and development approvals are administered by local government via the Building Code of Australia (BCA96). BCA96 comprises a series of comprehensive codes for the design and construction of buildings in various classes including class 9 which applies to hospital facilities but not uniformly day procedure centres.

The imposition of building and development standards under BCA96 has the potential to increase the cost of establishing a private hospital facility, and make it more attractive to establish a day procedure centre. The application of BCA96 therefore clearly has the potential to impact on the supply of both private hospitals and day procedure centres. In addition the need for local government approval of a development application may have an impact on supply in particular areas. This requirement may also favour day procedure centres with their shorter operating hours, including lower weekend utilisation, and smaller community footprint.

3.4 Other restrictions on competition

There appear to be a number of additional restrictions on competition in the market for private health facility services and these restrictions would appear to be most acute in the day procedure centre field.

The Act defines a day procedure centre as

..premises at which any patient is admitted and discharged on the same day...

The phrase *the same day* means the same calendar day rather than within a period of 24 hours. The use of this meaning of day obviously places restrictions on the ability of a centre to innovate with respect to flexible operating hours that might suit both practitioners and patients. There is also a restriction placed on the ability of a centre to provide extended post-operative care in those instances where it may be required and in such a case it may be necessary to discharge the patient or transfer them to either a public or private hospital for overnight recovery. An indicator of the impact that this has on day procedure centres may be gauged from the relative growth in the number of day only procedures performed in private hospitals in comparison to day procedure centres, see table 2.

The licensing system for private health facilities, both private hospitals and day procedure centres, may also preclude them from offering alternative models of outreach care such as hospital in the home. The Commonwealth Parliament recently passed the Health Legislation Amendment Act (No 1) 2001 which has amended the National Health Act to allow the payment of benefits where outreach services (such as hospital in the home) are provided by private health care facilities. The public sector has been able to offer these types of service for some time but it is unclear whether the Private Hospitals and Day Procedure Centres Act allows licensed facilities to take advantage of the recent Commonwealth legislative change.

3.5 Application of competition principles

Competition principles have an important role to play in determining the most appropriate level of regulation in the private health facilities market. However, that is not to say that application of the competition principles should be undertaken in a narrow fashion. Given the nature of the services being provided in the market and the potentially catastrophic, at least on an individual level, consequences of certain market failures the public interest test (see above at 1.2) must be given due weight in considering the level and nature of regulation in this area.

4. OBJECTIVES

4.1 Objectives of the current Act

The Issues Paper noted that in the absence of a statement of objects in the Act the objectives appear to be to:

- minimise the potential risk of harm that would be posed by the entry of unscrupulous or substandard operators in the market for private health facilities;
- ensure that consumers can have some confidence regarding the standard of care provided in these facilities through:
 - 1) ensuring the probity of the persons managing the facility;
 - 2) prescribing those policy and operational factors, such as staffing and equipment needs, which are concomitant to the provision of good clinical care by health care professionals;
- ensure the provision of appropriate clinical resources at each facility; and
- support public health services planning by allowing State health authorities to control the number, size and location of both private and public hospitals.

No submission took issue with this summation of the objectives of the current Act.

4.2 What are the problems that the legislation seeks to address

The Issues Paper noted a number of problems in the market that the Act is claimed to address. These problems are:

- Information problems in that consumers generally do not have sufficient knowledge to make an informed decision about the facility they will choose for a particular procedure. Therefore consumers are generally guided by their treating practitioner in the choice of facility and the practitioner may have a financial interest in the facility of choice.
- The potential for a failure in private facility standards to impact adversely on the public health system. This impact can occur in that specific instances of misadventure in the private system may result in patient admission to the public system. In addition, and far more importantly, a loss of public confidence in the private system will inevitably result in a significant number of those patients who would normally seek treatment in the private system seeking treatment in the public system with consequent impacts on public hospital budgets and waiting lists.
- The potential for over investment in and over use of private facilities.
- The potential for the distribution of private facilities to be inappropriately skewed in favour of metropolitan areas at the expense of rural and regional consumers.

Submissions drew attention to a number of other alleged problems within the market that the legislation should address. These problems include:

- The risk from procedures carried out in the rooms of medical practitioners and dentists (office based surgery). Submissions also argued that it was anti-competitive to subject day procedure centres to a higher level of regulation when the nature of the procedures

carried out in the centres was often indistinguishable from those carried out as office based surgery.

- The need to regulate the number and location of day procedure centres in order to prevent oversupply in particular areas.

4.3 The objectives of the Act as identified by PriceWaterhouseCoopers

PriceWaterhouseCoopers Economic Studies and Strategies Unit (the Assessment Team) examined the legislation, relevant extracts from Hansard and Department of Health Policy Statements as well as consulting with key stakeholders to reach a conclusion as to the objectives of the legislation. The Objectives have been divided into the objectives of the licensing system and the objectives of the restriction on private hospital patient capacity.

The Assessment Team came to the conclusion that the objectives of the licensing scheme are to:

- protect public health and safety;
- ensure quality of health care provision;
- reduce the physical and financial risks to the public; and
- promote public confidence in the private health care system.¹⁴

The Assessment Team came to the conclusion that the objectives of the restriction on patient capacity are to:

- provide a means for planning controls;
- control over-investment in private hospitals;
- achieve a more even distribution of private hospital services; and
- protect consumers from supplier induced demand.¹⁵

4.4 Is there a need for legislative intervention to address these problems?

4.4.1 Information problems

Consumers in the market for health care services are generally considered to lack the detailed technical knowledge that is required to make informed decisions about the services that they require and the most appropriate practitioner and facility to provide those services. In the circumstances patients often rely on the recommendation of their treating practitioner in choosing both specialist practitioners and the facility, be that public or private, in which to have a procedure undertaken. While it is not suggested that practitioners would refer patients to sub-standard facilities it is nonetheless the case that practitioners can have conflicts of interest in this area. These conflicts can arise from a practitioner having a direct pecuniary interest in a particular facility and from the interest that arises from practitioners having operating and admitting rights in a limited number of facilities. To a certain extent sections 112A and 112B of the Medical Practice Act address this matter by making it an offence for a

¹⁴ PriceWaterhouseCoopers, The National Competition Policy Review of the Private Hospitals and Day Procedure Centres Act – Economic Assessment, pages 7-8.

¹⁵ Ibid, page 9.

person to offer or accept a benefit for referring or recommending patients for particular services.

In these circumstances it is to a patient's advantage that a facility is subject to an independent licensing regime which is designed to ensure that specified standards are complied with. To a certain extent the patient is thereby relieved of the need to inquire into the standards in an individual facility. To a lesser degree the same can be said for treating practitioners who can also have some assurance that the facilities to which they admit patients and in which they operate are subject to independent standards monitoring.

In the absence of State Government licensing there would be a market created for accreditation bodies, health insurance funds or other private information providers to develop systems to provide consumers with information on the standards and performance of individual private facilities. While such a system would be able to provide information to consumers it would require greater diligence on the part of consumers to seek out that information. In addition such a system assumes that the consumer, or their agents, have sufficient technical knowledge to ask the right questions in each case.

However, the health insurance funds have cautioned against the assumption that in the event of deregulation they could play a more active role in providing information to consumers.

“Regulation is not the core business of health funds, and would not be an appropriate role, especially in the context of conducting business and contracting with private hospitals and day procedure centres.”¹⁶

“Medibank Private strongly rejects the proposal that as an alternative to the current licensing system, health funds could play an increased role in monitoring and improving standards of health care. Whilst Medibank Private seeks to influence that high quality health care is delivered to its members at all times, the role of health funds may be seriously compromised if they are also required to monitor health care facilities.”¹⁷

There is therefore a strong argument that can be made for the legislative intervention of Government to address the imbalance of information in the market.

4.4.2 The impact on the public hospital system of a lapse in private facility standards

While adverse events already occur in private facilities, just as they do in public facilities, deregulation could result in some reduction in standards and an increase in the frequency of adverse events. Each adverse event in a private facility has the potential, depending on its nature and the nature of the facility in which it occurs, to result in a transfer to a public facility with a resulting impact on the availability of public services.

Furthermore any significant increase in adverse events may result in a weakening of overall public confidence in private health industry. In such a case there would be greatly increased pressure on the public system as patients would elect to enter the public system rather than the private system. In this scenario public hospital waiting lists would grow and the cost of the

¹⁶ Submission, NSW Health Funds Association, page 12.

¹⁷ Submission, Medibank Private, page 2.

public system would also grow as not all patients who move across from the private system would elect to be treated as private patients, particularly where they have to join a waiting list.

There is therefore an argument that it is clearly in the public interest for the State Government to regulate private facilities in order to prevent a substantial increase in the pressure on the public system. It can also be argued that Government regulation assists the private sector to compete with the public sector by encouraging public confidence in private facilities.

4.4.3 The potential for over-investment in and overuse of private facilities.

It is not at all clear from a health perspective why over-investment in private health facilities is a problem that requires legislative attention. Investment decisions are taken by industry based on its research into the need for those services and the estimated return that can be achieved on investment. Where industry has over-invested in capacity it would be expected to experience diminished returns to the point where it becomes no longer economically viable to continue to operate.

However, this simplified analysis seeks to describe investment decisions in a free market situation. The free market analysis discounts the ability of service providers to influence demand for their products, if such an ability in fact exists, and the impact that demand generation has on overuse of services and on public health in general. The analysis also ignores the possibility that over-investment may result in under-utilisation of individual facilities and reduced cash flows which may have an impact on quality of care.

This is a complex issue and one that will be addressed in detail in **chapter 7** which deals with the limitation on private hospital capacity (the bed cap).

4.4.4 The potential for private facilities to be inappropriately skewed in favour of metropolitan areas.

There is clearly a benefit to the community and the public health system in having a statewide spread of private health facilities that approximates population distributions. The benefits that a spread of facilities generate are many and varied. The benefits to individuals include:

- The ability of a patient to be treated close to home and by their regular practitioner(s).
- Ease of access for family and friends, and the benefits this has in terms of recovery times.
- Improved capacity for patients to be discharged early with follow up treatment provided on an outpatient basis, with a reduction in problems associated with long hospital stay including infection and mobility related ailments.
- The ability for patients to be treated in the private sector at a time that suits them rather than when they reach the head of a waiting list.

Benefits to the public health system include:

- The ability of private patients to access local private facilities may free up capacity within the public system to the benefit of public patients and help reduce waiting lists.

Benefits to local economies and the State economy include:

- The siting of private health care facilities in non-metropolitan areas has the benefits of attracting health professionals to the area as well as creating a host of employment opportunities within a facility and the service industries that support it.
- Building and development of facilities can have an important one-off impact on local economies.
- The ability of people to be treated close to home, family and friends may assist in restraining the amount of sick and compassionate leave that is taken as a result of hospitalisation. Such a reduction would be expected to have a small impact on the productivity of the economy both at local and State levels.

Data supplied by the Department of Health's Private Health Care Branch shows that 83.7% of approved private hospital beds (and 80.7% of private hospitals) are situated in metropolitan areas¹⁸ and 16.3% are in rural areas. Private hospitals located in metropolitan areas accounted for 85% of procedures carried out in private hospitals 1999/2000.¹⁹ This is in comparison to demographic data that shows 77.4% of the State's population live in the metropolitan areas and 22.6% live in rural areas.²⁰ Of the private facilities located outside the metropolitan area the majority are situated in the larger rural cities such as Albury, Armidale, Bathurst, Coffs Harbour, Dubbo, Lismore, Port Macquarie and Wagga Wagga. In comparison the same data shows that 85.7% of day procedure centres are located in metropolitan areas.

Of the 17 area health services, 9 metropolitan and 8 rural, 3 metropolitan areas which account for 31.7% of the State's population account for 56% of day procedure centres, 49.4% of private hospitals and 48.7% of private hospital beds. Those areas are Central Sydney, Northern Sydney and South Eastern Sydney.

There is therefore evidence that the current restrictions on private facilities do not necessarily promote so-called 'rational planning' of facilities with a very high proportion of facilities clustered in a few metropolitan areas. That said however the clustering of private hospitals, which are subject to controls, appears to be slightly less concentrated than for day procedure centres, which are not subject to controls.

Obviously investors will not choose to site facilities in areas where they cannot make the required return on investment and no amount of planning control will encourage them to do so. It is therefore unclear that placing restrictions on private facilities, particularly private hospitals, is an effective way of planning for the distribution of health services and it is therefore also unclear whether this is an appropriate objective for legislation.

4.4.5 Procedures carried out in the rooms of medical practitioners and dentists (office based surgery).

Medical practitioners and dentists are regulated in professional practice by the Medical Practice Act 1991 and the Dentists Act 1989 (soon to be replaced by the Dental Practice Act 2001) respectively. As such their activities in rooms are subject to requirements that they act

¹⁸ The metropolitan area incorporates Sydney, the Hawkesbury, Penrith, the Blue Mountains, the Hunter and the Illawarra.

¹⁹ NSW Department of Health Annual Report 1999-2000, Appendix 6, http://internal.health.nsw.gov.au/health-public-affairs/ar9900/nswhealth_ar9900.pdf

²⁰ Data supplied by the Department of Health's Statewide Services Development Branch

in a professional manner and subject to legislative controls such as the relevant infection control regulations in the Medical Practice Regulation 1998 and the Dentists (General) Regulation 1996.

That said however, a number of submissions to the review as well as the Report of the Committee of Inquiry into Cosmetic Surgery²¹ (the Cosmetic Surgery Report) have called for the regulation, via the Private Hospitals and Day Procedure Centres Act, of the provision of services under local anaesthesia and sedation in the rooms of medical practitioners and dentists.

Submissions include:

“The problems in the market place that have perhaps been identified but not addressed is in relation to procedures carried out in doctors rooms and medical centres in private practice that are bordering on day surgery.”²²

Recommendations 4a and 4b of the Cosmetic Surgery Report are as follows:

4a. Amend the Private Hospitals and Day Procedure Centres Act and the Day Procedure Centre (sic) Regulation to require licensing for all facilities where medical procedures are performed using local anaesthetic and sedation. New risk factors should be defined under the Act, including level of drugs and drug combinations, patient assessment and selection and adequate provision for recovery and discharge of patients and risks associated with lasers. (majority view)

4b. The licence should be conditional on certification by a third party accreditation body, provided on a fee for service basis.

However in coming to these recommendations the Committee found that

the main indicator of risk .. is complications arising from mismanagement of anaesthesia²³.

The Committee also noted that

a lack of data makes it difficult to gauge the complications arising from procedures being performed in doctors' rooms. ...

The risk factors associated with procedures performed in doctors' rooms are similar to those in day procedure centres, even though the actual risks may be different.²⁴

Therefore while the Committee found that the factors contributing to patient risk in office based surgery are the same as in more complex surgery it was unable to assess the actual risk to patients and frequency of complications due to a lack of data. Similarly this review has

²¹ Health Care Complaints Commission, 1999, ISBN 0 9586382 1 7.

²² Submission, Australasian Day Surgery Association, page 3.

²³ Report of the Committee of Inquiry into Cosmetic Surgery, Health Care Complaints Commission, page 29.

²⁴ Ibid, page 30.

received no information nor been presented with any compelling argument that suggests a need for increased regulation of office based surgery.

However, it is of significant interest that the Commonwealth Department of Health and Aged Care (CDHAC) has suggested categorising, or grading, day procedure centres based on the patient classification system. Within this framework a Level 4 facility would be a facility that provides day only procedures in an office based surgery under either local anaesthesia or local anaesthesia and sedation. The patients of a facility that meets these Commonwealth criteria would then be able to access private health insurance benefits for those procedures but only if the facility is recognised by the Commonwealth. Such recognition is currently premised on the facility being licensed by the State. There would therefore be a substantial incentive for the operators of those facilities to obtain State licensing without the need to mandate it through legislation.

4.4.6 Regulation of the number and location of day procedure centres in order to prevent oversupply in particular areas.

The Australasian Day Surgery Association in its submission appears to have argued that there should be restrictions placed on the approval of day procedure centres particularly with respect to geographical distribution and the type of service that can be offered.

“The Act when under review should look at geographical issues in the placement on new centres seeking approval of licences, and the types of service being offered.”²⁵

The figures cited above in 4.4.4 show that the geographical placement of day procedure centres is to a small extent more heavily skewed in favour of inner metropolitan areas than the distribution of private hospitals. However, a number of factors may be at work here including the fact that most day procedure centres are small facilities conducted by one or more medical practitioners. Day procedure centres may therefore tend to cluster around hospitals to which the facility owners have appointments or visiting rights. In addition it is reasonable to postulate that day procedure centres cluster in inner metropolitan areas as these areas have a higher proportion of privately insured patients than many rural and outer metropolitan areas.

The Association has not presented an argument in support of restricting the number of each type of day procedure centre or restrictions on the geographical placement of those facilities. The only arguments that the Department can envisage supporting this proposal are that it would allow a more ‘equitable’ distribution of facilities and that it would help limit the problems associated with supplier induced demand. These arguments are dealt with in more detail in **chapter 7** in relation to the private hospital bed cap. Suffice to say that it is unclear that there can ever be a truly equitable distribution of facilities and that notions of degrees of equity often turn on where the relevant commentator is standing. Furthermore, it is unclear that there is a problem associated with supplier induced demand and even more fundamentally whether such a phenomenon in fact exists.

4.5 Proposed objectives of the Act

It is proposed that the Act should include a statement of its objectives. Such a statement should reflect that the objectives of the Act are the regulation of private health care facilities

²⁵ Submission, Australasian Day Surgery Association, page 4.

in the interests of maintaining high standards of care and practice in the interests of the health and safety of patients.

Recommendation 1

The objectives of the Act be the licensing and regulation of private health care facilities for the purpose of maintaining standards of health care and professional practice within those facilities.

5. REGULATORY OPTIONS

5.1 Introduction

As required by the Competition Principles Agreement the review has considered alternatives to the current regulatory regime for private hospitals and day procedure centres. The Issues Paper raised for discussion five separate regulatory options, one of which is the current licensing system.

The following alternative options were raised for discussion in the Issues Paper:

- 1) No market specific regulation.
- 2) Voluntary third party accreditation combined with a Government information campaign.
- 3) Negative licensing.
- 4) The status quo.
- 5) Legislative recognition of third party accreditation.

5.2 Overview of the options

5.2.1 No market specific regulation

Adoption of this option would see the Act and regulations repealed and not replaced. If this option were adopted there would be no specific controls on the number, size or location of private health facilities nor would there be any state controls on who may establish, own or operate such a facility.

That is not to say, however, that there would be no regulation of the services provided by private health facilities. Local government would retain regulatory oversight for the location of facilities and building standards through application of planning instruments and the Building Code of Australia (BCA96). In addition many, if not most, services provided within private health facilities will be required to be given by registered health professionals. While there are few explicit legislative restrictions on specific treatments it is a simple matter of good risk management, of considerable interest to a facility's insurers, that appropriately qualified and registered practitioners provide, or at the very least supervise the provision of, treatments. Where services are provided by registered health professionals, such as medical practitioners, nurses and dentists, the relevant professional registration board is responsible for maintaining professional standards.

In a broader sense private facilities will also be subject to the general laws of negligence and contract as well as the provisions of the Fair Trading Act 1987 (NSW) and the Trade Practices Act 1974 (Cth). Furthermore, private facilities will also be subject to the general complaints provisions in the Health Care Complaints Act and the controls laid down in the Poisons and Therapeutic Goods Act.

In addition to legislative restrictions there would be certain market based controls that facilities may wish to avail themselves of, or be required to utilise by their risk managers. For example private facilities could seek accreditation by one or more of the industry accrediting bodies and promote that accreditation to both patients and health care practitioners, as an indicator of the service's quality and standards. Examples of third party accreditation models widely used in the private health care industry are:

- the Australian Council on Health Care Standards (ACHS) Accreditation Program, which is the most common model of accreditation in use; and
- ISO 9000, promoted by Standards Australia.

This general framework will continue to apply under all options although in some cases specific statutory provisions may make some of the features of the general framework unnecessary.

It is also worth considering what role the Commonwealth would play in regulating private facilities if there were no state based regulation. Under the National Health Act the Federal Minister for Health can “declare”, or recognise, a private facility for the purposes of the Health Insurance Act. What this means is that Medicare benefits can be paid for medical services provided in that private facility and private health insurers must pay (at least) the basic benefit for the accommodation provided within the facility. Currently the Commonwealth relies on state licensing to monitor and maintain standards and a facility is generally recognised on proof of state licensing. If the State was to withdraw from licensing the Commonwealth Government may be forced to develop and apply a comprehensive assessment and monitoring system for private facilities.

5.2.2 Voluntary third party accreditation combined with a government information campaign.

Adoption of this model would see the repeal of the current Act and regulations. As with option 1 service providers could seek accreditation by one of the recognised accrediting bodies and could then promote that accreditation to both patients and health care practitioners, as an indicator of the service’s quality and standards. The significant difference in this option is that the Government would also conduct a public education/information campaign to promote the benefits to consumers of utilising accredited facilities.

Again this approach would have significant implications for Commonwealth Government recognition of private facilities and the Commonwealth may be forced to develop and apply a comprehensive assessment and monitoring system for private facilities.

5.2.3 Negative licensing

A negative licensing model provides for minimum standards which must be adhered to. Service providers would be able to establish a service and operate without restriction until excluded. Exclusion could occur as a result of complaints that the minimum standards are not being adhered to, such as complaints regarding the quality of service. Under this option any person would be free to set up a private health care facility, and subject to other legislation, would not be required to submit to probity checks, nor would the proposed premises have to be assessed as to their suitability as a health facility. This option would also require the development of standards against which complaints would be assessed and it would be necessary to separately provide powers for the appropriate body, such as the Health Care Complaints Commission, to investigate complaints.

5.2.4 The status quo.

Under this option the present statutory licensing system would be retained although the regulatory system could be modified to remove those anti-competitive elements which are not in the public interest. Further modifications, such as the incorporation of outcome or

performance based standards rather than the current prescriptive input based licensing standards, could be considered as part of this process.

5.2.5 Legislative recognition of third party accreditation

Under this option a statutory licensing system would be maintained. However, the prescription of specific licensing standards would be replaced by a requirement for private health care facilities to have approved third party accreditation before a licence is issued and the facility can operate.

Features of both options 2 and 4 are incorporated into this model. The State would continue to conduct fitness and probity checks of applicants for licences and would maintain a complaint handling and monitoring role. Loss of accreditation would result in licence removal.

A variation on this option would involve introduction of legislation requiring all operators to hold accreditation with a recognised third party, thus removing the requirement for government licensing completely.

5.3 Assessment of options by PriceWaterhouseCoopers

As noted in chapter 1 of this Interim Report the Department of Health engaged PriceWaterhouseCoopers (the Assessment Team) to undertake an independent economic assessment of the current licensing system and to recommend the most effective and efficient means of achieving the objectives of the Act. In undertaking this assessment the Assessment Team examined the current licensing system and the four alternative options discussed above.

The Assessment Team essential findings on the efficacy of each of the regulatory options is as follows:

Option 1

“On balance, the Assessment Team considers the major potential costs of self regulation to outweigh the major potential benefits because this regime may be inadequate in addressing the major objectives of the licensing restriction as identified...”²⁶

Option 2

“The Assessment Team finds on balance the major potential costs of third party accreditation to outweigh the major potential benefits. In particular .. this option is inadequate in protecting consumers from physical and financial harm, and in protecting consumer’s (sic) health and safety.”²⁷

Option 3

“The Assessment Team finds on balance negative licensing is a reactive system, that is, private health care providers are punished only after detection of a misconduct has occurred. Therefore, the Assessment Team considers the major potential costs associated with negative

²⁶ PriceWaterhouseCoopers, The National Competition Policy Review of the Private Hospitals and Day Procedure Centres Act – Economic Assessment, page 20.

²⁷ Ibid, page 21.

licensing, mainly relating to information asymmetry and externalities, to significantly outweigh the major potential benefits of lower compliance and administrative costs.”²⁸

Option 4

“The Assessment Team considers the requirement in the Act that private hospitals and day procedure centres be licensed, on balance, is an efficient mechanism to achieve the objectives of this restriction and therefore produces a net public benefit.”²⁹

Option 5

“The Assessment Team finds this option [legislative recognition of third party accreditation] does not produce a net public benefit as there is a real possibility that it may restrict further entry rather than encourage entry into the private health care industry.”³⁰

5.4 Submissions

Overwhelmingly submissions that actively advocated a particular regulatory model or models endorsed the current licensing system, although a number have also suggested modifications to the system. A representative sample of those submissions, including views on the alternative regulatory models, follows.

Option 4: The current licensing system

“The NSW HFA strongly supports Option 4 and recommends that the state licensing system be retained.”³¹

“[T]he Committee strongly agreed that Option 4 (retention of the current licensing system), of the five options for regulation put forward in the paper, was the option clearly preferred.”³²

“[W]e would endorse options 4.2.4 [option 4] or 4.2.5 [option 5] in terms of the nature of the regulation required. The other ‘free market’ options in the short term may be cheaper, but the cost will not only be in severe decline in standards of patients care and safety, but ultimately significantly increased costs in terms of litigation, penalties and then re-implementation of standards.”³³

“The Commission supports Option 4 – retain the current licensing system with relevant amendments to include quality and safety developments since the Act was introduced. .. There is no viable alternative, at this time, to ensure safe delivery of health services in private health facilities and day procedure centres.”³⁴

²⁸ Ibid, pages 23-24.

²⁹ Ibid, page 18.

³⁰ Ibid, page 22.

³¹ Submission, NSW Health Funds Association, page 13.

³² Submission, Private Hospitals and Day Procedure Centres Advisory Committee, page 2.

³³ Submission, Australian and New Zealand College of Anaesthetists, New South Wales Regional Committee.

³⁴ Submission, Health Care Complaints Commission, page 8.

Option 1: No market specific regulation

“The Commonwealth would not be supportive of this option. This would raise concern as to both quality and safety as well as consumer confidence.”³⁵

“The NSW HFA is strongly opposed to no market specific regulation and does not support Option 1.”³⁶

“This option .. puts the community at a greater risk of harm since it relies heavily on consumers to take civil action or make complaints in order to identify unlawful operators. Not only would such a system place an enormous burden on consumers, it would also invariably contain unacceptable delays during which time more consumers could be affected.

...
Medibank Private agrees with the statement that self-regulation would not engender consumer confidence and would also suggest that the perceived risk to the community would be detrimental to the sustainability of the private health care sector.”³⁷

Option 2: Voluntary third party accreditation combined with a government information campaign

“The NSW HFA does not support Option 2.

It is highly unlikely that a government information campaign on voluntary third party accreditation would prove to be a viable alternative to state regulation in the interests of patient safety and quality of care.”³⁸

“This option has the disadvantage that there would be non-enforceability of standards and a lack of universality of standards.”³⁹

Option 3: Negative licensing

“The effects of allowing unsuitable operators to run a private hospital in the first instance followed by the removal of that licence following a serious adverse event would appear to be closing the gate after the horse has bolted. This approach would have the potential to seriously compromise patient care.”⁴⁰

“Negative licensing is reactive rather than pro-active and is philosophically unsound.”⁴¹

³⁵ Submission, Commonwealth Department of Health and Aged Care, page 6.

³⁶ Submission, NSW Health Funds Association, page 12.

³⁷ Submission, Medibank Private, page 2.

³⁸ Submission, NSW Health Funds Association, page 12.

³⁹ Submission, Australian Council on Healthcare Standards, page 3

⁴⁰ Submission, Commonwealth Department of Health and Aged Care, page 6.

⁴¹ Submission, The Royal Australian College of General Practitioners.

“This model is totally unacceptable to Medibank Private as it unnecessarily exposes consumers to the highest risk of harm. In allowing any operator into the market until they are proven to be unsuitable relies predominantly upon consumers to formally complain or take civil action ...”⁴²

Option 5: Legislative recognition of third party accreditation

“The Commonwealth has no objection to independent licensing as long as the current regulatory and licensing requirements remain the responsibility of the State.”⁴³

“The NSW HFA does not support Option 5 as a superior alternative to Option 4...”⁴⁴

“This option would clearly enforce the requirement of accreditation as an alternative to licensing standards and places the responsibility for monitoring standards within facilities with a third party. ... If the suggestion that there is currently only one likely candidate for the role of third party accreditation is correct then it could be argued that creating such a monopoly in the market place would in itself be in conflict with the National Competition Principles Agreement.”⁴⁵

A number of submissions, including those from operators of day procedure centres and the Health Care Complaints Commission, have echoed the views of the Commonwealth and the health insurance industry in endorsing independent accreditation as an important quality assurance mechanism but in addition to licensing rather than as an alternative. The substance of the objections to replacing licensing with third party accreditation centre around concerns relating to the independence of the accreditation body and the creation of an effective monopoly in the market given that ACHS occupies a dominant position.

Concerns about an ACHS monopoly may however be unfounded. The International Standards Organisation (ISO) has developed ISO 9000 as a quality assurance and accreditation tool for health care facilities. In this country ISO 9000 is promoted by Standards Australia and it has had some success in capturing a share of the market. In addition there is the Institute for Health Communities Australia Inc which provides accreditation services. All three of these bodies are recognised for accreditation purposes in Queensland’s *Private Health Facilities Act 1999*.

Of possibly greater concern is the erosion of the independence of accreditation bodies. The market for accreditation services in NSW is growing due to the growth in the number of day procedure centres. However, the rate of growth in numbers of day procedure centres is slowing and when combined with the small decrease in the number of private hospitals over the last decade (largely due to amalgamations) there appear to be limited opportunities for new players in the accreditation market. With this in mind there may be cause for concern that in order to promote the use of its services an accreditation body might be disinclined to refuse a facility accreditation. There is also the concern that a facility denied accreditation by

⁴² Submission, Medibank Private, page 2.

⁴³ Submission, Commonwealth Department of Health and Aged Care, page 7.

⁴⁴ Submission, NSW Health Funds Association, page 13.

⁴⁵ Submission, Medibank Private, page 3.

one body may apply for and obtain accreditation from one of the other bodies without any meaningful change to its procedures.

In its submission ACHS demonstrated a distinct lack of enthusiasm for the use of third party accreditation as either an alternative to or an integral element of a regulatory system. The concerns of ACHS appear largely to centre on the impact that such a system would have on its relations with its clients and the very real potential for accreditation decisions, which would *de facto* be decisions as to whether a facility can operate, to be legally challenged with the attendant impact on costs and the perceived standing of the accreditation body in its marketplace.

5.5 Interstate approaches

An overview of the approach to regulation taken in a number of interstate and overseas jurisdictions is provided for comparative purposes.

5.5.1 Queensland

The Private Health Facilities Act 1999 provides for the licensing of private health facilities in Queensland. Private health facilities include private hospitals and day hospitals. The Act defines “private hospital” as

“a facility at which health services are provided to persons who are discharged from the facility on a day other than the day on which the persons were admitted to the facility.” (Excluding facilities run by the State, nursing homes and aged care facilities.)

The Act defines day hospital as

“a facility at which day hospital health services are provided to persons who are admitted to, and discharged from, the facility on the same day, but does not include a facility operated by the State.”

Day hospital health service is defined as

“(a) a diagnostic, surgical or other procedure performed by a medical practitioner involving—

- (i) the administration of a general, spinal or epidural anaesthetic; or*
- (ii) sedation, other than simple sedation;*

(b) a diagnostic, surgical or other procedure—

- (i) performed by, or under the direction of, a medical practitioner; and*
- (ii) involving a significant risk that a person on whom the procedure is performed may, because of cardiac, respiratory or other complications arising from the performance of the procedure, require resuscitation; and*
- (iii) prescribed under a regulation.”*

Simple sedation is defined as

“the administration of one or more drugs to a person, that depress the person’s central nervous system, to allow a procedure to be performed on the person by a medical practitioner in a way that—

- (a) allows communication with the person to be maintained while the procedure is being performed; and*
- (b) makes loss of the person's consciousness unlikely."*

The Act requires the licensing of all facilities with probity testing of applicants, or in the case of a corporation its executive officers.

Part 5 of the Act deals with the issuing of approvals, which are the equivalent to an approval in principle issued under the NSW Act.

Facilities are graded in accordance with different levels of service. The following is a general description for each level of service:

- **Level 1: Core general service.**
- **Level 2: Limited speciality service.**
- **Level 3: Extensive speciality service capable of undertaking complex services on high risk patients.**

The Act also takes the approach of requiring facilities to comply with an extensive set of standards which are more rigorous for level two and three facilities. The standards can be obtained from the Queensland Department of Health website (www.health.qld.gov.au/lpu/clinical.pdf).

5.5.2 Victoria

Private hospitals and day procedure centres are licensed under the Health Services Act 1988. The Act incorporates a mechanism for the granting of approval in principle at the initial planning stage. Licensing criteria include:

- suitability of the design and construction of the premises for the intended use;
- fitness of the proprietor and associates;
- compliance with planning constraints (the bed cap);
- ongoing compliance with minimum safety and quality standards as set out in the Act and regulations; and
- compliance with any conditions on the licence.

Regulations made under the Act set minimum standards and are aimed primarily at patient safety. The regulation cover matters such as minimum staffing ratios, patients' rights and record keeping.

The Act has been subject to an extensive review over the last two years. The Review has recommended that:

- building standards for hospitals should be incorporated into the Victoria Building Regulations, removing the need for the Department of Human Services to approve the design and construction of private hospital premises;
- the statutory licensing framework, including the approval in principle process, assessment of fitness and propriety of applicants and capacity to impose conditions on registration and inspect premises should be retained; and

- regulations under the Act should be reviewed for relevance.⁴⁶

As a result of the review the Victorian Government has agreed to retain the statutory licensing system and has commenced a review of existing regulations as proposed by the Report. The Government has also agreed to consider the feasibility of incorporating private hospital building standards into the Victoria Building Regulations.

To date no legislation has been released.

5.5.3 Western Australia

In Western Australia private hospitals are licensed under the Hospitals and Health Services Act 1927. Before issuing a licence the Commissioner for Health is to be satisfied that an applicant is a fit and proper person, or in the case of a corporation its officers are fit and proper, and that it has the financial resources to conduct the facility according to the Act. The Commissioner is also to ensure that the premises at which the applicant proposes to conduct the private hospital are satisfactory for that purpose and that the arrangements for the management, equipment and staffing of the private hospital are satisfactory before granting the licence.

The recent review of the licensing of private facilities in Western Australia has recommended retention of the licensing system, including approvals in principle, with a number of changes including:

- development of outcome based licensing standards; and
- creation of a new Licensing Standards and Review Unit to administer the system.

To date legislation to implement the proposed changes has not been introduced.

5.6 International approaches

5.6.1 United Kingdom

The current regulatory environment in the United Kingdom has private hospitals and day facilities registered as nursing homes under the Registered Homes Act 1984. Under this Act registration is conducted by each of the 100 health authorities throughout the UK and each authority may apply a different set of standards to that process.

The estimated size of the private health facility sector is⁴⁷:

Facility Type	Number	Number of Beds
Acute hospitals (including cosmetic surgery)	234	9,909
Mental health hospitals	182	1,465
Psychiatric clinics	95	468
Hospices	137	2,068
IVF/Fertility clinics	50	

⁴⁶ The Final Report of the Review and the Government's response are available on the Department of Human Services website, <http://www.dhs.vic.gov.au/ahs/servrev/>

⁴⁷ Source, UK Department of Health National Care Standards Commission (NCSC) Implementation Project, <http://www.doh.gov.uk/ncsc/independent.htm>

Abortion clinics	76	
Maternity clinics	2	
Private dentists using general anaesthesia	50	

The inappropriateness of registering private hospitals as nursing homes has been recognised and the recently passed Care Standards Act 2000 therefore provides for a regulatory system for private health care facilities, including the above types of facility. The legislation creates the National Care Standards Commission (which is scheduled to commence operation on 1 April 2002) to undertake the licensing and regulation of private health care facilities. The UK Department of Health is currently in the process of developing regulations and national minimum standards which will require health care providers to ensure the provision of quality care for which they are accountable.

5.6.2 United States

As in Australia, private facilities in the United States are certified by the Federal Government for participation in the Federal Medicare health insurance scheme and separately licensed by individual states. However the overwhelming majority of facilities certified for Medicare purposes obtain that certification based on certification by the Joint Commission on Accreditation of Healthcare Organisations (JCAHO). JCAHO is an independent non-profit organisation that is governed by a 28-member Board of Commissioners, which includes representatives from a broad range of backgrounds including medical practitioners, nurses, consumers, ethicists, health insurance administrators and educators. JCAHO is in practice the equivalent of the Australian Council on Healthcare Standards (ACHS).

In addition to JCAHO certification for Medicare purposes most states also defer to JCAHO certification for licensing purposes.

JCAHO generally certifies facilities for three years, or two years in the case of medical laboratories. The certification process involves scrutiny of a facility's operation against over 700 quality of care standards including standards in patient rights, patient care and nursing and medical staffing.

The conclusion to be drawn is that the regulatory regime in the US is essentially one where the industry based third party accrediter is largely responsible for setting industry standards and in a sense the industry is therefore to a large degree self-regulating.

5.7 Conclusions

As discussed in **chapter 4** the Department of Health recommends that the objectives of the legislation regulating private health care facilities should be the maintenance of high standards of health care in private facilities. Realisation of such an objective will serve the public interest in a number of ways, including:

- Delivering improved outcomes for those members of the community who use private health facilities. In addition to delivering obvious benefits to the individuals concerned improved outcomes will benefit the whole community by reducing overall rates of morbidity and mortality with the following economic benefits;
 - (a) improvements to work productivity,

- (b) reduction in payments from health and life insurance policies with a related decrease in insurance premiums,
- (c) reduced rates of emergency readmission as a result of unexpected complications or infections thereby allowing scarce health resources to be used in treating a greater number of patients.
- Delivering benefits to the public hospital system by;
 - (a) increasing public confidence in, and therefore use of, the private sector thereby reducing demands on public facilities,
 - (b) reducing the need for emergency transfers from private facilities (particularly small facilities) to public facilities,
 - (c) reducing the number of emergency readmissions, many of which result in admission to public facilities.
- Assisting to address information problems that may be experienced by members of the public in selecting a private facility.
- Preventing unscrupulous people from entering the private health facility market, thereby:
 - (a) reducing the potential for financial considerations to override patient welfare and safety considerations,
 - (b) reducing the potential for facility operators to misappropriate patients funds, particularly in those instances where uninsured patients pay in advance for accommodation services.

The licensing of private health care facilities also allows for certain types of high risk treatment, such as those requiring the use of anaesthesia, to be restricted to licensed facilities in which standards and controls are in place. Similarly licensing allows for other types of treatment which the community has an interest in regulating, such as treatments involving the admission of child patients, to be confined to facilities which meet minimum standards and where the operators have been judged fit and proper to provide those treatments.

The Department of Health is of the view that regulatory legislation with the objectives identified in **chapter 4** will deliver substantial public benefits. The Department is also of the view that those objectives and benefits can be most effectively and efficiently delivered through the use of a licensing system that sets minimum standards that facilities must meet in order to obtain and maintain a licence.

Therefore it is recommended that the Department of Health continue to license private health facilities. It is also recommended that the current regulatory system be updated to reflect recent developments in both the market and regulatory approaches. Those developments and the legislative amendments required will be considered in the following chapters.

In support of the Department's conclusions is the overwhelming support shown by stakeholders for the retention of a regulatory regime for private health facilities. Further support for the Department's conclusions is provided from the regulatory experiences of other jurisdictions, both domestically and abroad.

Recommendation 2

That NSW Health continue to license private health facilities.

6. DISTINCTIONS BETWEEN PRIVATE HOSPITALS AND DAY PROCEDURE CENTRES

6.1 Background

The Private Hospitals and Day Procedure Centres Act draws a distinction between private hospitals and day procedure centres with each being separately defined and subjected to different standards. For practical purposes the licensing process that applies to each type of facility is the same, although private hospitals are licensed for a specified number of overnight beds. Significant differences in the regulation of facilities arise in the licensing standards in the Day Procedure Centres Regulation 1996 and the Private Hospitals Regulation 1996.

Applicants for both private hospital and day procedure centre licences pay an application fee of \$615. An application may be refused if the applicant is not a fit and proper person to be a licensee, if the facility cannot be conducted in accordance with the applicable licensing standards, or in the case of a private hospital if approval would result in an increase in the number of patients that can be accommodated overnight in private hospitals (ie due to the bed cap).

If an application is approved the Private Health Care Branch (PHCB) issues an approval in principle which is effective for one year, although this period may be extended. The issuing of an approval in principle is designed to afford the industry some certainty in its investment decisions as the industry may not risk the expense of building a facility or modifying an existing facility to meet applicable licensing standards in the absence of some certainty about the issue of a licence. (Approvals in principle are considered in detail in **Chapter 9**.) Following completion of the construction or alteration of the premises to which an approval in principle relates a licence is issued unless the approval in principle has expired, the building was not constructed or altered in accordance with the plans submitted as part of the approval process, or any other condition to which the approval was subject has not been complied with.

6.2 The licensing of private hospitals

The Act defines a private hospital as:

“premises at which any patient is provided with medical, surgical or other treatment, and with ancillary nursing care, for fee, gain or reward, but does not include:

- *an institution conducted by or on behalf of the State, or*
- *a hospital or health service under the control of a public health organisation within the meaning of the Health Services Act 1997, or*
- *a nursing home within the meaning of the Nursing Homes Act 1988.”*

Private hospitals pay an annual licence fee which ranges between \$1,130 and \$4,270 depending on the number of beds the hospital is licensed for.

Private hospitals are licensed in a specified class and different licensing standards apply depending upon that class. The five classes of hospital are:

- general;
- surgical (including endoscopic procedures);
- obstetric;
- rehabilitation; and
- psychiatric.

Schedule 1 of the Private Hospitals Regulation 1996 sets out in detail the licensing standards that apply to all private hospitals. Schedule 2 of the Regulation sets out additional standards that apply to hospitals that are licensed in particular classes, and Schedule 3 sets out standards that apply to facilities that are authorised to provide specialised services such as cardiac catheterisation and emergency services.

6.3 The licensing of day procedure centres

The Act defines a day procedure centre as:

“premises at which any patient is admitted and discharged on the same day for such medical, surgical or other treatment, and in such circumstances, as may be prescribed by the regulations, but does not include:

- *premises conducted by or on behalf of the State, or*
- *a public hospital or health service under the control of a public health organisation within the meaning of the Health Services Act 1997, or*
- *a licensed private hospital; or*
- *a nursing home within the meaning of the Nursing Homes Act 1988.”*

Day procedure centres pay an annual licence fee of \$1,130.

Day procedure centres are licensed in specified classes and different licensing standards apply depending upon that class. The five classes of day procedure centres are:

- surgical;
- endoscopic;
- dialysis;
- cytotoxic; and
- early childhood.

Schedule 1 of the Day Procedure Centres Regulation 1996 sets out in detail the licensing standards that apply to all day procedure centres. Schedule 2 of the Regulation sets out four sets of additional standards that apply to centres that are licensed as surgical, endoscopic, dialysis or cytotoxic class facilities respectively. Schedule 3 of the Regulation sets out standards that apply to centres that are separately authorised to provide cardiac catheterisation services.

6.4 A uniform approach to licensing

The licensing standards for private hospitals and day procedure centres are to a large extent comparable, and in many cases are identical. Similarly the licensing process for facilities of

all types is parallel and where it varies that variation is in large part due to the different requirements under the licensing standards.

In considering a uniform approach the Health Care Complaints Commission has submitted that:

“..the suggestion is supported if it is possible to construct a combined classification that incorporates different levels of risk and complexity. It may be possible to base a classification on factors such as nature of pre-preparation procedures, complexity and risk of the procedure, population risk, anaesthetic level, competency required to perform procedure .. complexity of infection control procedures and range of after care or rehabilitation requirements.”⁴⁸

6.4.1 Rationale for the distinction between private hospitals and day procedure centres

The primary rationale for the distinction between private hospitals and day procedure centres appears to be the overnight accommodation of patients in private hospitals. Clearly there are other historical factors at work as well, including the fact that until the passage of the current Act there was no statutory regulation of day procedure centres and also that until relatively recently it was generally only the less complex procedures that were performed as day only surgery.

It is not immediately apparent that the distinction retains any utility given recent developments in surgical procedures and anaesthesia and the expansion in the type of procedure that can now be conducted on a day only basis. The growth in the utilisation of day only surgery and the concomitant fall in overnight surgery is evidenced by the following figures:

Category	1993/1994 (=100)	1999/2000
Public hospital Overnight	815,874	729,339 (=89.4)
Public hospital Day only	426,400	507,069 (=118.9)
Private hospital Overnight	224,309	240,814 (=107.4)
Private hospital Day only	150,189	230,187 (=153.3)
Day Procedure Centre	102,084	131,331 (=128.6)
Total State Overnight	1,040,183	970,153 (=93.3)
Total State Day only	678,673	868,587 (=128)
Total State	1,718,865	1,838,740 (=107)
Sources: NSW Department of Health Annual Report 1993/4, Appendix 4. The figures for 1999/2000 will be published in the Annual Report for 2000/2001.		

⁴⁸ Submission, Health Care Complaints Commission, page 9.

Further there has now been 8 ½ years of compulsory licensing of day procedure centres and any uncertainty that there may have been about the role that they would fill in the health care system has now been dispelled. To a very large extent it is clear that private hospitals and day procedure centres offer many services that are the same or substantially the same. Private hospitals are required to comply with a more detailed series of licensing standards which theoretically provide patients with a greater degree of safety in complex procedures but it is questionable whether in reality there is a higher level of safety over day procedure centres for most procedures. It is also highly questionable whether consumers can recognise and appreciate the effect of the difference in standards.

6.4.2 Categorisation of day surgery by the Commonwealth

The Commonwealth Department of Health and Aged Care is eager to widen the scope for private health insurance to cover treatment provided outside traditional hospital settings. This wider scope would include office based surgery, hospital in the home services and ‘limited care accommodation’ services for step down recovery from the acute sector.

As part of this scheme the Commonwealth has proposed that day facilities be categorised into one of four levels. Those levels are:

- | | |
|---------|--|
| Level 1 | Day surgery services provided in a public or private hospital or a licensed day hospital facility covering all types of professional attention including arrangements for extended (overnight) recovery and limited care accommodation. |
| Level 2 | Day surgery services provided in a public or private hospital or a licensed day hospital facility covering all types of professional attention including arrangements for extended (overnight) recovery or limited care accommodation. |
| Level 3 | Day surgery services provided in a public or private hospital or a licensed day hospital facility covering all types of professional attention on a same day basis. |
| Level 4 | Facility* able to provide same day only procedures in an appropriately equipped office based surgery unit with the surgery performed under <ul style="list-style-type: none"> • Local anaesthesia or • Local anaesthesia and sedation. |

***Note: A Level 4 facility is eligible to receive health insurance benefits only if it has State licensing or Commonwealth recognition as a day hospital facility.**

The Commonwealth proposal would therefore encourage some day procedure centres to step up and provide limited overnight care which has traditionally been a service associated with hospitals. Equally the proposal envisages more extensive use of office based surgery to provide some services that have previously only been provided in day procedure centres. Access to health insurance benefits for procedures performed as office based surgery would be premised on the facility being recognised by the Commonwealth and therefore in NSW licensed by the Department of Health. The current licensing system does not accommodate this model.

6.4.3 Outcome based standards

To a large extent the licensing standards under the current Act prescribe minimum inputs and rely on the provision of those inputs to ensure that quality care is provided. While there is no evidence that this approach has failed it can nonetheless restrict opportunities to innovate and improve efficiency.

The Department of Health is by no means suggesting that regulation be completely outcomes based as there are clearly certain services that cannot be safely provided in the absence of specified equipment. However, a carefully crafted set of input and output standards can be used to both maintain an appropriate level of necessary inputs and allow flexibility in the operation of a facility.

“The Commission suggests a mixed approach .. that incorporates system requirements, outcome standards, physical requirements, equipment and minimum staffing requirements and quality improvement processes and structures.”⁴⁹

One option to consider in addressing the issue of prescribed inputs versus outcome standards and the appropriate mix of the two is adopting, by regulation, the published guidelines of the learned colleges, such as the Australian and New Zealand College of Anaesthetists and the Royal Australian and New Zealand College of Ophthalmologists.

6.4.4 Minimum throughputs

An alternative approach is to set a broad range of outcome standards that a facility must meet in providing services. Such outcome standards could conceivably include a series of minimum throughputs for certain procedures. This approach has been adopted in Queensland and the Private Health Facilities Regulation 2000 provides that minimum throughput standards may be made for

- (a) cardiac surgery;
- (b) cardiac catheterisation;
- (c) intensive care; and
- (d) obstetrics.

In this respect the Queensland Department of Health’s *Guidelines For Clinical Services In Private Health Facilities*, published in November 2000 provide for the following minimum throughputs:

- (a) Minimum throughput for Cardiac Surgery 400 procedures per year. If minimum caseload cannot be achieved, a formal affiliation with another cardiothoracic unit to ensure staff skill levels is maintained.
- (b) Minimum throughput for cardiac catheterisation 900 procedures per year. If minimum caseload cannot be achieved, a formal affiliation with another cardiac catheter unit to ensure staff skill levels is maintained.
- (c) Minimum throughput for intensive care more than 350 mechanically ventilated patients per annum. If minimum caseload cannot be achieved, a formal affiliation with another intensive care unit to ensure staff skill levels is maintained.

⁴⁹ Ibid.

(d) Minimum throughput for obstetrics 240 births per facility per year. If minimum caseload cannot be achieved, a formal affiliation with another obstetric unit to ensure staff skill levels is maintained.

In medical journals there have been a number of reports of studies conducted to consider if there is a link between procedure volumes and patient outcomes for particular procedures. One such study is that conducted by Farley and Ozminkowski⁵⁰ which concluded that for certain procedures higher patient throughput resulted in generally better outcomes, although some of those results were attributed to referral patterns.

Given that there appears to be a link between patient volumes and outcomes for certain specialty services it is appropriate to consider whether licensing standards should incorporate minimum patient throughput for selected specialty services. However, there is concern that setting minimum throughputs for facilities does not address the issue of practitioner competence and where a minimum throughput for a particular procedure is divided between a number of medical practitioners there may be little meaningful impact on outcomes.

There is also concern that setting minimum throughputs can encourage narrowing of the private health care industry and its consolidation into a small number of large facilities. Such narrowing of the range of service providers is not in the interests of consumers and may not deliver benefits to the health system as a whole.

The matter of minimum throughputs is also pertinent when discussing issues of service planning and will be considered again in Chapter 7 which deals with restrictions on patient capacity.

6.4.5 Reclassification of existing facilities

If the legislative distinction between private hospitals and day procedure centres were removed and facilities were simply licensed as private health care facilities and categorised on the basis of the procedures performed, consideration would need to be given to the range and nature of those categories. Currently there are five classes of private hospital and five classes of day procedure centre. There are also six categories of specialised treatment that a private hospital can be authorised to provide and one category of special treatment that a day procedure centre can be authorised to provide. It is conceivable that some of these classes and categories could be subsumed into others just as it is possible that new classes and categories may be required.

Furthermore consideration would need to be given to the categorisation of those facilities that are currently licensed. For this purpose there would be a transitional period during which existing licenses would be carried forward and an assessment undertaken of the procedures and treatments provided in a licensed facility to determine if and how it should continue to be licensed.

⁵⁰ Farley D and Ozminkowski R, *Volume-Outcome Relationships and Inhospital Mortality: The Effect of Changes in Volume Over Time*, *Medical Care* January 1992 volume 30 no. 1, pp 77-94.

6.5 The Cosmetic Surgery Report

In October 1998 the then Minister for Health appointed a Committee of Inquiry into Cosmetic Surgery. In October 1999 the Committee reported its findings to the current Minister for Health. The Report notes that the risks associated with office based surgery are similar to those associated with surgery in day procedure centres. The type of risks include:

- those associated with anaesthesia; and
- arrangements for patient transfer in case of complications or an emergency.

Amongst the Committee's recommendations is recommendation 4 which is concerned with the undertaking of medical procedures under local anaesthetic and sedation as office based surgery. Recommendation 4(a) recommends amendment of the Private Hospitals and Day Procedure Centres Act to require the licensing of facilities where medical procedures are undertaken under local anaesthesia and sedation.

6.6 Submissions

Of the submissions that directly addressed the distinction between private hospitals and day procedure centres the majority supported its removal. Most submissions considered that licensing could then be effected based on criteria developed with regard to the degree of risk from procedures rather than the setting in which a procedure takes place.

*"It would seem reasonable to rationalise the current licensing system given the changes in technology and medical science. Removing the separate licensing requirement for private hospitals and day procedure centres would enable licensing to be uniformly based on procedures performed..."*⁵¹

*"Separate licensing requirements for private hospitals and day procedure centres could be removed and outcome based measures with their foundation in clinical indicators developed."*⁵²

"We submit that:

- *Separate licensing requirements for Private Hospitals and Day Procedure Centres should be removed;*
- *Private facilities should be able to run both as a Hospital and a Day Procedure Centre under common requirements for the purposes of the legislation;*
- *Licensing should continue, to establish a minimal basis for operation of a private health facility with outcome based accreditation established for the carrying out of more advanced procedures and treatments, whether on a day only or in-patient basis."*⁵³

"..the licensing distinction between private hospitals and day procedure centres could disappear with the blurring of distinctions in medical care. However the day surgery representative and consumer representative on the Committee were of the view that

⁵¹ Submission, Office of the Chief Nursing Officer, page 3.

⁵² Submission, Greater Murray Area Health Service, page 2

⁵³ Submission, NSW Nurses Association, page 5.

*there should be a separate Act for day procedure centres and stand alone day hospitals rather than those facilities being subject to the more stringent levels of control which apply to private hospitals and overnight facilities.*⁵⁴

The Australian and New Zealand College of Anaesthetists, NSW Regional Committee, has also submitted that the separate licensing of private hospitals and day procedure centres should be removed and that classification should be reconsidered with respect to the degree of complexity of the procedures undertaken at a facility.

By way of comparison MBF health funds has argued that the current distinction should be retained.

*“..it remains appropriate to have separate licensing arrangements for private hospitals and day facilities. There is currently a Commonwealth review underway that is examining differentiation between facilities. Until this is complete, we do not see any need for changes to this section ...”*⁵⁵

6.7 Anaesthesia

6.7.1 Background

The Private Hospitals and Day Procedure Centres Act and the Day Procedure Centres Regulation rely in a number of areas on the level of anaesthesia used in a procedure to determine whether a facility requires licensing as a day procedure centre.

As noted above in 6.3 the Act defines a day procedure centre as:

premises at which any patient is admitted and discharged on the same day for such medical, surgical or other treatment, and in such circumstances, as may be prescribed by the regulations..

The regulations provide that the prescribed treatment and circumstances are:

- (a) surgical treatment that involves the administration of a general, spinal, epidural or major regional block anaesthetic or intravenous sedative otherwise than for the purpose of simple sedation,*
- (b) endoscopic treatment that involves the administration of a general anaesthetic or intravenous sedative otherwise than for the purpose of simple sedation,*
- (c) treatment that involves dialysis, haemofiltration or haemoperfusion,*
- (d) treatment that involves prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent,*
- (e) treatment that involves cardiac catheterisation,*
- (f) treatment that involves the management and assessment of early childhood conditions, or disorders, of children who are less than 5 years of age.*

Therefore a facility which undertakes treatment on a day only basis and the treatment involves the administration of a general, spinal, epidural or major regional block anaesthetic or

⁵⁴ Submission, Private Hospitals and Day Procedure Centres Advisory Committee, page 3.

⁵⁵ Submission, MBF Ltd, pages 6 - 7.

intravenous sedative otherwise than for the purpose of simple sedation is required to be licensed as a day procedure centre. The regulations do however provide two exceptions and these are:

- (a) *emergency treatment provided by a medical practitioner in circumstances that render impracticable the transfer of the patient to a hospital or day procedure centre,*
- (b) *dental treatment provided by a dentist in the course of the practice of dentistry.*

The Issues Paper noted that procedural and technical developments and the increased safety of anaesthesia may mean that using the level of anaesthesia as a basis for licensing decisions may no longer be meaningful.

6.7.2 Submissions

While the Issues Paper did not explicitly seek submissions on the ongoing utility of basing licensing decisions on the use of anaesthesia, a number of submissions addressed the point.

“Considering best possible patient outcomes, the licensing of day procedure centres should still be linked to the level of anaesthesia administered. While there is no doubt that there have been improvements in the safety of anaesthesia, it must be acknowledged that there are a large number of patients who remain at significant risk of complications directly related to anaesthesia.”⁵⁶

“We agree that using anaesthesia as an indicia of whether or not licensing is required may no longer be relevant as it may not be a good guide as to the complexity of the procedure.”⁵⁷

“..the cut off point where simple sedation becomes general anaesthesia is not readily or easily defined in clinical practice. Many variables determine the distinction and it is unique for every patient and instance. This is in marked contradiction to the way it has been so simplistically delineated in the Act to the point that the separation has been used as a primary rationale for basing licensing requirements.”⁵⁸

“The Commission supports the view posed in the Issues Paper that it may be unsafe to ‘base licensing requirements on the level of anaesthesia...’”⁵⁹

The Commission has also drawn attention to the fact that the definition of day procedure centre exempts facilities where dentists carry on the practice of dentistry even where general anaesthesia is used.

“The Issues Paper did not canvas the inclusion of private dental clinics, where general anaesthesia is used, as a category of day procedures centre. The risks from the use of general anaesthesia are as significant in dental procedures as they are in medical procedures. In addition, risks arise from unexpected bleeding, poor infection

⁵⁶ Submission, Australian Council on Healthcare Standards, page 5.

⁵⁷ Submission, MBF Ltd, page 3.

⁵⁸ Submission, Australian and New Zealand College of Anaesthetists, page 2.

⁵⁹ Submission, Health Care Complaints Commission, page 3.

control, absence of suitably qualified practitioners and lack of resuscitation and monitoring equipment. The Commission has received complaints where patients have suffered harm in such situations. The Commission believes there is a strong public interest argument that supports the inclusion of private dental clinics, where general anaesthetics are administered, to be licensed as a day procedures centre."⁶⁰

6.7.3 Background to the exemption for dentistry

Clause 22 of the Dentists (General) Regulation 1996 regulates the use of general anaesthesia and simple sedation in dentistry and provides:

- 1) A dentist must not carry out any procedure forming part of the practice of dentistry on a patient to whom a general anaesthetic has been administered unless the general anaesthetic has been administered by a registered medical practitioner who:
 - (a) is a specialist in anaesthesia, or
 - (b) is accredited for the purposes of administering any general anaesthetic at a public or private hospital where surgery may lawfully be carried out.Maximum penalty: 5 penalty units.

- 2) A dentist must not administer simple sedation by the intravenous route unless the dentist:
 - (a) has received appropriate training in techniques of intravenous sedation and resuscitation, as approved by the Board, and
 - (b) is assisted by another person who is either:
 - (i) a registered nurse (within the meaning of the Nurses Act 1991) who has received training in intensive care or anaesthesia, or
 - (ii) a dentist.Maximum penalty: 5 penalty units.

- 3) In this clause:

“general anaesthetic” means any drug or substance which when administered to a patient will render the patient:

 - (a) unaware of the patient's surroundings, and
 - (b) unable to retain reflex control of the airway, and
 - (c) incapable of understanding and obeying a spoken command.

"simple sedation" means a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, and in which:

 - (a) verbal contact with the patient is maintained throughout the period of sedation, and
 - (b) the drugs and techniques used have a margin of safety wide enough to render unintended loss of consciousness unlikely.

Clause 41 of the previous regulation, the Dentists Regulation 1991, was in similar terms.

⁶⁰ Ibid., page 1.

It has therefore been considered that the dental profession is appropriately regulated in its procedural use of anaesthetics and sedation and that there has been no need for additional regulation via the Private Hospitals and Day Procedure Centres Act. In fact the Medical Services Committee, in expressing its view on the Private Hospitals and Day Procedure Centres Act 1988 - Regulation (Relating to the definition of day procedure centres), made the point that

“The procedures to be followed and the limitations for the performance of general anaesthesia in dentists’ surgeries are covered in the Dentists Act 1989. It was not intended at any time for procedures performed in dentists’ surgeries in accordance with the restrictions imposed by the Dentists Act to come under the Day Procedures Legislation.”

6.8 Conclusion

In practice there is little if any real difference in the licensing process followed for private hospitals and day procedure centres. The legislative distinction between facilities is based on the potential for patients to be accommodated overnight in hospitals which theoretically facilitates the performance of more complex procedures. However, given developments in technology and clinical practice many procedures that required overnight stay less than a decade ago can now be performed safely on a day only basis. Likewise procedures which previously required admission to a day procedure centre and the administration of anaesthesia can now be performed as office based surgery under ‘simple sedation’ as opposed to more extensive anaesthesia.

As noted above the Australian and New Zealand College of Anaesthetists has expressed the view that basing the decision as to whether a facility should be licensed as a day procedure centre or not on the level of anaesthesia is problematic. The College is concerned that the distinction between simple sedation and anaesthesia is both unclear and fine. In the circumstances the College recommends basing licensing decisions on the type of procedure performed rather than the level and type of anaesthesia used.

There seems to be a substantial amount of support for removing the legislative distinction between private hospitals and day procedure centres. Such a move would have a number of advantages including:

- requiring the same standards to be applied irrespective of the physical location in which a procedure is performed; and
- facilitating the use of appropriately equipped day procedure centres as 23 and 36 hour care centres offering limited accommodation and after care services.

Discussion Point 1

Should the licensing of private hospitals and day procedure centres be amalgamated with all facilities being licensed as private health care facilities?

If amalgamation of licensing is supported should facilities be licensed in separate classes based on the type and complexity of procedure performed and if so what classes should be developed? Should any classification based on the type of procedure performed incorporate consideration of the type or degree of anaesthesia used?

Discussion Point 2

Should the licensing standards be based on minimum prescribed inputs or outcome standards or a mixture of the two?

Is it appropriate to adopt by regulation the published guidelines of the learned colleges as an element of the licensing standards?

Should licensing standards include the prescribing of minimum patient throughput for particular procedures and if so which procedures and what level of throughput is appropriate?

Discussion Point 3

Is there a need for licensing to extend to office based surgery carried out by medical practitioners?

Is there a need for licensing to extend to office based surgery carried out by dentists?

7. RESTRICTIONS ON PATIENT CAPACITY

7.1 Background

Section 9(3)(d) of the Private Hospitals and Day Procedure Centres Act provides that an application for a private hospital licence may be refused if approval would result in an increase in the total number of patients who may be accommodated overnight at private hospitals in New South Wales. This restriction is commonly known as the ‘bed cap’.

Given that section 9(3)(d) simply provides the Director-General with grounds for refusing a licence application there is no strict prohibition on new capacity in the private hospital market. The Department of Health does not strictly enforce the bed cap and criteria have been developed for the approval of new private hospital capacity. The criteria are:

- i. there is an identifiable demographic, geographic or other need for the service; or
- ii. the service offers a meritorious innovative clinical service; or
- iii. the service is the result of a tender process sponsored by the Department of Health.

Individuals or corporations wishing to establish a facility which does not meet any of these criteria may have that application approved if they hold existing bed approvals (beds) which can be allocated to that facility or are able to obtain (purchase) beds from another operator. Where the applicant is able to purchase beds it can apply to the Director-General for the beds to be transferred from another operator. This process underlies the market in private hospital beds. There are no geographic restrictions and theoretically beds could be transferred between facilities any where in the state.

The Private Hospitals Act 1908, the original legislation regulating private health facilities in New South Wales which remained in operation until 1988, did not restrict the number of patients that could be accommodated in private facilities. The Private Health Establishments Act 1982, which was in operation between 19 February 1988 and 1 September 1990, allowed for an application to be refused if:

- i. the premises were less than the prescribed distance from an existing private hospital or public hospital (although no distance was prescribed); or
- ii. approval of the licence would result in a local oversupply of facilities of a particular class; or
- iii. approval of the licence would be prejudicial to the economic or efficient delivery of health services in NSW.

The 1982 Act therefore did not impose an explicit restriction on the number of beds or facilities but did allow for overall health service planning matters to be considered in a licensing decision. The current Act is the first legislation to explicitly set out to restrict the number of beds in the market.

No similar restriction exists in respect of day only facilities whether they be stand alone or contained within a private hospital.

7.2 Rationale for the restriction

A number of different rationales are commonly cited for the existence of the bed cap. The most common rationales are those identified by the Productivity Commission and cited in the Issues Paper:

- facilitating orderly industry development;
- promoting equitable access to private hospital services;
- guarding against supplier induced demand; and
- containing health care costs by limiting access to expensive, high technology equipment.

It is questionable whether the restriction on capacity achieves its desired aims and in fact if any legislative mechanism could do so. As the bed cap has been identified as having a significant impact on competition it is necessary to consider whether it serves the public interest and therefore the objectives of the bed cap as well as its costs and benefits must be examined.

7.3 Assessment of the restriction

7.3.1 Assessment carried out by PriceWaterhouseCoopers on behalf of the NSW Department of Health

PriceWaterhouseCoopers (the Assessment Team) found that the bed cap imposes significant costs on the community. Those costs are:

- The cost of purchasing beds on the open market increases the overhead costs experienced by private hospital operators which can be expected to be passed on to patients in the form of higher fees.
- Costs to economic efficiency in that competition and innovation within the private hospital industry will be hindered through restrictions on market entry.
- Resource allocation distortions which may manifest in excessive investment in day procedure centres which are not subject to a bed cap.
- Administrative costs of managing the bed cap and approving exemptions, this may result in higher licence fees which may also be passed on to consumers.

The Assessment Team have made the following observations with respect to the costs of the bed cap to the community.

Cost of beds

“[L]imiting patient capacity has created a de facto market for existing private hospital beds where existing beds which are no longer in use are either held ‘in reserve’ or traded on the open market. .. Higher prices for private hospital beds may lead to higher prices for private health care services offered by private hospitals as they may pass on the cost to consumers.”⁶¹

⁶¹ PriceWaterhouseCoopers op cit, page 26.

Costs to economic efficiency

“Limiting patient capacity acts as a barrier to entry to the industry. It also hinders competition and innovation in the industry. In addition, limiting patient capacity via the ‘bed cap’ imposes a significant cost on society as it reduces net social welfare by imposing costs on both consumers and suppliers.”⁶²

Resource allocation distortions

“In addition to the restriction on patient capacity for private hospitals, the market in private hospital beds is also being eroded by the shift of some medical procedures previously performed in private hospitals to day procedure centres that have no restrictions on patient capacity. ...

This uneven playing field may skew the market in favour of day procedure centres and is therefore a cost on private hospitals of doing business which their competitor, day procedure centres, don’t have. This may lead to dynamic inefficiency in the allocation of society’s scarce resources.”⁶³

Administrative costs

“The current restriction on patient capacity imposes administrative costs on the Department in managing the ‘bed cap’ regime. This includes:

- *determination of the bed quota;*
- *granting approval for new bed licences; and*
- *issuance of new bed licences, etc.”⁶⁴*

The assessment team also discussed the benefits to the community that flow from the restriction. These benefits are:

- Controls on over-investment in private hospital capacity.
- A more even distribution of private hospital services.
- Protecting the community from supplier induced demand.
- Protecting investment in public hospitals.

Over-investment in private hospital capacity

“The major potential benefit of limiting patient capacity is to control unfettered and unplanned increase of private hospitals, and to avoid unnecessary duplication of costly facilities.

However, the Victorian Department of Human Services (Vic H&CS) notes;

‘An objective of orderly development implies that the public would not be well served by an environment where competition might result in some private hospitals closing due to poor financial viability or new hospitals opening to compete with existing hospitals. Moreover, it assumes that government has the capacity to judge the optimum size of the private hospital market and to refuse

⁶² Ibid.

⁶³ Ibid, page 27.

⁶⁴ Ibid, page 28.

entry to prospective new proprietors once that limit has been reached. The development of a market in bed licences provides strong evidence of the failure of government to determine the optimum size of the private hospital market.’ (The Role of Government in Regulating Private Hospitals, A Discussion Paper, November, 1995).”⁶⁵

Distribution of private hospital services

“It is argued that one of the benefits of limiting patient capacity is to enable the Government to re-direct private hospital beds from areas of ‘over supply’ to areas of ‘under supply’. The argument assumes that the Government can identify better than the marketplace areas of ‘over supply’ and ‘under supply’ and encourage redistribution of beds from ‘over supply’ to ‘under supply’ areas.”⁶⁶

Supplier induced demand

“One of the major objectives of limiting patient capacity is to minimise the supplier-induced demand effect. The supplier-induced demand phenomenon is a situation whereby a health care provider, usually a physician, influences a person’s demand for health care services due to information asymmetry between the health care providers and the health care recipient. It is argued that if the Government does not limit patient capacity, then the supplier-induced demand phenomenon may arise where the physician, given the existence of information asymmetry, will insist the patient stay overnight at a private hospital, even though the patient’s condition may not warrant an overnight stay.”⁶⁷

Protecting investment in public hospitals.

PriceWaterhouseCoopers also considered that the restriction on capacity has the benefit of protecting the government’s investment in public hospitals.

“As private hospitals are in direct competition with public hospitals, governments can protect their own investments in public health facilities by limiting patient capacity.”⁶⁸

7.3.2 Comment on the costs and benefits of the bed cap as identified by PriceWaterhouseCoopers

Cost of beds

In the current market a bed licence is effectively valued by industry for accounting purposes at nil.⁶⁹ It is therefore unlikely that there is in fact an impact on the cost of private hospital services. That said however, it is true that in the past beds have traded on the open market for substantial sums of money, up to \$50,000 each,⁷⁰ and there may have previously been a significant impact on the cost of services, with a small residual impact on the current cost of services.

⁶⁵ Ibid.

⁶⁶ Ibid, pages 28 and 29.

⁶⁷ PriceWaterhouseCoopers, op cit, page 29.

⁶⁸ PriceWaterhouseCoopers, op cit, page 29

⁶⁹ Submission, Private Hospitals Association, page 12.

⁷⁰ Source, NSW Private Hospitals Association, cited by PriceWaterhouseCoopers The National Competition Policy Review of the Private Hospitals and Day Procedure Centres Act – Economic Assessment, page 26.

It is also worth considering that the write down in the value of bed licences and the current prices for beds on the open market may simply reflect a view within the industry that the bed cap is likely to be abandoned and an unwillingness to outlay capital on an asset that may therefore have no value. Retention of the bed cap may therefore result in a sudden increase in open market prices.

Impacts on economic efficiency

Through restricting entry to the private hospitals market the bed cap may reduce the supply of services available to the public. This can have the effect of increasing demand relative to supply and thereby theoretically drive up prices. While the Department of Health's inpatient statistics show that the overall annual bed occupancy rate for private hospitals in 1999/2000 was 73.8% (with a range of 45.8% for New England up to 82.4% for the Hunter) they also show that the occupancy rate is rising. Furthermore, the statistics provide an overall annual rate with no allowance being taken for periods of particularly low activity such as the Christmas/New Year period, therefore there could be periods in which occupancy rates are significantly higher than the annual figures tend to suggest.

The potential result of the bed cap's impact on economic efficiency could be to reduce the number of patients that can be economically and satisfactorily treated by the private sector. This reduction could have the effect of increasing the burden on the public system, and therefore on society in general, for minor or elective procedures. A further impact may be that patients who might otherwise have been treated within the private system are forced to join a waiting list for the public system in which time their condition may deteriorate with the result that far more intensive and expensive treatment is required and with potential social, economic and emotional consequences for the individual.

Resource allocation distortions

As noted by the Assessment Team the bed cap imposes a restriction, and cost, on private hospitals which is not equally imposed on day procedure centres. This could lead to a relative increase in the number of day procedure centres and an increase in the number and type of procedure undertaken in day procedure centres.

Clearly it is not an objective of the bed cap to advantage day procedure centres relative to private hospitals nor is it an objective to expand the range of procedures undertaken as day surgery. In fact it would be of significant concern if complex procedures were being inappropriately performed as day surgery due solely to the relative ease with which day surgery facilities can be established. There is no evidence that day surgery is being inappropriately used for complex procedures, however if private hospital occupancy rates continue to grow without an expansion in available facilities there may be financial pressures to reclassify certain unsuitable procedures as day surgery.

Administration costs

It is unclear to what extent the costs of administering the Department of Health's Private Health Care Branch are related to the administration of the bed cap. It is also unclear that removing the bed cap would reduce administrative costs. Nonetheless removing the bed cap would at the very least allow the time and resources previously devoted to administering the bed cap to be productively employed in other areas.

Over-investment in private hospital capacity

The argument that the bed cap allows the Department of Health to guard against over-investment in private hospital capacity assumes that the Department is somehow able to recognise the most appropriate level of investment and that it is one of the roles of the Department to protect the private sector from poor investment decisions. This is not an appropriate function for the Department and in all likelihood not an appropriate objective for legislative intervention.

However, the countervailing argument is that the sudden collapse of a private facility, or even a gradual decline in utilisation and services, can have a significant impact on the public system which may be required to manage a sudden increase in patient load, or address complications arising from the fall in standards at the private facility.

Distribution of hospital services

As the following figures on the distribution of private hospital beds demonstrates there has not been a marked shift of beds out of areas of ‘over supply’ into areas of ‘under supply’ over the last decade. (Source NSW Department of Health Annual Reports 1992/3 to 1999/2000.)

Area	90/1	91/2	92/3	93/4	94/5	95/6	96/7 ³	97/8	98/9	99/00
Northern Sydney	1,793	1,563	1,533	1,449	1,548	1,484		1,502	1,640	1,645
South Eastern Sydney ¹	1,270	1,238	1,242	1,246	1,247	1,402		1,159	1,123	1,135
Hunter	427	427	418	423	496	459		459	459	460
Central Sydney	546	535	530	502	510	531		497	458	430
Western Sydney	412	400	393	388	364	384		388	388	372
Central Coast	288	288	310	310	310	310		305	304	300
Wentworth	165	169	170	170	170	169		296 ⁴	296 ⁴	299 ⁴
Illawarra	262	270	273	272	275	270		282	279	278
South Western Sydney	375	366	376	330	330	367		259	250	272
Mid Nth Coast ^{2,5}						396		396	396	408
Greater Murray ²						181		158	158	179
Mid Western ²						102		102	102	116
Northern Rivers ²						151		151	116	105
New England ²						77		72	91	91
Macquarie ²						58		47	51	55
Southern ²						0		0	0	0
Far West ²						0		0	0	0
TOTAL	6,371	6,105	6,094	5,855	6,191	6,341		6,073	6,111	6,145

Notes:

- ¹ Figures for 1992/3 to 1994/5 are an amalgamation of the figures for the Southern Sydney and Eastern Sydney Area Health Services.
- ² The districts were reorganised in 1996 and became area health services, with the same borders, in 1998. Meaningful figures for non-metropolitan areas cannot be provided prior to the 1996 re-organisation.
- ³ Not reported.
- ⁴ Includes Hawkesbury Hospital.
- ⁵ Includes Port Macquarie Base Hospital.

As noted in the Victorian Health Services Policy Review Final Report, November 1999, in relation to the bed cap in Victoria:

“It is evident that the bed cap has manifestly failed as a device for ensuring equity of access to private hospital services. Data supplied to us by the Department of Human Services suggests that the location of private hospitals reflects patterns of private health insurance coverage in the community and possibly the capacity of operators to attract suitably qualified medical practitioners. It stands to reason that proprietors will not seek to open private hospital facilities in areas of likely low demand. The existence of a bed cap will not encourage for-profit proprietors to establish a private hospital in an area where the business will not be viable. Controls which simply limit the number of private hospital beds in the marketplace are necessarily a blunt instrument and may operate to impede the introduction of innovative new services which could better meet changing community needs.”⁷¹

The same observations can be made of the marketplace in New South Wales.

Supplier induced demand

The theory of supplier induced demand was developed to explain the observed incidence of an increase in the cost of medical services and the incomes of medical practitioners in areas where the practitioner to patient ratio was higher. Such theories exist in a number of critiques of neo-classical economic theory but it is only within the study of health care markets that the theory enjoys widespread acceptance.⁷² However, the theory is by no means universally accepted and there appears to be a significant amount of evidence that the theory is at best unproven. As the Productivity Commission notes;

“[T]he theory, and the supporting empirical evidence, remain controversial;

- *Critics argue that conventional economic analysis can explain much of the supplier induced demand phenomenon. For example Paterson [‘A New Look at National Medical Workforce Strategy’, Australian Health Review, 1994, Volume 17 pages 5–42] contends that where consumers value medical services sufficiently to contribute to their cost, an expansion in services in response to increased numbers of suppliers may be no more than the market operating efficiently to satisfy unmet demand.*

⁷¹ Victorian Health Services Policy Review Final Report, November 1999, page 33.

⁷² Auster and Oaxaca, *Identification of Supplier Induced Demand in the Health Care Sector*, *Journal of Human Resources*, Volume XVI, no 1 Winter 1981, 327-342, pages 3-4.

- *However, others argue that this line of reasoning depends on the assumption that consumers of medical services are well informed about their treatment needs. They go on to contend that if this is not the case, there is likely to be scope for doctors to over service, even when consumers are prepared to contribute to the costs of their treatment.*⁷³

Other researchers have also questioned the validity of the theory:

“Patient-based studies, on the other hand, generally find little evidence that physicians induce demand. In an early study .. May [“Utilisation of Health Services and the Availability of Resources.” In Equity in Health Services: Empirical Analyses in Social Policy, ed. R Andersen et al, Ballinger, 1975] reported a positive correlation between the physician-to-population ratio and the number of office visits and visits to outpatient departments. May was careful not to label this physician-induced demand, indicating only that an availability effect was found. Pauly [Doctors and Their Workshops, University of Chicago Press, 1980] .. concludes that physician-induced demand is an issue that can safely be ignored.”⁷⁴

“As we have discussed, physician density, the most frequently cited correlate of inducement, is not consistently important, and its effect is not very large when present. .. physicians initiate medical care for their patients primarily because of their patients’ health status modified by their patients’ financial interests rather than in a way that is consistent only with their own self interest.”⁷⁵ [original emphasis]

The Victorian Health Services Policy Review Final Report was non-committal on the validity of the theory but did nonetheless strongly argue that the ‘bed cap’ was an inefficient means of addressing any such problem and that there were a number of other more appropriate mechanisms for attacking overservicing.

“In an environment of substantial asymmetry of information between consumers and providers of health services, and Commonwealth subsidies for private health insurance, the concern raised in a number of submissions about suppliers inducing demand among consumers for services that may be unnecessary has some foundation. However, other mechanisms exist which are designed to tackle directly the provision of inappropriate or unnecessary health services. For instance, the Commonwealth Health Insurance Act 1974 enables strong penalties to be invoked against health practitioners who are found guilty of overservicing, including removal of their Medicare provider numbers and substantial fines. Such conduct is also punishable by State health practitioner registration boards which are empowered to deregister practitioners who are found guilty of unprofessional conduct. The Health Services Act also requires registered proprietors of private hospitals to be fit and proper to run such establishments at all times, and to ensure that service quality is maintained.

⁷³ Productivity Commission, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra, 1999, page 116.

⁷⁴ Wilensky and Rossiter *Physician-induced Demand for Medical Care*, Millbank Memorial Fund Quarterly Spring 1983, 252-277, page 257.

⁷⁵ *Ibid*, page 272.

*In our view, supplier induced demand is best tackled directly by strong Commonwealth measures to deal with overservicing and by implementing initiatives at both State and Commonwealth level designed to empower consumers and redress asymmetry of information, instead of through indirect means such as a bed cap. If aggressive advertising for private hospital services is proving to be a problem, this could be tackled directly by Commonwealth or State health departments, for instance by developing guidelines on what constitutes misleading advertising in the health context in conjunction with the ACCC and fair trading bodies and mandating the disclosure of specified information to consumers. Advertising controls could be generic or targeted at areas of particular concern such as cosmetic surgery. Care would have to be taken to ensure that any controls on advertising do not unduly restrict competition.*⁷⁶

While not being in a position to say whether supplier induced demand occurs to a significant degree in the private hospitals market, the view expressed in the Victorian review, that the ‘bed cap’ is an inefficient means of regulating for such a phenomena, is supported. The view that there are a number of other more direct and appropriate mechanisms for dealing with any identified problem is also supported.

Protecting investment in public hospitals

The NSW Department of Health considers that the assessment team has overstated the degree of competition between the private and public hospital sectors. It is by no means clear that private hospitals and public hospitals are in direct competition and in many cases it is clear that there is in fact no competition at all. The Productivity Commission reported a significant overlap in the top ten separations recorded for the public sector and the private sector and reported that, amongst other things, this is evidence of competition between the sectors. However the Commission was careful to note the argument that while 19% of private patients, Australia wide, are treated in public hospitals

“a significant number of private patients treated in public hospitals initially enter as ‘emergency’ patients and/or receive treatments not available in nearby private hospitals.”⁷⁷

This view is supported by the submission from Dr KR Burgess of the Peninsula Private Sleep Laboratory, a licensed private hospital:

“..many private patients attend public hospitals because they are taken there by the ambulance service rather than out of choice.”⁷⁸

There is also no account made for those private patients who choose to be treated in a public hospital due to the non existence of private facilities within their local communities or within a reasonable travelling distance of their homes. In this context it is of note that two Area Health Services, incorporating such major communities as Broken Hill, Goulburn and Queanbeyan, have no private hospital facilities. This is also the case in a number of other significant regional centres such as Grafton and Cooma. Clearly the majority of people from

⁷⁶ Victorian Health Services Policy Review Final Report, November 1999, page 34.

⁷⁷ Productivity Commission, op cit, page 92.

⁷⁸ Submission, Dr KR Burgess, Peninsula Private Sleep Laboratory, page 2.

these areas will choose, wherever possible, to be treated within their local communities and that means being treated within the public system. It is also the case that a number of these individuals will choose, for a variety of personal reasons, to be treated as private patients. There is obviously no competition with the private sector for these private patients as the private sector has not seen fit to establish facilities to address their needs.

It is therefore difficult to understand the position that there could be a need to protect the State's investment in public hospitals if this means ensuring that the public sector is not under-utilised. This is further emphasised by the fact that in 1999/2000 the Statewide bed occupancy rate for public hospitals was in excess of 85% and in the metropolitan area, where some 85% of private hospital beds are located, the occupancy rate was over 89%.⁷⁹ It appears that the public system is far from being at risk of under-use and the State's investment does not require protection by restricting the expansion of the private sector.

However, there is an argument that specific specialty services, for example transplant services, should be restricted to a limited number of locations in order to develop and maintain critical levels of expertise and specialised facilities. Allowing for the unchecked and unplanned expansion of these facilities in the private sector is not in the public interest. This issue is discussed in more detail in section 7.6.

7.4 Submissions

A number of submissions addressed this matter with a reasonably even split between those that called for retention of the bed cap, those that called for its removal and those that advocate removal of the cap but implementation of controls on the location of private hospitals.

Submissions arguing for retention of the bed cap

“Healthcare research strongly shows that supply driven demand can lead to an increase in healthcare costs, since over servicing can be used as an (sic) strategy to increase revenue. .. Therefore, there is a risk that in deregulating the number of operators that can enter the private sector, the costs of health care provision would increase significantly.”⁸⁰

“Another issue that would arise from any lessening of the regulation may be an undesired increase in the number of beds available. The market is already saturated with the number of day hospital and private hospital beds. We consider that it is in the interests of quality and the orderly development of health facilities in NSW that the current licensing arrangements should be retained.”⁸¹

“We agree that planning controls are appropriate in this area. We consider that regulating capacity does prevent over-servicing and ensures minimum standards of health care.”⁸²

⁷⁹ NSW Department of Health Annual Report 1999/2000, appendix 5.

⁸⁰ Submission, Medibank Private, page 1.

⁸¹ Submission, MBF Ltd, page 1.

⁸² Ibid, page 6.

Submissions arguing for removal of the bed cap

“The Commonwealth recognises that while some planning controls used by States are required to ensure proper care and servicing, some measures (such as regional bed caps) may not be an appropriate policy tool for limiting supply and encouraging cost control in the private patient market.”⁸³

“Bed licences have virtually no tangible value and have systematically been written down from company /organisation balance sheets over the last 5 years.”⁸⁴

“I see no reason to limit private hospital bed capacity particularly when there is no limitation on day procedure centre bed capacity. The private hospital bed licence system should be abolished. Provided appropriately high standards were maintained by one means or another in any private health care facility then the number of beds in the market place should be determined by the market place.”⁸⁵

Submissions arguing for removal of the bed cap with retention of planning controls

“In the view of NSW HFA, the application of the total bed cap on private hospital bed capacity in NSW is arbitrary. The inclusion of this cap may have had more to do with government ideology than with sound appraisal of the management of community needs. Firstly, such a cap could prove detrimental to the public interest if there were inadequate capacity to cope with increased needs, for example, through the impact of increased take-up of private health insurance and the expected shift of utilisation from public hospitals to private hospitals and day procedure centres.

Secondly, the imposition of the bed cap on private hospitals in the absence of anything equivalent regarding day procedure centres has undoubtedly lead (sic) to distortions in the market. An overall bed cap on a state-wide basis is a very blunt instrument and does not appropriately address community needs specific to hospital and day procedure centre service areas in defined geographic locations.

*...
If the bed cap were to be repealed, then the NSW HFA would only support this with the inclusion of adequate criteria determining patient needs for additional bed capacity in a specific geographic area.”⁸⁶*

7.5 The interstate approach

7.5.1 Queensland

The current legislation regulating private hospitals in Queensland is the Private Health Facilities Act 1999 and the Private Health Facilities Regulation 2000, both of which commenced on 30 November 2000. Under the Act there is no bed cap or other planning controls as such. To the extent that there are planning controls these are effected by guidelines that require a facility with an endorsement for certain specialty services to show a minimum throughput of that specialty during a licensing period.

⁸³ Submission, Commonwealth Department of Health and Aged Care, page 5.

⁸⁴ Submission, Private Hospitals Association, page 12.

⁸⁵ Submission, Dr KR Burgess, Peninsula Private Sleep Laboratory, page 3.

⁸⁶ Submission, NSW Health Funds Association, page 13-14.

The current Act replaced the private hospital licensing provisions of the Health Act 1937 and the Health (Private Hospitals) Regulation 1978. Under the previous Act there was no provision for a bed cap but it appears that at an administrative level a bed cap was imposed in the early 1990s and abandoned in around 1996.

7.5.2 South Australia

Private hospitals are licensed under the *South Australian Health Commission Act 1976* and the *South Australian Health Commission (Private Hospitals) Regulations 1985*. Sections 57D(1)(d) & (e) of the Act require the licensing authority to consider the location and adequacy of existing facilities when determining if a licence is to be granted and section 57D(1)(g) requires the consideration of whether the prescribed limit of hospital beds for the State or region has been reached or exceeded. For those purposes clause 5a of the regulations provides that there is a limit of 5,169 hospital beds, both public and private, that may be provided in an area that is effectively the greater Adelaide area.

7.5.3 Tasmania

The Tasmanian Department of Community and Health Services' Issues Paper for the Review into Tasmanian State Government Licensing Controls of Private Hospitals notes that two of the objectives of the Hospitals Act 1918 are:

- regulation of the level of private hospital provision; and
- regulation of the type of private hospital services provided.

Section 61(5A) of the Hospitals Act 1918 provides that the Minister may refuse to grant a licence on the ground that adequate health care facilities already exist in the locality in which the hospital is proposed to be established.

The Regulatory Impact Statement for the Review of the Hospitals Act 1918⁸⁷ notes that “although the Act does allow the Minister to restrict bed numbers, in practice no restrictions have been applied in recent times.”⁸⁸ The Regulatory Impact Statement concludes that

*“The application of strict bed caps on private hospitals is not considered to be in the public interest as restrictions on the bed supply are likely to lead to an artificially created market in bed licences leading to additional costs to private hospitals which are likely to be passed through as additional costs to consumers.”*⁸⁹

To date the Act has not been amended.

7.5.4 Victoria

Section 83(1)(b) of the Health Services Act provides that in determining whether to register or refuse to register premises as a health service establishment, the Department must consider whether the carrying on of the establishment may result in more than adequate health services of any kind becoming available in the area. In other words there is a bed cap which on its face is more sophisticated and flexible than that in NSW.

⁸⁷ <http://www.dhhs.tas.gov.au/moreinfo/publications/hospital.pdf>

⁸⁸ Page 30.

⁸⁹ Page 51.

However, the Final Report of the Health Services Policy Review argues that the provisions of section 83(1)(b) do not function effectively and should be repealed.

“In summary, the planning controls do not appear to be working effectively and now simply function as an anti-competitive price barrier to new entrants into the private hospital market and those who wish to expand. As we argued in the Discussion Paper, we believe there is little benefit to consumers in maintaining these controls.”⁹⁰

To date the Act has not been amended to remove the bed cap.

7.5.5 Western Australia

Private hospitals are regulated under the Hospitals and Health Services Act 1927. There is no provision allowing for a cap to be placed on bed numbers.

7.6 Conclusion

As noted above the claimed objectives of the bed cap are

- facilitating orderly industry development;
- promoting equitable access to private hospital services;
- guarding against supplier induced demand; and
- containing health care costs by limiting access to expensive, high technology equipment.

It has not been demonstrated that the bed cap delivers, or can deliver, any of these objectives nor that they are in fact appropriate objectives for legislative intervention.

The reasons for the apparent failure of the bed cap to deliver on its objectives include:

- the restriction is state-wide with no capacity to adjust regional bed numbers for demographic profiles; and
- the lack of reliable evidence that the supplier induced demand phenomena is real.

The above discussion also shows that there are a number of costs, which have been described in qualitative rather than quantitative terms, associated with the bed cap. It must be acknowledged that many of these costs, such as administration and the impact of the cost of beds on the cost of services, are minor, and a number of others, such as costs to economic efficiency, rely on speculation about industry behaviour in an unregulated environment. However, when all costs are considered together there are clearly costs to industry and society as a whole from the bed cap.

There has also been identification of a number of benefits that are claimed to result from the bed cap. Of these it appears that the benefit of limiting supplier induced demand should be excluded due to real concerns over the existence of the phenomenon. The benefit of producing a more equitable distribution of private hospital services can also be discounted due to the lack of evidence both as to what an equitable distribution of services might be, given that what constitutes an equitable distribution may be a highly individual assessment, although use of the Department of Health *Resource Distribution Formula* would provide an objective means for assessing the need for private services in a particular area. It is also

⁹⁰ Victorian Health Services Policy Review Final Report, November 1999, page 32.

highly questionable whether the bed cap could have any impact on the distribution of services given that fact that it is not regionally based.

The claimed benefits of preventing over investment in private hospitals and protecting the State's investment in the public health system may deliver benefits to the community although a blanket statewide limit on the number of private hospital beds is an inefficient and clumsy means of achieving those benefits.

Reviews carried out in other States have recommended removal of bed caps and the economic assessment carried out by PriceWaterhouseCoopers found that the costs imposed on the community as a result of the bed cap outweigh the benefits it delivers.

Submissions have been divided on the issue, however it is clear that most stakeholders, with the notable exception of health funds, favour removal of the bed cap. While those individual health funds that addressed this matter argued in favour of retaining the bed cap the industry association has argued that the bed cap should be removed and replaced with a type of regional planning control.

Therefore the Department of Health considers that the bed cap should be removed as it has not been demonstrated that it has achieved its objectives nor is there evidence that it delivers a net benefit to the community.

Recommendation 3

That the restriction on private hospital patient capacity be removed.

Discussion Point 4

Should the restriction on private hospital patient capacity be replaced with a regional hospital capacity planning mechanism?

Submissions advocating a regional planning mechanism should demonstrate that the public interest requires such a mechanism, including demonstrating that government planning will deliver benefits in excess of those that can be delivered by the market, and describe the type of planning controls envisaged.

8. APPROVALS IN PRINCIPLE

8.1 Background

An important part of the licensing process for both private hospitals and day procedure centres is the granting of an approval in principle (AIP). When an application for a licence is made the Director-General can either grant an AIP or refuse the application. The applicant must address the licensing standards and probity requirements of the legislation in order to obtain an AIP. Applicants must therefore consider the design and structural standards imposed by the Act and Regulations in preparing their application. Approval of the design gives an early indication as to whether the structure of the hospital meets the applicable licensing standards thus, in theory, avoiding the need for structural changes before the licence application is finally determined.

An AIP expires after one year unless it is extended by the Director-General.

There are a number of reasons for the use of the AIP process. The most obvious reason is that there is a clear need for private facility developers to have a guarantee that a facility will be granted a licence before investing the significant amounts of time and money required to build or redevelop a site as a private hospital or day procedure centre. In the case of private hospitals this need is compounded by the bed cap and the potential for a development to be rejected due to the inability of the applicant to purchase beds on the market or meet one of the exceptional criteria applied by the Director-General of Health. Other reasons include:

- Administrative efficiency is enhanced in that many of the inquiries that must be undertaken in assessing an application can be carried out early on in the process rather than at the stage where a facility owner is striving to get the facility open and earning revenue in the shortest possible time. This can also allow the applicant to resolve any significant impediment to an approval early on in the process.
- Under existing arrangements many local government authorities require that developers provide them with evidence of the Director-General having granted an AIP before a development application will be considered.
- The issuing of AIPs may, particularly for significant private hospital developments which take many years to eventuate, provide the Department with useful information to guide forward planning of public services.
- An AIP can be of substantial benefit to private developers in their capital raising activities and there is a view that receipt of an approval in principle increases the value of a speculative development site. While these matters should clearly not be a relevant consideration for the Department in considering the utility of the AIP process they are nonetheless benefits that flow from it.

8.2 Possible amendments to the approval in principle process

Because an AIP is valid for twelve months there is an expectation created that the relevant development will be completed within that twelve-month period. While this is sometimes the case there are a number of projects which, for a variety of reasons, run over the twelve-month limit. In such cases developers can have the AIP extended if the submission of a development timetable has been made a condition of the AIP and there has been a reasonable attempt to comply with the timetable.

However it is also the case that a significant number of AIPs have been granted for speculative projects which have been the subject of requests for multiple extensions. That is, applicants have applied for an AIP, knowing that it can be extended and have sought multiple extensions often over periods in excess of five years.

When an application is made for a licence (and an AIP is granted) the applicant is required to provide specific information about the proposed facility and its significant personnel. There is, however, no requirement for similar information to be provided when an AIP is extended nor is there any opportunity for a fee to be charged. This is in contrast to the annual renewal of a licence. Section 17 of the Act provides that a licensee must pay an annual fee, set by clause 9 of the Regulation, when renewing their licence. Furthermore clause 20 of the Regulation provides that specific information, including the details of directors and major shareholders of a licensee corporation, must be provided with the annual licence renewal. Information about any change in the directors or major shareholders of a corporate licensee must also be supplied as soon as practicable after the change occurs.

There are a number of clear rationales for extending these obligations to holders of AIPs. These include:

- there is an administrative cost to the Department of Health in extending an AIP, which is a valuable asset in the hands of a developer, and currently this cost cannot be recovered; and
- the Department of Health conducts fitness and probity testing of applicants, including the directors, executive officers and significant shareholders of corporate applicants, in the case of licensees fitness and probity testing is undertaken whenever there is a change in these details but such testing is not carried out when there is a change in the details of the holder of an AIP.

The Issues Paper proposed that AIPs should be granted for the duration of the project, rather than for a fixed period of 12 months, with the proviso that the applicant produce evidence of a building development application or approval, or where no such approval is required evidence of a signed building contract and development timetable. Submissions on this issue were mixed with 50% supporting the proposal in the Issues Paper and 50% rejecting it in favour of retaining fixed terms for AIPs.

8.3 Conclusion

The Department of Health considers that the AIP process has substantial utility for both the Department and for the developers of private health facilities. It is, however, clear that the utility of the process, from the Department's perspective, is somewhat compromised by the length of time that many developments take to complete and the resultant lengthy extensions that are granted.

Therefore modification of the AIP process may be in order. Potential modifications could include:

- granting AIPs for an unrestricted period, or for the life of the project;
- granting AIPs for a fixed period with an option to apply to renew an AIP subject to the provision of specified information and the payment of a fee;
- requiring holders of AIPs to advise the Department of Health of significant changes in their structure, ownership or management; and

- requiring holders of AIPs to advise the Department of Health of progress in completing a development.

Discussion Point 5

What role does the approval in principle process serve? How should the process be modified, if at all, to ensure that it fulfils that role?

Should an annual fee be charged for the retention of an approval in principle and should holders of approvals in principle be required to periodically provide the Department of Health with specific information about their corporate structure, ownership, management and development progress?

9. BUILDING DEVELOPMENT

9.1 Background

As the Issues Paper noted the Private Hospitals and Day Procedure Centres Act provides for the regulations to include design and construction standards for facilities. The Act also provides that a facility may not be altered or extended unless the Director-General of Health has given approval.

The Issues Paper sought comment on the requirement for the Director-General to approve alterations and extensions, however there was no discussion of the continued efficacy of including in the legislation the power to regulate for design and construction standards. Clearly there is potential for the standards set under the Act to overlap or contradict with building standards set under the Building Code of Australia (BCA96). BCA96 is administered by local government in its role as the consent authority for building and development applications.

9.2 Current regulation

In terms of the design and construction of premises both the Private Hospitals Regulation and the Day Procedure Centres Regulation provide that each facility must have adequate ambulance access. Each regulation also provides a number of additional design and construction standards for facilities in particular classes or with particular licence endorsements. In the case of private hospitals additional building requirements are prescribed for obstetric and psychiatric class facilities and for facilities with endorsements for cardiac catheterisation, emergency services, dialysis, open heart surgery, intensive care and neonatal intensive care. In the case of day procedure centres facilities in the dialysis and cytotoxic classes and those with an endorsement for cardiac catheterisation must comply with additional standards.

In addition to allowing for the prescribing of standards for particular classes of facilities the Act stipulates that any alteration or extension to a licensed facility requires the Director-General's approval. The Issues Paper noted that this requirement may confer an unfair advantage upon facilities which already have the capacity to provide such services without making alterations or additions to their premises.

Local Government is responsible for ensuring the structural integrity and fire safety of buildings. Therefore the role of the Department of Health could be limited to certifying the design suitability of those areas of the building associated with clinical practice, and the related fittings, fixtures and equipment, associated with services that impact on patient care and safety. This is in effect what the existing prescribed standards relate to.

9.3 Submissions

Submissions in this area were divided three ways:

- i) those that advocated the status quo, that is an active role for the Director-General in all design matters;

- ii) those that considered the Director-General's role could be limited to the design of clinically significant areas only; and
- iii) those that considered that local government should be solely responsible for assessing and approving the design of facilities.

*"Private operators agreed that the Department generally played a useful and helpful role to facilities. It was agreed that there were often concerns about the inappropriate location of things such as coffee shops in the midst of counselling areas."*⁹¹

*"The Department's role in building development alterations and extensions in private health care facilities should be limited to facility modifications .. of major clinical infrastructure only."*⁹²

"We submit that the requirement for the Director-General of Health's approval for alterations and extensions for such things as coffee and florist shops are unnecessary. We agree that Local Government should be responsible for ensuring the structural integrity and fire safety of buildings."

*The Department of Health should be limited to certifying the design and suitability of those areas of the building associated with clinical practice and the related fitting, fixtures and equipment associated with such practice."*⁹³

*"NSW Department of Health should no longer have a role associated with the undertaking of building development, alterations or extensions in private health care facilities. However, NSW Department of Health should work collaboratively with Local Government to ensure clinical issues in building alterations are appropriately identified and undertaken."*⁹⁴

9.4 Conclusion

The Building Code of Australia (BCA96) is administered by the Australian Building Codes Board (ABCB) and applied by local government in approving development and building applications. Class 9a of BCA96 contains detailed design and construction standards for hospitals. Given that a detailed set of standards exist for the design and construction of hospitals it is questionable whether the officers of the Department of Health can effectively add value at the general design and construction stage of private health care facilities.

However, a compelling case can be made for the Department to continue to be involved in the design and equipping of clinical facilities, such as intensive care and emergency units, theatres and treatment rooms. Such a role could see the regulations setting out minimum standards for the fitting out of particular facilities and retain within the Department the ability to inspect facilities for compliance and order remedial action where the prescribed standards are not met. One option is to require by regulation that facilities comply with the Department of Health's *Health Building Guidelines*.

⁹¹ Submission, Private Hospitals and Day Procedure Centres Advisory Committee, page 3.

⁹² Submission, Private Hospitals Association of NSW Inc, page 13.

⁹³ Submission, NSW Nurses Association, page 5.

⁹⁴ Submission, Greater Murray Area Health Service, page 2.

Comments are sought on the type of clinical areas which should be regulated and the manner of that regulation.

Recommendation 4

That the legislation continue to prescribe minimum standards for clinical areas within private health facilities but that in all other respects approval, design and construction of facilities be regulated by local government or the Planning NSW as the case may be.

Discussion Point 6

Which clinical areas should the legislation set standards for? What should those standards encompass? How should regulation be effected?

10. STAFFING

10.1 Background

The Private Hospitals and Day Procedure Centres Act defines a private hospital as:

premises at which any patient is provided with medical, surgical or other treatment, and with ancillary nursing care, for fee, gain or reward, ...

Clearly nursing care is central to the concept of private hospitals as regulated by the Act. There is no similar requirement for ancillary nursing care in the definition of day procedure centre.

Section 41 prohibits the conduct of a private hospital or day procedure centre unless there is a person appointed to carry out the duties of chief nurse. The chief nurse is required to be a registered nurse who holds such additional qualifications as are prescribed. In addition, section 43 requires that there is to be a registered nurse on duty in the private hospital or day procedure centre at all times when the establishment is being conducted.

The Issues Paper noted that the requirement that there be staff with specific qualifications may impose restrictions on a facility and impose unnecessary costs without meeting the facility's particular needs and providing any real benefits to patients.

10.2 Submissions

Submissions overwhelmingly supported retaining the requirement that there be a registered nurse on duty at all times when a facility is being conducted. There was also strong support for the retention of the role of chief nurse, although a number of submissions suggested modification of the provisions relating to the chief nurse.

10.2.1 Chief Nurse

Most submissions supported the retention of the role of the chief nurse although there was some disagreement as to whether there should be a chief nurse for each individual licensed establishment or if establishments in the same group could share the services of a single chief nurse. There was also comment that the role of chief nurse is redundant in certain types of facility, specifically sleep laboratories.

*"[C]oncerns have arisen and will continue to do so in demanding that the chief nurse is positioned full time at each site. Greater flexibility is required to support modern, flat management structures and to recognise modern telecommuting in support of multi-site responsibilities."*⁹⁵

"The Committee was however strongly of the view that the current requirements of a chief nurse and a registered nurse on duty at all times should be retained. The Committee considered the chief nurse should be an appropriately trained nurse with

⁹⁵ Submission, Private Hospitals Association, page 13.

sufficient knowledge, skill and experience to adequately supervise both nursing care and personnel so as to ensure patient safety and quality of care.”⁹⁶

*“In line with the public sector we suggest replacing [the title] Chief Nurse with Director of Nursing (DON), Senior Nurse Executive or Senior Nurse Manager. Such terms as matron (section 42 of the Act) are outdated and are no longer acceptable to the profession.”*⁹⁷

*“For a sleep laboratory, probably for any modern private hospital, the duties of a chief nurse could easily be carried out by a ‘public officer’ and are certainly irrelevant to the running of a sleep laboratory.”*⁹⁸

10.2.2 Registered nurse on duty at all times.

As with discussion of the requirement for a chief nurse most submissions were solidly in support of retaining the requirement that a registered nurse be on duty whenever a licensed facility is being conducted. Once again there was comment that there is not necessarily a need for a registered nurse to be on duty at all times in certain types of facility, specifically sleep laboratories, unless nursing care is to be provided.

*“[W]ith regard to .. the requirement for a registered nurse to be ‘on duty in the private hospital or day procedure centre at all times when the establishment is being conducted’ – the College strongly endorses this requirement. ..it is the patient who will suffer if a registered nurse is not present.”*⁹⁹

*“ACHS would be concerned if a registered nurse was not required to be on duty at all times.”*¹⁰⁰

*“With regard to having a registered nurse on duty whenever the facility is being conducted, I think that it is a reasonable requirement that should remain for institutions providing nursing care to patients. That is not the case in a sleep laboratory so it is inappropriate for a sleep laboratory, but very appropriate for a general private hospital or day procedure centre.”*¹⁰¹

10.3 Conclusion

The Department is of the view that the title ‘Chief Nurse’ should be replaced with the title ‘Director of Nursing’.

It is clear that the concept of nursing care is central to the provision of private hospital services. Given this situation it can be argued that a facility that provides treatment that does not require ancillary nursing care is by definition not a private hospital and should not be

⁹⁶ Submission, Private Hospitals and Day Procedure Centres Advisory Committee, page 3.

⁹⁷ Submission, Office of the Chief Nursing Officer, page 3.

⁹⁸ Submission, Dr KR Burgess, Peninsula Private Sleep laboratory, page 4.

⁹⁹ Submission, Australian and New Zealand College of Anaesthetists, page 1.

¹⁰⁰ Submission, Australian Council on Healthcare Standards, page 5.

¹⁰¹ Submission, Dr KR Burgess, Peninsula Private Sleep laboratory, page 4.

licensed as one. Furthermore submissions on this matter were overwhelmingly supportive of retaining the current staffing requirements for private hospitals.

However, the definition of day procedure centre does not include a reference to nursing care and the argument is not as clear cut in this situation. Nonetheless, given the number of increasingly complex procedures being performed in day procedure centres it is proposed to retain those requirements. This conclusion is further reinforced by the Department's view that there may be good reason to remove the legislative distinction between private hospitals and day procedure centres and replace it with a single category of private health facility with a number of separate licensing classes.

However, if facilities providing office type surgery are required to be licensed, or have the option of becoming licensed, it may be argued that it is not necessary to require them to provide ancillary nursing care. Therefore while the Department is of the view that there should be a registered nurse on duty at all times when a facility providing hospital type services is in operation it does not necessarily follow that this should be extended to facilities which only provide office type surgery.

It is also the Department's view that a director of nursing should be required in all facilities providing hospital type services. However, again it does not necessarily follow that this should extend to facilities that only provide office type surgery.

The question of whether each facility requires a dedicated director of nursing warrants further consideration. It is conceivable that in certain circumstances a single director of nursing could be responsible for more than one facility, although obviously each of those facilities would require a registered nurse on the premises to be responsible for management of the nursing staff on duty at any particular time.

Recommendation 5

That the requirement for each private health care facility providing hospital type services to appoint a chief nurse be retained with a change in title to Director of Nursing (with additional consideration to be given to whether each facility requires a dedicated DON).

The requirement that each private health care facility providing hospital type services have at least one registered nurse on duty at all times whilst the facility is being conducted be retained.

Discussion Point 7

Does each individual private health facility require a dedicated Director of Nursing or is it possible for a Director of Nursing to be responsible for more than one facility? If it is possible for a Director of Nursing to take responsibility for more than one facility in what circumstances should this be permitted?

Discussion Point 8

If facilities providing office type surgery only are able to become licensed what sort of staffing requirements should apply? Submissions should detail the type of staffing arrangements considered appropriate and consider the impact of those arrangement on patient safety and amenity.

11. ENFORCEMENT

11.1 Powers of entry

11.1.1 Background

The Act provides that authorised persons may enter and inspect licensed premises and those premises the subject of an approval in principle. Authorised officers are also entitled to inspect the records maintained in a licensed facility. However, difficulties arise when complaints are received about unlicensed premises to which authorised officers have no right of access. This makes it difficult to prosecute persons who operate unlicensed premises in contravention of the Act. While there have been no experiences of facilities being used illegally as private hospitals, cases of problematic medical and/or surgical care in unlicensed day procedure centres which, prima facie, suggest a violation of the Act, are not uncommon.

It is not unusual for legislation to contain a provision to enable an authorised justice to issue a warrant to enter and inspect premises if satisfied that entry has been refused, or it is not appropriate to approach the person in charge of the premises to seek entry as such an approach would be prejudicial to the investigation of the matter. The Issues Paper noted that as an alternative to approaching a justice, the Director-General could be empowered to authorise entry, if satisfied that there exists sufficient need to enter and inspect unlicensed premises.

It must be clarified that such a power of entry would extend to the rooms of a medical practitioners and potentially dentists if there was evidence that the rooms were being used illegally as a private health facility.

11.1.2 Submissions

All submissions that addressed this matter supported there being a power for authorised officers to enter unlicensed premises. Those submissions include:

“.. this Association strongly supports a power of entry and inspection into unlicensed premises in the context defined in the issues paper.”¹⁰²

“In light of the increasingly complex interventions that may occur in clinics and doctors’ rooms, we consider that such power is desirable in the interests of patient safety.”¹⁰³

“If they reasonably suspect that services are being provided in violation of the Act power of entry should be permitted.”¹⁰⁴

11.1.3 Conclusion

The Department is of the view that the carrying out of complex procedures of the type that should be performed in a hospital or licensed day procedure centre raises significant public safety concerns. Given that the Act is designed to minimise the risk of harm to patients through the maintenance of high clinical standards in private health care facilities the inability

¹⁰² Submission, Private Hospitals Association of NSW Inc, page 14.

¹⁰³ Submission, MBF Ltd, page 8.

¹⁰⁴ Submission, The Royal Australian College of General Practitioners, New South Wales Faculty, page 3.

of the Department of Health to effectively police illegal practices in unlicensed facilities is a major impediment to successful achievement of the Act's objectives.

Therefore it is recommended that authorised officers have a power of entry to both licensed facilities and to unlicensed facilities where there are reasonable grounds for believing that a breach of the Act is occurring. Given the overwhelming support in the submissions for this proposal it is recommended that authorised officers be able to enter unlicensed premises where they are authorised to do so by the Director-General of Health.

Recommendation 6

That officers who hold a certificate of authorisation from the Director-General of Health be empowered to enter unlicensed premises if they have reasonable grounds on which to believe that a breach of the Act is occurring.

11.2 Extension of the limitation period

The Issues Paper noted that by operation of the Justices Act 1902 an action in relation to an offence under the Private Hospitals and Day Procedure Centres Act must be commenced within six months of the alleged offence. This statutory limitation period places significant constraints on the investigation and prosecution of offences.

The Issues Paper therefore proposed that the timeframe in which action may be taken should be extended to two years from the date of the alleged offence. This period provides a reasonable time for the reporting and investigation of complaints without significantly prejudicing the defendant by allowing an excessively long period of time to elapse before a prosecution is instituted.

All submissions that addressed this point supported the extension of the limitation period to two years.

Recommendation 7

That a prosecution under the Act is to take place within two years of the alleged commission of the offence.

11.3 Self enforcing infringement notice scheme (SEINS)

11.3.1 Background

The Issues Paper discussed the use of SEINS as a mechanism for swiftly and economically dealing with relatively minor breaches of the Act and regulations. The benefits arising from the use of SEINS are:

- the opportunity to finalise a matter administratively removes the need for the parties to expend time and money in court;
- the avoidance of criminal convictions;
- matters can be disposed of quickly; and

- the scale of investigations and the time taken to conduct them can be reduced, producing savings for business and government.

It is essential to note that there always remains the option to defend the matter in Court and a defendant's rights are in no way denied through use of SEINS.

In relation to private health facilities SEINS may be appropriate for lesser offences which do not involve a serious and continued breach of licensing conditions, for example, single offences in relation to patient registers.

11.3.2 Submissions

There was substantial support in the submissions for the adoption of SEINS, although that support is not universal. The Private Hospitals Association has also raised the use of alternative compliance tools such as Provisional Improvement Notices (PINs). PINs operate through the issuing of a notice requiring that specified action be taken, failure to take the required action or appeal the issue of the notice results in penalties for that failure rather than for the matter in respect of which the notice was issued. Clearly failure to comply with a notice could lead to further action on the part of the licensing authority, for example cancellation of a licence, where serious deficiencies within a facility remain unrectified.

*“ On the spot fines would be appropriate for lesser offences. Serious and continued breaches should still proceed to prosecution. ”*¹⁰⁵

*“We also agree with this proposal in the interests of time, efficiency, and quality and safety of care. ”*¹⁰⁶

*“[T]he Committee was generally split between those who did not support the use of this scheme at all in this sector, and those who were equivocal about it. ”*¹⁰⁷

*“The NSW HFA considers that it is not appropriate to a positive health care culture, and could be seen as a punitive approach, to have inspectors responsible for on-the-spot fines for trivial breaches of the regulations. Where there are serious breaches, these are a matter for court action. ”*¹⁰⁸

The submissions from the Australian Day Surgery Association, the Health Care Complaints Commission, the Office of the Chief Nursing Officer and Dr KR Burgess of the Peninsula Private Sleep Laboratory were also supportive of the use of SEINS.

11.3.3 Conclusion

The Department is of the preliminary conclusion that the adoption of SEINS would provide a valuable additional tool for responding to and managing breaches of the Act and Regulations. However, it is also the Department's view that SEINS should only be adopted in cases of breaches of relatively minor provisions of the Act and Regulations and that serious breaches,

¹⁰⁵ Submission, Greater Murray Area Health Service, page 2.

¹⁰⁶ Submission, MBF Ltd, page 8.

¹⁰⁷ Submission, Private Hospitals and Day Procedure Centres Advisory Committee, page 4.

¹⁰⁸ Submission, NSW Health Funds Association, page 16.

including all breaches which impact on, or have the potential to impact on, patient health and safety should be dealt with by way of prosecution.

The use of PINs, as advocated by the Private Hospitals Association, has a great deal to recommend it. This is particularly the case in respect of many of the current licensing standards where there may be shortcomings that do not at the stage they are detected present a risk to patients but which could, if unaddressed, result in misadventure. A PINs system should allow for a range of penalties to apply for failure to comply with a notice ranging from fines up to suspension or cancellation of a licence for the most serious cases where a substantial risk to patients may develop.

Recommendation 8

That SEINS be adopted for minor breaches of the Act and regulations.

Discussion Point 9

Should a Provisional Improvement Notice system be adopted in the legislation? If so what type of matters should it apply to and what type of penalties (eg fines or cancellation/suspension of a licence) and remedies should apply for failure to comply with a notice?

12. OTHER MATTERS

12.1 Insurance and indemnity matters

12.1.1 Background

On 29 June 2001 the New South Wales Parliament passed the Health Care Liability Act 2001.¹⁰⁹ The Act, with the exception of Part 3 of the Act (relating to professional indemnity insurance), received the Governor's Assent on 5 July 2001 and commenced operation.

The Act modifies the law with respect to the recovery of damages for injury or death caused by medical practitioners and other health care providers, and protects medical practitioners, nurses and certain other health practitioners from liability when providing voluntary health care in an emergency. The Act also makes professional indemnity insurance compulsory for medical practitioners and regulates the provision of that insurance.

The stated objects of the Act as set out in section 3 are:

- (a) to facilitate access to fair and sustainable compensation for persons who sustain severe injuries from the provision of health care,
- (b) to keep the costs of medical indemnity premiums sustainable, in particular by limiting the amount of compensation payable for non-economic loss in cases of relatively minor injury, while preserving principles of full compensation for those with severe injuries involving ongoing impairment and disabilities,
- (c) to promote the reasonable distribution across the medical indemnity industry of the costs of compensation for persons who sustain severe injuries from the provision of health care,
- (d) to facilitate the effective contribution by medical indemnity providers to risk management and quality improvement activities in the health care sector,
- (e) to enable the medical profession and the community to be better informed as to the costs of compensation for, and developing trends in, personal injury claims arising from the provision of health care.

It is essential to note that the Act will require medical practitioners, with certain exceptions, to hold approved professional indemnity insurance as a condition of registration and failure to hold cover may be unsatisfactory professional conduct. Therefore all visiting and contract practitioners in private facilities, as well as practitioners who are the owners of private facilities, will be required to hold approved cover. The Act also makes provision for these requirements to be extended to other health professions by way of regulation.

12.1.2 Impact on private health facilities

Schedule 1 of the Health Care Liability Act has made amendments to sections 15 and 21 of the Private Hospitals and Day Procedure Centres Act 1988 to enable adequate insurance or other liability cover to be prescribed and imposed on private health facilities as a licence condition. At this stage no regulation has been made with respect to the insurance cover to be required of private facilities.

¹⁰⁹ The Act is available from the Department of Health Website:
www.health.nsw.gov.au/csd/llsb/legislation/HealthCareLiabilityAct2001.pdf

The Act also enables regulations to be made which can apply the provisions in Part 2, which provide for certain limitations on the damages that can be awarded following an injury, to licensees of private health facilities by including them in the definition of "health care provider".

In the Minister for Health's second reading speech¹¹⁰ when introducing the Health Care Liability Bill to Parliament an undertaking was given that stakeholders would be consulted prior to the making of a regulation in relation to compulsory liability cover. Detailed consideration will be given to the type and level of liability cover that private facilities may be required to hold and whether all types of facility should be required to hold cover. As part of consultation on the question of insurance requirements for licensed facilities, consideration will be given to whether it is appropriate to include licensed facilities in the definition of "health care provider" for the purposes of applying the provisions of Part 2 of the Act.

Discussion Point 10

Should all licensed private health care facilities be required to hold indemnity insurance?

What type and level of indemnity insurance, if any, should private health facilities be required to hold? Should the level of cover required depend on the type of procedure a facility is licensed to undertake?

12.2 The Private Hospitals and Day Procedure Centres Advisory Committee

Part 2 of the Private Hospitals and Day Procedure Centres Act provides for the establishment of the Private Hospitals and Day Procedure Centres Advisory Committee. Section 4 provides that the Committee is to be appointed by the Minister for Health and must comprise at least 6 people who are:

- an officer of the Department of Health,
- a person nominated by the Private Hospitals Association of New South Wales,
- a person nominated by the Australian Medical Association (NSW) Limited,
- a person nominated by the New South Wales College of Nursing,
- a person appointed to represent the interests of health insurance organisations,
- a person appointed to represent the interests of consumers.

The Committee currently comprises 8 members and includes representatives of consumers, the Medical Colleges, the Australian Medical Association, the Health Funds Association, Associations representing private facility operators, and the Medical Services Committee.

The Committee's main function is to provide advice to the Minister on the following matters:

- the effective operation of the Act,
- proposed regulations under the Act,
- such other matters in respect of private health establishments as may be referred to it by the Minister.

¹¹⁰ Legislative Assembly Hansard 19 June 2001 at page 14777.

<http://www.parliament.nsw.gov.au/prod/web/PHWeb.nsf/Hansard?OpenFrameSet>

The Committee meets infrequently and some stakeholders have suggested that it should be reformed. Such reform could include

- revising the stakeholders who are represented on the Committee,
- removing the statutory right of particular groups to a position on the Committee, or
- abolishing the Committee.

Discussion Point 11

Is there a need for the Private Hospitals and Day Procedure Centres Advisory Committee to be retained? If the Committee is to be retained should its composition be reformed?

12.3 Medical advisory committees

The licensing standards under both the Private Hospitals Regulation 1996 and the Day Procedure Centres Regulation 1996 require licensed facilities to establish medical advisory committees. Committees must comprise at least five persons each of whom is a medical practitioner or dentist and may include additional people, for example psychologists or nurses, as determined by each facility. Committees are responsible for:

- advising the licensee on the accreditation of medical practitioners and dentists to provide services at the facility and the delineation of their clinical responsibilities,
- advising the licensee on matters concerning clinical practice at the facility,
- advising the licensee on matters concerning patient care and safety at the facility,
- reporting any persistent failure by the licensee of the facility to act on the committee's advice in respect of the above matters to the Director-General of Health.

The Day Procedure Centre Regulations make an exception from the requirement that a medical advisory committee be appointed for day procedure centres where the only medical practitioners or dentists authorised to practise at the centre are themselves the licensees. However, it is the current practice of the Department of Health that all day procedure centres appoint a medical advisory committee and that where a committee is not required by the regulations it will be required by licence condition.

Given current practice it is important to examine whether medical advisory committees should be required by regulation for all facilities. It is also important to ask whether the current prescriptive composition of committees should be reformed and greater flexibility allowed for licensees to establish committees as best suit the nature of individual facilities.

Discussion Point 12

Should there be reforms to the nature and structure of medical advisory committees? If so what should those reforms be?

12.4 Medical records

Part 6 of Schedule 1 of both the Private Hospitals Regulation and the Day Procedure Centres Regulation contain detailed provisions with respect to the creation and keeping of clinical records and patient access to those records.

Importantly from the perspective of patients both sets of regulations provide that, except in specific circumstances, residents have a right to access the records that relate to them and where necessary be given assistance in interpreting those records.

The New South Wales Government has recently developed draft legislation to govern access by health care consumers to their clinical records. The provisions of the draft Health Records Information Privacy Bill 2001 include:

- Providing that access to health care information held about a person is to be made available to that person on request and that request for access are to be treated consistently irrespective of the health care professional or organisation holding the records.
- Access can be refused in specified circumstances including where access would unreasonably impact on the privacy of another person or would present a serious risk to the physical or mental health of any person.
- Complaints can be made to the Privacy Commissioner and the Administrative Decisions Tribunal about a refusal to grant access where there is a prima facie case for access to be granted.

The Department is of the view that the provisions of the Health Records Information Privacy Bill will provide a comprehensive system for patients from private health care facilities to gain access to their clinical records.

Recommendation 9

That access to health records kept in private health care facilities be governed by the proposed Health Records Information Privacy Act.

APPENDIX A – TERMS OF REFERENCE

1. The New South Wales Department of Health will review the Private Hospitals and Day Procedure Centres Act 1988 in accordance with the terms for legislative review set out in the National Competition Principles Agreement. The guiding principles of the review are that legislation should not restrict competition unless it can be demonstrated that:
 - i) the benefits of the restriction to the community as a whole outweigh the costs; and
 - ii) the objectives of the legislation can only be achieved by restricting competition.
2. Without limiting the scope of the review, the Department shall:
 - i) clarify the objectives of the legislation and their continuing appropriateness;
 - ii) identify the nature of the restrictions on competition;
 - iii) analyse the effect of the identified restrictions on competition on the economy generally;
 - iv) assess and balance the costs and benefits of the restrictions; and
 - v) consider alternative means for achieving the same results, including non-legislative approaches.
3. When considering the matters in (2), the review should also identify and consider:
 - (a) potential problems for consumers seeking to use the services of private hospitals and day procedure centres, and other market failures, which need to be, or are being addressed by the legislation; and
 - (b) whether the effects of the legislation contravene the competitive conduct rules in Part IV of the Trade Practices Act 1974 (Cth) and the NSW Competition Code.
4. In addition to considering the matters identified above, the Department will consider the effectiveness of the current Act.
5. The review shall consider and take account of relevant regulatory schemes in other Australian jurisdictions, and any recent reforms or reform proposals, including those relating to competition policy in those jurisdictions.
6. The review shall consult with, and take submissions from, the profession, relevant industry groups, Government and consumers.

APPENDIX B – SUBMISSIONS RECEIVED

Australasian Day Surgery Association
Australian and New Zealand College of Anaesthetists
Australian Birth Control
Australian Council on Healthcare Standards
Dr KR Burgess (Peninsula Private Sleep Laboratory)
Central Sydney Area Health Service
Centre for Clinical Policy and Research (NSW Department of Health)
Centre for Mental Health (NSW Department of Health)
Commonwealth Department of Health and Aged Care
Dr R Dethlefs
Greater Murray Area Health Service
Health Care Complaints Commission
Illawarra Area Health Service
MBF Ltd.
Medibank Private Ltd.
New South Wales College of Nursing
New South Wales Health Funds Association
New South Wales Nurses Association
New South Wales Psychologists Registration Board
Office of the Chief Nursing Officer (NSW Department of Health)
Private Hospitals and Day Procedure Centres Advisory Committee
Private Hospitals Association of NSW Inc.
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian College of General Practitioners (NSW Faculty)
Royal College of Pathologists of Australasia
Sydney Haematology and Oncology Clinics
Yeoval Multi-Purpose Health Centre
Dr G Zipser

APPENDIX C - COMPLAINTS STATISTICS*Table 1. Total complaints investigated by facility type 1999 to 2001*

YEAR	TOTAL	PRIVATE HOSPITAL	DAY PROCEDURE CENTRE
1999	53	49	4
2000	40	38	2
2001*	48	48	0

* to 30/6/01

Table 2. Complaint referrals by source 1999 to 2001

REFERRAL SOURCE	PRIVATE HOSPITAL			DAY PROCEDURE CENTRE		
	1999	2000	2001*	1999	2000	2001*
HCCC	13	15	27	2	2	0
Direct contact with Department	28	17	11	2	0	0
Other agency	0	0	0	0	0	0
Minister for Health	8	6	10	0	0	0
	49	38	48	4	2	0

* to 30/6/01

Table 3. Complaints by main category 1999 to 2001

COMPLAINT CATEGORY	PRIVATE HOSPITAL			DAY PROCEDURE CENTRE		
	1999	2000	2001*	1999	2000	2001*
Access to records	0	0	1	1	1	0
Adverse treatment outcome	0	0	1	0	0	0
Cleaning	2	3	3	0	0	0
Communication	0	6	12	1	1	0
Facility practices	8	7	20	0	0	0
Fees & charges	2	1	1	0	0	0
Food/catering	2	1	2	0	0	0
General standards of care	10	10	21	0	0	0
Hygiene	0	3	6	0	0	0
Inadequate treatment	9	10	4	0	0	0
Inadequate personnel	1	5	7	0	0	0
Inappropriate care	6	5	20	0	0	0
Inappropriate discharge	0	4	3	0	0	0
Inappropriate transport	0	0	1	0	0	0
Infection control	2	3	9	1	1	0
Interpreter not used	0	0	1	0	0	0
Medication practices	0	0	6	0	0	0
Privacy & dignity	0	0	1	0	0	0
Statutory compliance	0	0	1	0	0	0

* to 30/6/01

The National Competition Policy Review of the Private Hospitals and Day Procedures Act - Economic Assessment

Final Report

7 June 2000

Prepared for the New South Wales Department of Health



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EXECUTIVE SUMMARY

The New South Wales (NSW) Department of Health (the Department) is currently reviewing the *Private Hospitals and Day Procedure Centres Act 1988* (the Act) to determine what changes, if any, are required to reflect the current needs of Government, the community, industry and consumers.

The *primary* focus of the Department’s review is to fulfill the National Competition Policy (NCP) review requirements. As part of the review process, the Department has engaged PricewaterhouseCoopers, Economic Studies and Strategies Unit (ESSU)¹¹¹, to assist with the NCP review requirements. More Specifically, the Department requires the Assessment Team to prepare an independent economic assessment of the following major restrictions on competition:

- the requirement in the Act that private hospitals and day procedure centres be licensed; and
- legislation and administrative practices that impose limits on private hospital capacity.

The Terms of Reference for this economic assessment require the Assessment Team to address the following:

- clarify the objectives of the two restrictions under investigation;
- identify the nature of the restrictions on competition;
- analyse the likely effect of each of the restrictions on competition and on the economy generally;
- assess and balance the costs and benefits of the restrictions; and
- consider alternative means for achieving the same result including non-legislative approaches.

The Department requires the Assessment Team to focus principally on the two major restrictions mentioned above because these are considered by the Department to be the most significant in terms of potential costs and benefits. This was further confirmed at the consultation meeting with the Department.

In consultation with the Department, the Assessment Team has undertaken a targeted consultation program in accordance with that required for a specific industry assessment. This ensures that any interested party has had a reasonable opportunity to participate in the assessment. Consultations and participation also form a major basis for the collation of the information necessary to conduct the public benefit analyses required for the assessment.

Clarifying the objectives

In line with the Terms of Reference, the Assessment Team is required to clarify the objectives of the two major restrictions under investigation. Clarifying the objectives of the restrictions enables the Assessment Team to understand the types of outcomes, and hence benefits, that each restriction is intended to provide.

¹¹¹ Hereafter referred to as the “Assessment Team”.

Objectives of the licensing restriction

The Assessment Team considers the key objectives of the licensing restriction are to:

- protect public health and safety;
- ensure quality of health care provision;
- reduce the physical and financial risks to the public; and
- promote public confidence in the private health care system.

Objectives of restriction on patient capacity

The Assessment Team considers the key objectives of limiting patient capacity are to:

- provide a means for planning controls;
- control over-investment in private hospitals;
- achieve more even distribution of private hospital services; and
- protect consumers from supplier induced demand.

Assessment of licensing restriction

Under the current Act, private hospitals and day procedure centres operating in NSW are required to be licensed. Licensing is a restriction on competition because it permits entry to the industry only to those holding a license. It may also restrict competition to the extent that it prescribes how private hospitals and day procedure centres are to conduct their operations. The Assessment Team has focussed primarily on the mechanism of licensing, *per se*, the conduct and operational aspects of private health care facilities will be considered in a broader review to be conducted by the Department.

The Assessment Team finds the licensing system to be an efficient means in achieving the objectives of the licensing restriction. Moreover, the four alternative options analysed are not adequate in providing the same outcomes as the licensing restriction, especially in relation to protecting public health and safety, and to reducing physical and financial risks to consumers.

The Assessment Team considers on balance the major benefits of the licensing restriction to outweigh the major costs, and hence produces a net public benefit. In contrast, the Assessment Team finds on balance the major potential costs of each of the four alternative options to outweigh the major potential benefits. Consequently, the Assessment Team recommends *the retention of the requirement in the Act that private hospitals and day procedure centres be licensed.*

Assessment of restriction on patient capacity

Under the current Act, the Director-General of the Department may refuse an application for a licence where the approval would result in the total number of patients who may be accommodated overnight at private hospitals in NSW will be increased. As stated in the Department's Issues Paper:

Not only may this impose restrictions upon new entrants into the field, but it has also created a de facto market in private hospital "beds" which favours existing operators, with "beds" which are no longer in use held "in reserve" by operators and traded on the open market (p.33).

Under present Departmental policy with regard to “new” patient capacity for a new facility or the extension of an existing facility without purchasing existing or reserve beds on the open market, the Director-General will consider the approval for an increase in overall patient capacity if one of the following four criteria is satisfied:

- there is a identifiable demographic, geographic or other need for the increase in the number of private hospital beds;
- the service offered by the applicant is a meritorious, innovative clinical service;
- a service that has been the subject of a Department sponsored tender process; and
- the applicant has purchased on the market existing bed capacity or bed capacity recognised by the Department as being in reserve.

In recent times, the Department has placed conditions upon any new capacity which is granted. In particular, new beds granted cannot be transferred to another facility or held in reserve. This has reduced the potential for new beds to be traded on the open market.

The Assessment Team finds the current legislation and administrative practices that impose limits on private hospital capacity to be an inefficient means of achieving the desired objectives, because the costs significantly outweigh the benefits. In addition, the current system is inadequate and ineffective in addressing one of major objectives that it was designed to achieve i.e. to control the supplier induced demand effect.

Among the four major alternative options, the Assessment Team considers Option 1 (deregulation) to be the most efficient alternative. It reduces significantly the costs of the current regime such as: higher prices for beds and services; costs of economic efficiency; distortion of resource allocation; administrative costs; and measurement errors. At the same time, it allows new approaches to be developed to deal more effectively with the supplier induced demand problem.

On balance, the Assessment Team recommends *that the current practice of restricting bed capacity be abolished and be replaced by a deregulated market for private hospital beds.*

1 INTRODUCTION

1.1 The legislative review context for this assessment

In April 1995, the Commonwealth, State and Territory Governments agreed to implement the National Competition Policy (NCP). In practical terms, this represented a commitment by all Australian Governments to adopt a consistent approach to improving the competitiveness of the Australian economy. Part of the Agreement to implement the NCP between the Commonwealth, States and Territories includes around \$5 billion of payments from the Commonwealth to the States and Territories, with payment depending upon suitable progress being made in terms of implementation.

As part of the process the Governments signed the Competition Principles Agreement (CPA). The legislation review component of the CPA commits Governments to review and, where appropriate, reform all legislation (including subordinate legislation such as regulations) that restricts competition. Subclause 5(1) of the CPA states that the guiding principle of legislation review is that legislation (including Acts, enactments, Ordinances or regulations) should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

1.2 Objective of the assessment

The New South Wales Department of Health (the Department) is currently reviewing the *Private Hospitals and Day Procedure Centres Act 1988* (the Act) to determine what changes, if any, are required to reflect the current needs of Government, the community, industry and consumers.

The review must also address the NSW Government's review obligations arising under the Council of Australian Government's CPA. The CPA is designed to ensure restrictions on competition are fully assessed, and where possible reformed to minimise adverse impacts on competition.

As noted above, the CPA review principle states that legislation should not restrict competition unless it can be demonstrated that the benefits of the restriction to the community as a whole outweigh the costs; and the objectives of the legislation can only be achieved by restricting competition.

The *primary* focus of the Department's review is to fulfill the NCP review requirements. As part of the review process, the Department has engaged PricewaterhouseCoopers, Economic Studies and Strategies Unit (ESSU), to assist with the NCP review requirements. More Specifically, the Department requires the Assessment Team to prepare an independent economic assessment of the following major restrictions on competition:

- the requirement in the Act that private hospitals and day procedure centres be licensed; and

- legislation and administrative practices that impose limits on private hospital capacity.

The Terms of Reference for this economic assessment requires the Assessment Team to address the following:

- clarify the objectives of the two restrictions under investigation;
- identify the nature of the restrictions on competition;
- analyse the likely effect of each of the restrictions on competition and on the economy generally;
- assess and balance the costs and benefits of the restrictions; and
- consider alternative means for achieving the same result including non-legislative approaches.

1.3 The Assessment Team's tasks

The Department requires the Assessment Team to focus principally on the two major restrictions mentioned above because these are considered by the Department to be the most significant in terms of potential costs and benefits. This was further confirmed at the consultation meeting with the Department.

During the assessment process, a number of other restrictions on competition that relate to the prescribed licensing standards and the conduct of private hospitals and day procedure centres were identified. The Assessment Team, however, will not assess the potential costs and benefits of these other restrictions as it is outside the scope of this Terms of Reference. These issues will be considered further in a broader review to be undertaken by the Department.

1.4 Outline of the Report

Chapter 2 outlines the assessment process.

Chapter 3 clarifies the objectives of the two restrictions under investigation. These objectives help to identify the benefits that each restriction is intended to achieve.

Chapter 4 assesses the licensing restriction on competition and presents the Assessment Team's analysis of whether it provides net public benefits. Alternative courses of action are also presented for discussion and recommendation made.

Chapter 5 assesses the legislation and administrative practices that impose limits on private hospital capacity and presents the Assessment Team's analysis of whether it provides net public benefits. Alternative courses of action are also presented for discussion and recommendations made.

2 THE ASSESSMENT PROCESS

This chapter describes the process that the Assessment Team used to conduct this assessment. Section 2.1 briefly describes the current Act regulating private hospitals and day procedure centres in NSW. Section 2.2 provides an overview of the private health sector in NSW. Section 2.3 describes in more detail the assessment process of the two restrictions.

2.1 The current Act

The *Private Hospitals and Day Procedure Centres Act 1988* is the principal legislation that provides for the licensing of private hospitals and day procedure centres in NSW. The current Act has a long history dating back to 1908 when licensing of private health care facilities was first mandated in NSW following the proclamation of the *Private Hospitals Act 1908*. The 1908 Act was subsequently replaced by the *Private Health Establishment Act 1982*. The 1982 Act came into force in 1988 but was later repealed in 1990 following the proclamation of the current *Private Hospitals and Day Procedure Centres Act 1988*. Whilst the 1908 and 1982 Acts provided for the licensing of private hospitals and nursing homes, separate legislation was not drafted until the 1988 Act. The licensing of day procedure centres did not commence until 1992, two years after the commencement of the current Act.

The Act defines a private hospital as:

“... Premises at which patients are provided with medical, surgical or other treatment, and with ancillary nursing care, for fee, gain or reward...”

A day procedure centre is defined as:

“... Premises at which patients are admitted and discharged on the same day for such medical, surgical or other treatment (for fee, gain or reward), and in such circumstances”.

The above definitions do not include institutions conducted on behalf of the state, public hospitals and other facilities operated by area health services, and nursing homes. Private hospitals are not included in the definition of day procedure centres.

2.2 The private health sector in NSW

During 1997-98 the NSW private health sector comprised 89 private acute and psychiatric hospitals and 84 day procedure centres. During this period there were 0.97 private hospital beds available per 1,000 population, including the ACT (which has 2 private hospitals). There were 6476 beds available in private hospitals with 4547 of these located in capital cities.¹¹²

Private hospitals in NSW range from hospitals with fewer than 25 beds to those with over 200 beds. The majority of private hospitals in NSW have between 26 and 100 beds, with only 5 having fewer than 25 beds and 3 having over 200 beds. The

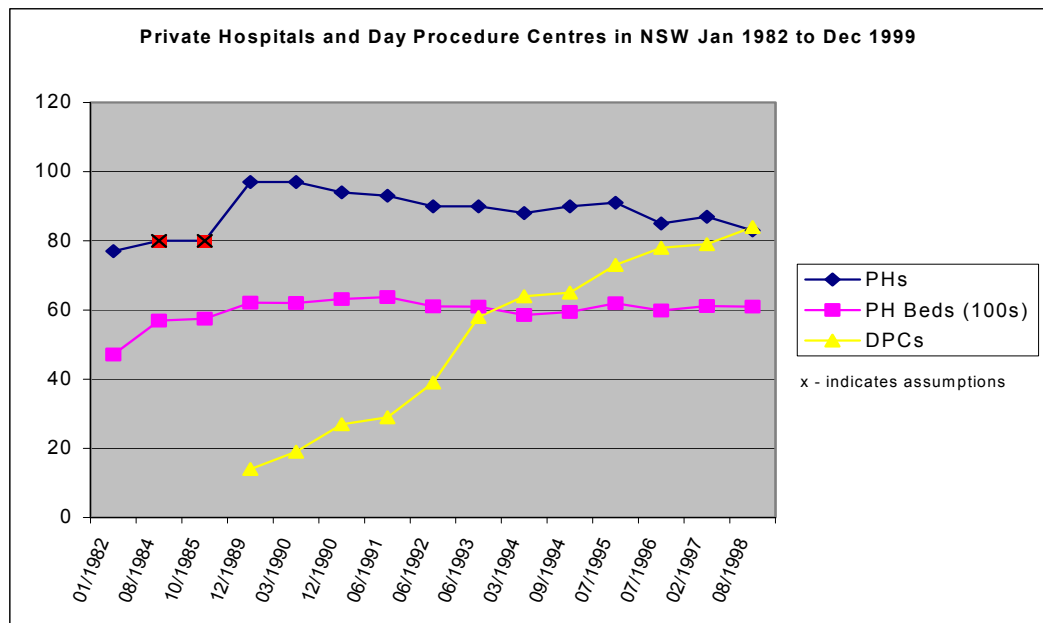
¹¹² All statistics are taken from ABS, Private Hospitals 1997-98, Report number 4390.

smaller private hospitals tend to be converted day procedures centres which have had a niche market in a particular area of surgery and/or care.

Ownership of private hospitals in NSW can be characterised into three broad categories: for profit facilities which consist of corporations; not for profit facilities' which consists of religious and charitable organisations; and other which includes bush nursing, community and memorial hospitals. Day procedure centres are typically owned by individual medical practitioners, resulting in these facilities providing specialised services which generally reflect the specialisation of the medical practitioner

Whilst the number of private hospitals and private hospital beds have remained relatively unchanged over the past decade, the number of day procedure centres has increased dramatically. This is largely driven by technological advances that have increased the range of treatments that can be provided without the need to stay overnight in hospital. Figure 1 presents the trend of private hospitals and day procedure centres in NSW for the periods 1982 to 1999.

Figure 1: Trend of private hospitals and day procedure centres in NSW



Source: NSW Department of Health: Review of the Private Hospitals and Day Procedure Centres Act 1988

2.3 The assessment process

The process that the Assessment Team used to conduct this assessment involved both a consultation process and an analytical process. The consultation process involved detailed consultations with relevant key stakeholders, and the analytical process involved a rigorous economic assessment of the key tasks as outlined in the Terms of Reference. The consultation and analytical processes for this assessment are discussed in more detail below.

2.3.1 Consultation and participation

In order to address the Terms of Reference, the Assessment Team has undertaken a targeted consultation program in accordance with that required for a specific industry assessment. This ensures that any interested party has had a reasonable opportunity to participate in the assessment. Consultations and participation also

form a major basis for the collation of the information necessary to conduct the public benefit analyses required for the assessment.

The Assessment Team discussed aspects of the assessment with many interested parties. Members of the Assessment Team also met with representatives of a number of organisations to: draw out their views concerning this assessment; enable the interested parties to respond to the key areas of this assessment; and draw out other issues that are considered to be critical to this assessment. The list of organisations consulted is included in Appendix A.

2.3.2 The analytical process

The five stages of the Terms of Reference describe in broad terms the analytical process the Assessment Team has used in developing its findings. The major analytical elements are discussed below.

Clarifying objectives of the restrictions

The objectives of the two restrictions under investigation are found in policy statements, parliamentary speeches and sometimes in legislation itself. Clarifying the objectives of the restrictions enables the Assessment Team to understand the types of outcomes, and hence benefits, that the restrictions are intended to provide. It is not the purpose of the assessment to question the merits of the objectives of each restriction. Rather, the assessment provides an opportunity to examine whether the objectives of the restrictions are being pursued efficiently.

Identifying restrictions on competition

There are many ways in which the two restrictions under investigation may restrict competition. The second stage of the assessment process is to identify the nature of the restriction on competition.

Public benefits and costs

There are a number of ways in which to assess whether a restriction on competition produces a net public benefit. By its nature, a public benefit analysis considers the balance of both costs and benefits created by a restriction. Sometimes these may be measured quantitatively, for example, in terms of dollars lost or gained. However, there are many situations in which only some of the costs and benefits can be measured quantitatively.

The various costs and benefits encountered may also be distributed unevenly across the community. As a result, the Assessment Team has sought to identify both where the cost or benefit arises and upon whom the burden (or the benefit) falls.

Alternative approaches

The Terms of Reference requires the Assessment Team to consider alternative approaches to achieving the objectives of the restrictions, including non-legislative alternatives. Such alternatives are sought as it is recognised that it may be possible to achieve the objectives in lower cost ways, preferably without restricting competition. The net public benefit analyses conducted as part of the assessment process provide a relatively objective basis for comparison of the merits of the various alternative courses of action available.

3 CLARIFICATION OF OBJECTIVES

In line with the Terms of Reference, the Assessment Team is required to clarify the objectives of the two major restrictions under investigation. As noted earlier, clarifying the objectives of the restrictions enables the Assessment Team to understand the types of outcomes, and hence benefits, that each restriction is intended to provide. This chapter outlines what the Assessment Team understands to be the objectives of each of the two major restrictions under investigation. Section 3.1 describes the objectives of the present licensing restriction. Section 3.2 describes the objectives of the restriction on patient capacity.

3.1 Objectives of the licensing restriction

As previously mentioned, the licensing restriction is concerned with the requirement in the Act that private hospitals and day procedure centres be licensed.

Under the current Act, private hospitals and day procedure centres that operate in NSW are required to be licensed. It is imperative that the objectives of this restriction are clearly identified and understood because they provide the necessary targets in which to assess whether the licensing system is the most efficient framework to achieve these objectives.

The objectives of the licensing restriction are not stated in the Act, however, section 7(3) of the Act notes:

*The regulations may prescribe standards for or with respect to any matter relating to the **safety, care or quality of life of patients** at establishments,...*

The objectives of licensing may be indistinguishable from the objectives of the Act, as the long title of the Act states:

An Act to provide for the licensing and control of private hospitals and day procedure centres...and for other purposes.

While the Act does not contain any stated objectives, the then Minister's (Minister for Health and Minister for Arts) second reading speech in the Legislative Assembly for the Private Hospitals and Day Procedure Centres Bill in 1988 stated the following principal objectives of the Bill¹¹³:

- to strengthen standards to ensure patient care and safety;
- to reduce economic regulation of the private health sector;
- to eliminate arbitrary and trivial bureaucratic interference; and
- to provide a sound legislative basis for day procedure centres.

After a thorough examination of relevant policy statements and parliamentary speeches, and in-depth consultations with key stakeholders, the Assessment Team considers the key objectives of the licensing restriction are to:

- protect public health and safety;
- ensure quality of health care provision;
- reduce the physical and financial risks to the public; and
- promote public confidence in the private health care system.

¹¹³ Hansard Assembly 29 November 1998, p.3818.

3.1.1 Objectives of licensing regulations in other States

As a way of comparison, Table 1 presents some stated objectives of licensing regulations in other States.

Table 1: Objectives of licensing regulations in other states.

State	Objectives
Victoria	To strike a fair balance between the right of proprietors and developers to conduct their business dealings freely and the right of the community to ensure that necessary clinical services which are of high quality are available throughout the state. To achieve the orderly development, adequacy, improved distribution and avoidance of unnecessary and costly duplication of health services in the whole or part of Victoria.
Queensland	To provide a framework for protecting the health and wellbeing of patients receiving health services at private health facilities.
Western Australia	To provide maximum protection for patients by ensuring there are acceptable minimum standards of care
South Australia	To achieve the rationalisation and co-ordination of health services.
Tasmania	To ensure that hospitals provide care within their staffing and structural capacity and that procedures or services are offered or undertaken only where appropriate support services are provided and safe and effective relevant care can be expected.

Source: Productivity Commission (1999), Private Hospitals in Australia.
Victorian Department of Human Services (2000), A Report on National and International Regulation of Private Health Facilities.

3.2 Objectives of limiting patient capacity

As mentioned, the second major restriction is concerned with legislation and administrative practices that impose limits on private hospital capacity.

Under the current Act, the Director-General of the Department (the Director-General) may refuse an application for a licence where the approval would result in the total number of patients who may be accommodated overnight at private hospitals in NSW will be increased (section 9 (3) of the Act). As noted in the Department’s Issues Paper:

Not only may this impose restrictions upon new entrants into the field, but it has also created a de facto market in private hospital “beds” which favours existing operators, with “beds” which are no longer in use held “in reserve” by operators and traded on the open market (p.33).

The Productivity Commission has identified general rationale for limiting patient capacity:

- facilitating orderly industry development, particularly through reducing the level of unused bed capacity in private hospitals;
- promoting equitable access to private hospital services;
- guarding against supplier induced demand;
- Containing health care costs by limiting access to expensive, high technology equipment.

In addition, the Victorian Guidelines for the Development of Acute Hospital Services 1990 (the Guidelines) made under section 12 of the Victorian Health Services Act 1988 has identified the following objectives of limiting patient capacity:

- avoiding over investment and unnecessary duplication of costly facilities;
- achieving a more equitable distribution of services; and
- preventing over servicing through capping the volume of private hospital services provided.

After a thorough assessment, the Assessment Team considers the key objectives of limiting patient capacity are to:

- provide a means for planning controls;
- control over-investment in private hospitals;
- achieve more even distribution of private hospital services; and
- protect consumers from supplier induced demand.

4 ASSESSMENT OF LICENSING RESTRICTION

As outlined earlier, the Terms of Reference for this assessment requires the Assessment Team to assess the following two major restrictions on competition, namely,

- the requirement in the Act that private hospitals and day procedure centres be licensed; and
- legislation and administrative practices that impose limits on private hospital capacity.

The Assessment Team has adopted the following approach in assessing the two major restrictions on competition:

- identification of the costs imposed by the restriction, be they administrative, compliance or other types of costs;
- identification of the benefits of the restriction;
- assessment of the current restriction in terms of whether the Assessment Team considers it to produce a net public benefit;
- consideration of alternative approaches; and
- provision of recommendations.

Having identified the objectives of the licensing restriction in Section 3.1, the assessment now turns to consider whether the current licensing regime is an efficient framework to achieve these objectives. In addition, as part of the assessment process, the Assessment Team will also evaluate the range of options to achieve the same objectives. Section 4.1 briefly describes the present licensing process. It also examines the costs and benefits of the existing licensing system, and assesses whether the current restriction produces a net public benefit. Section 4.2 considers the range of alternative approaches to achieve the same results as the licensing restriction. Section 4.3 presents the Assessment Team's recommendation.

4.1 Licensing

The Act requires private hospitals and day procedure centres operating in NSW to be licensed. The principal objectives of the licensing restriction, identified in Section 3.1 are to:

- protect public health and safety;
- ensure quality of health care provision;
- reduce the physical and financial risks to the public; and
- promote public confidence in the private health care system.

Licensing is a restriction on competition because it permits entry to the industry only by those holding a license. Licensing may also restrict competition to the extent that it prescribes how private hospitals and day procedures centres are to conduct their operations. The Assessment Team will focus primarily on the mechanism of licensing, *per se*, the conduct and operational aspects of private health care facilities will be considered in a broader review to be conducted by the Department.

The licensing process

An application for a licence of a private hospital or day procedure centre may be made to the Director-General by the person who intends to conduct the facility. In addition to being accompanied by the application fee of \$615 and specifying the class of the establishment, the application must also:

- in the case of day procedure centres, specify the number of procedure rooms; and
- in the case of private hospitals, specify the maximum number of patients to be accommodated in the hospital overnight.

In addition, the application must use ‘Form 1’ as prescribed in the regulations.

Upon receiving the application for a licence for either a private hospital or a day procedure centres, the Director-General may either approve the application in principle or may refuse the application. In addition, the Director-General may impose conditions on an approval of a licence. These restrictions may relate to:

- the design and construction of any building for the purposes of the facility; and
- the preparation and submission to the Director-General of a development timetable for any buildings to be constructed in relation to the facility.

The Director-General may refuse to give approval in principle to an applicant if:

- the applicant is a not fit and proper person to conduct a private hospital or day procedure centre; or
- the proposed facility is incapable of being conducted in accordance with the relevant licensing standards; or
- the proposal is not consistent with the Government’s objectives and policy in relation to the health care sector.

If an application is approved in principle, the Director-General must give the applicant written notice of the approval and any conditions that may apply to the licence. An approval of a license application in principle is effective for 1 year from the date of the applicant is given written approval. Upon the completion of building the facility the Director-General may issue a licence approved in principle. A Temporary licence may be issued if a request is made for a licence in respect of an existing building.

The Director-General may not refuse the application for a licence unless:

- the approval in principle expired before the completion of the construction, alteration or extension of the proposed facilities; or
- the facility was not constructed, altered or extended in accordance with the approval in principle; or
- any other condition to which the approval in principle was subject has not been complied with.

Once a licence is issued it remains in force until it is cancelled under the Act. The licence shall specify:

- to person to whom it is issued;
- the address of the establishment;

- the class of the establishment; and
- in the case of a private hospital the maximum number of patients who may be accommodated overnight.

An annual licence fee is payable on or before 31 December each year. Finally, a licence for a day procedure centre or private hospital is transferable by making an application to the Director-General.

4.1.1 Costs

Compliance costs

The major costs that licensing imposes on private hospitals and day procedure centres are compliance costs. That is, the costs of complying with the requirements imposed by the licensing restriction including an annual licence fee and costs of complying with the licensing standards.

The licensee of a private health care facility is required to pay an annual licence fee to the Department on or before 31 December in each year. Licensing imposes a real financial cost on the private health care proprietors, which may be passed on to consumers. The prescribed annual licence fee for a day procedure centre is \$1,130. The prescribed annual licence fee for a licensed private hospital is presented in Table 2.

Table 2: Prescribed annual licence fee for a private hospital

Number of persons to be accommodated in a private hospital	Licence fee
Fewer than 40	\$1,130
40 – 49	\$1,570
50 – 59	\$2,020
60 – 69	\$2,470
70 – 79	\$2,945
80 – 89	\$3,375
90 – 99	\$3,810
100 or more	\$4,270

Source: Private Hospital Regulations 1996.

According to the NSW Private Hospitals Association,

the costs of complying with the licensing standards comprise about 3 percent of the total construction budget for a new private hospital.

Administrative, monitoring and enforcement costs

The Department incurs direct financial costs in administering, monitoring and enforcing the existing licensing regime for private health care facilities in NSW. In relation to monitoring, the Department grouped private health care facilities into five levels, ranging from high risk (Level 1) to low risk (Level 5). For example, if a private health care facility is in the high risk category (Level 1), then an inspector from the Department may inspect the premise once a month. Whereas, if a private health care facility is in the low risk category (Level 5), then an inspector from the Department may inspect the premise once every 1 or 2 years.

The Department's Private Health Care Branch (PHCB) is responsible for administering, monitoring and enforcing the existing licensing regime. The total

cost of running the PHCB is \$1.35 million per year.¹¹⁴ However, it is virtually impossible to separate out the costs of administering, monitoring and enforcing the licensing regime from the total cost because these are the core businesses of the Branch. However, the PHCB has two full-time staff dedicated to administering the licensing system costing \$100,000 per year, and a database enhancement and administration scheme costing about \$10,000 per year. Given the lack of detailed disaggregated data, the lower bound for the cost of administering the present licensing regime is estimated to be about \$110,000 per year, not including monitoring and enforcement costs.

The PHCB also notes that:

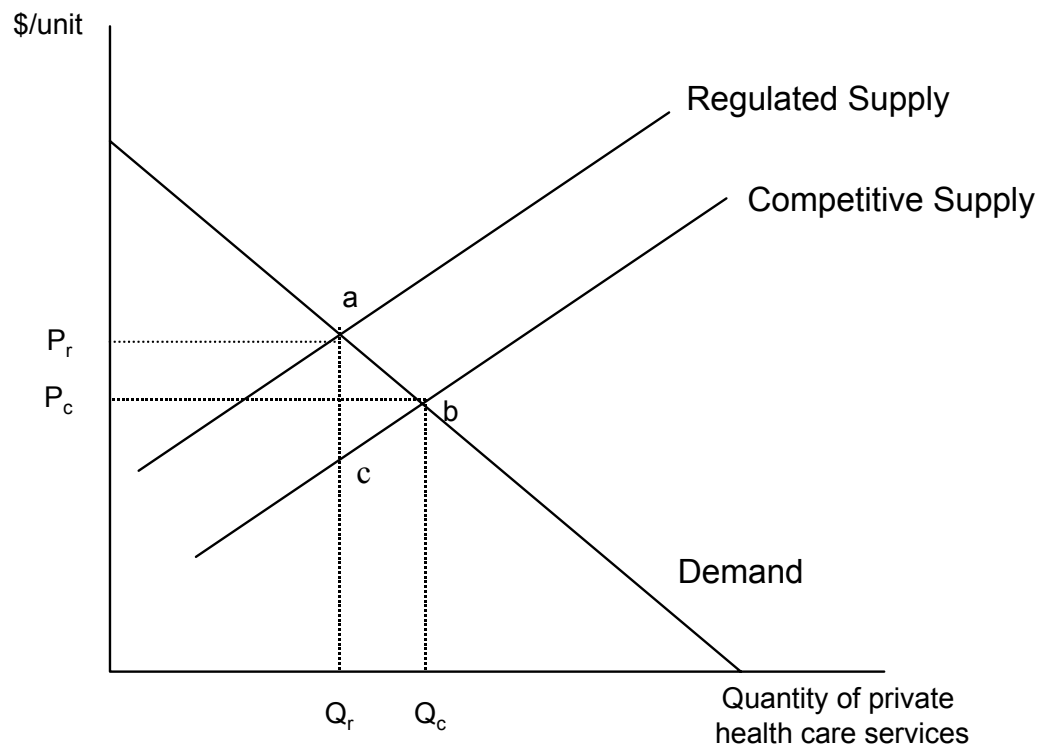
the revenue generated from license fees are covering the costs of administering, monitoring and enforcing the licensing regime.

Costs of economic efficiency

The licensing regime restricts entry into the private health care industry and thereby reduces the competitive pressures on private health care providers. The resulting outcome would be higher prices for private health care services and lower quantity of private hospital services provided. The licensing restriction imposes economic cost to society by reducing the overall efficiency of the industry.

Figure 2 presents a simple demand and supply model for private health care services that illustrates the potential efficiency costs associated with the licensing regime

Figure 2: Costs of economic efficiency



Source: Derived from Logan, Milne and Officer, “Competitive Policy in Regulated Markets” in James (ed.), *Regulating for Competition? Trade Practices Policy in a Changing Economy*, Center for Independent Studies, Sydney, 1989, p.115-139.

¹¹⁴ This includes the costs of administering other private health care establishments such as nursing homes.

In Figure 2, the demand schedule for private health care services shows the quantity of private health care services that are demanded at various prices for private health care services. The supply schedule for private health care services shows the quantity of private health care services that suppliers are willing and able to supply at different prices for private health care services. Market equilibrium exists when the quantity demanded equates with the quantity supplied of private health care services, and net social welfare is maximised.

Under the licensing restriction, market equilibrium exists with Q_r quantity of private health care services are supplied at price P_r . If the licensing regime is removed, the supply schedule will shift to the right, because entry is easier, creating an expansion of services (Q_c minus Q_r) at a lower price (P_c).

The move from licensing to free entry removes the ‘deadweight loss’ associated with licensing. The triangle *abc* in Figure 5.2 represents a loss in economic efficiency because there are a number of consumers who are willing to pay above the competitive market price (P_c) but below the regulated market price (P_r), are denied private health care services because licensing creates a minimum price of P_r .

Dynamic inefficiency and discourage innovation

The licensing restriction may discourage higher standards as its focus is principally on those who are regulated solely on achieving compliance with the regulated standards instead of striving to achieve best practice, innovation and continuous improvement. That is, there may be no incentive for operators to achieve beyond the minimum standards set by the regulations, which may lead to dynamic inefficiency.

4.1.2 Benefits

The major general benefits of licensing are derived from the principal objectives of the licensing restriction as discussed in Section 3.1, namely, to:

- protect public health and safety;
- ensure quality of health care provision;
- reduce the physical and financial risks to the public; and
- promote public confidence in the private health care system.

More specific benefits of licensing are discussed below. Benefits derived from the licensing system are the most difficult to quantify because of the lack of available data, and in most cases these potential benefits are qualitative in nature and not possible to measure. However, where possible, the Assessment Team will provide an appropriate quantitative assessment.

Transparency, consistency and accountability

The licensing system provides a transparent independent model of regulation that all private health care establishments can be measured against. The licensing system through the licensing process attempts to ensure that a person who is granted a licence is a fit and proper person and that the person is able to meet a minimum standard of patient care. The licensing regime also provides a system for accountability to parliament, users and the public in general.

In addition, the licensing model provides private health care operators the benefit of operating in a consistent environment in which the “rules of the game” are not readily changed and where the actions of the licensing authority are subject to the requirements of administrative law.

Compliance, monitoring and enforcement

A critical aspect of the licensing scheme is the compliance, monitoring and enforcement program. A compliance program is a core component of ensuring that the private health care facilities comply with the terms and conditions of their registration and as such reduces the risk of adverse impact on patients.

In particular, the licensing regime provides the Department with the necessary information to monitor whether private health care facilities are complying with the prescribed licensing standards. One of the advantages of the licensing mechanism is that “it has teeth via legislation”. That is, it is enforceable by law, and it equips the enforcement authority, in this case the Department, with the necessary power to punish unscrupulous and substandard private health care providers.

There are penalties within the legislation for persons who breach the regulations or who operate an unlicensed day procedures centre or private hospital. The penalties can either be pecuniary in nature or can be as severe as restricting a person from operating a private health care establishment.

Addressing market failure due to information asymmetry

A licensing system attempts to balance the information asymmetry between the patient and the private health care provider. When consumers seek out health care services, they very often lack the necessary information and knowledge to know what is wrong with them, and what is the appropriate treatment required to restore their health. The consumer mainly relies on the private health care professional to diagnose the condition and to prescribe the appropriate course of treatment in order to restore his/her health. Hence, there is an imbalance in the level of information, or an information asymmetry, between the patient and the private health care provider. Moreover, as noted in the Department’s Issue Paper, the consumer may or may be able to obtain information in relations to:

- quality of theatre and other equipment;
- quality of arrangements in an emergency; and
- appropriate staffing levels and qualifications of staff; and procedures to minimise risks of harm such as infection control standards.

Information asymmetry may also violate the assumption of “consumer knows best” which underlies evaluative policy assessment in much of economics. It is also a significant source of market failure in the health care sector because it gives the health care professionals considerable market power. Market failure may justify a role for government action on the bases of improving efficiency.

Therefore, licensing is one of the mechanisms used to protect the consumers from problems that can arise from information asymmetry associated with health care professionals acting as agents on behalf of their patients in the selection of private health care facilities. Without a licensing system any person could operate a private health care facility and it would be difficult for patients to determine which hospitals are reputable and able to offer safe and consistent medical services. With

regulation ethical operators have an assurance that their less ethical counterparts are required by law to maintain the same basic standards.

Addressing market failure due to externalities

A licensing system attempts to minimise externalities. Health care often creates external effects beyond those which accrue to the recipient of the medical treatment. For example, in an unregulated market for health care, private health care providers may not adopt adequate standards of health care which may impose a significant cost on the public hospital system as the patient may be readmitted to a public hospital due to inadequate treatment or adverse complications. Health funds would also incur a significant cost as a large number of medical services are provided under health insurance arrangements. Therefore, licensing is one of the mechanisms used to internalise the externalities, that is, to minimise the adverse impact of the externalities.

In addition, if private hospitals were not licensed, then the private health care market may be flooded with non-experienced operators which may damage the image and reputation of the private hospitals industry. An oversupply of private health care facilities may also lead to a large number of unqualified staff working at these establishments. This is because of the long gestation period required to train new medical professionals. In this case, private health care facilities would aggressively bid for existing qualified medical professionals which would eventually impose considerable financial pressures on the proprietors of private health care facilities. The overall impact may result in a lower level of provision of private health care services, at least in the short to medium term.

For example, a recent article on “An Analysis of the Causes of Adverse Events from the Quality in Australian Health Care Study”¹¹⁵ found that large number of adverse events resulting from both public and private health care are preventable and associated with human errors and inadequate treatment (see Table 3). This would suggest that the number of adverse events may be higher under an unregulated private health care market than under the current licensing system mainly due to the lack of minimum standards, and monitoring and enforcement measures.

Table 3: Number of adverse events resulting from health care

Category	Frequency	High Preventability
Complication of, failure in, the technical performance of an indicated procedure/operation	1017 (34.6%)	49.5%
Failure to synthesise, decide and/or act on available information	465 (15.8%)	76.3%
Failure to request or arrange investigation procedure or consultation	346 (11.8%)	84.7%
Lack of care or attention, failure to attend	320 (10.9%)	78.1%
Misapplication of, or failure to apply, a rule; or use of a bad inadequate rule	258 (8.8%)	90.3%
Violation of a protocol or rule	140 (4.8%)	79.3%

¹¹⁵ McL Wilson, R., Harrison B., Gibberd R., and Hamilton J. (1999), “An Analysis of the Causes of Adverse Events from the Quality in Australian Health Care Study”, The Medical Journal of Australia, Vol. 170, No. 9.

Unable to use a code	92 (3.1%)	53.3%
Lack of knowledge	33 (1.1%)	100%
Electively practising outside area of expertise	30 (1%)	80%
Questionable practice ethics	14 (0.5%)	92.9%

Source: McL Wilson, R., Harrison, B., Gibberd, R., and Hamilton, J. (1999), "An Analysis of the Causes of Adverse Events from the Quality in Australian Health Care Study", *The Medical Journal of Australia*, Vol. 170, No. 9.

4.1.3 Assessment of the current restriction

The Assessment Team considers the requirement in the Act that private hospitals and day procedure centres be licensed, on balance, is an efficient mechanism to achieve the objectives of this restriction and therefore produces a net public benefit.

The Assessment Team considers the major benefits of the licensing regime in terms of:

- protecting consumers from problems arising from information asymmetry;
- providing minimum standards to minimise negative externalities; and
- promoting safety and quality of health care services,

to significantly outweigh the major costs of complying with the prescribed licensing standards. Moreover, the costs of administering, monitoring and enforcing the licensing regime are closely aligned with the income derived from licensing.

4.2 Alternative approaches

Having analysed the economic impact of the current licensing system, the Assessment Team now turns to consider the four major alternative options for achieving the same results as the licensing restriction including non-legislative approaches.

Option 1: Self regulation

Under self regulation, the Act would be repealed and not replaced. Anyone would be permitted to operate a private hospital or day procedure centre. The private health care industry would rely solely on a combination of civil law, other Acts, and consumer recourse to the courts or trade practices authorities to achieve the same objectives as licensing.

The Department's Issues paper outlines the following framework which would regulate private hospitals and day procedure centres in NSW.

- The Fair Trading Act 1987 (NSW) and the Trade Practices Act 1974 (Commonwealth) prohibit private hospitals and day procedure centres from engaging in deceptive and anti-competitive conduct.
- Consumers could seek action against the proprietor of the private health care facility for negligence or breach of contract through civil law.
- The Local Government Act and Environmental Planning and Assessment Act would continue to regulate the construction and maintenance of premises and the Workers Compensation Act, occupational health and safety issues.
- Complaints could be made to the NSW Health Care Complaints Commission regarding the nature of care provided and related concerns regarding standards of clinical practice.

- The various health professional registration legislation would regulate the conduct of registered health professionals such as doctors and nurses within private health facilities.
- Other public health legislation such as the Poisons and Therapeutics Goods Act, the Public Health Act and the Food Act would regulate various aspects of the activities of private health facilities.

Table 4 presents the major potential costs and benefits associated with the self regulation option.

Table 4: Costs and benefits of self regulation

Major benefits of Self Regulation	Major costs of Self Regulation
Elimination of regulatory costs in administering the licensing regime including administrative, monitoring and enforcement costs. Minimum cost savings of administration would be approximately \$110,000 per year.	Costs associated with market failure due to information asymmetry. Private health care providers will have considerably more market power than consumers. The objectives relating to protecting public health and safety, and to reducing physical and financial risks to consumers may not be adequately achieved.
Private health providers would no longer incur the costs of complying with the licensing standards. This may result in lower prices for private health care services as private health care proprietors pass on the cost savings to consumers.	Related to information asymmetry, consumers may incur high transaction costs as they lack the means to distinguish the quality of private health operators. This means consumers may have to spend more time researching to find a quality operator.
Self regulation may encourage private health care providers to provide more innovative health care services so as to meet the needs of consumers	In a deregulated market for private health care services, proprietors may reduce costs and increase profits which may result in lower standards of patient care and safety. This may lead to lower level of public confidence in the private health care system.
	Costs associated with market failure due to externalities. A lower level of patient care and safety may lead to more patients being re-admitted to public hospitals.
	In a self regulated market compliance costs such as litigation and time spent at tribunals, would be borne by the consumer. Hence the cost of compliance to society will not be removed, it will just shift from private health care facility operators to patients
	There may be a lack transparency, consistency and accountability under self regulation.

It is not possible to quantify most of these potential costs and benefits due mainly to the lack of available data, and some of these potential costs and benefits are qualitative in nature and not possible to measure.

On balance, the Assessment Team considers the major potential costs of self regulation to outweigh the major potential benefits because this regime may be

inadequate in addressing the major objectives of the licensing restriction as identified in Section 3.1.

Option 2: Voluntary third party accreditation

Under this option, anyone is allowed to operate a private health care facility provided the person is able to meet certain accreditation standards. Third party accreditation of a private health care facility refers to a defined process whereby a private hospital or a day procedure centre is measured against and meets a set of standards as set out by the accreditation authority. These standards may be set similar to those as prescribed under the licensing system. However, in contrast to the licensing system, the accreditation model generally operates without legislative support.

In this case, accreditation is a means whereby independent reviewers inspect a private health care facility in order to assess its compliance with the agreed standards relating to its organisational structures and processes.

At present a majority of private hospitals in NSW are voluntarily accredited with the Australian Council on Healthcare Standards (ACHS). Many Health Funds will not enter into a contract with a private hospital unless it accredited with a legitimate accreditation authority. Moreover, in recent years an increasing number of day procedure centres are being accredited.

Major potential costs of accreditation include:

- Non-enforceability of standards. Operators who are unable to meet accreditation standards or through complaints investigation may continue to operate in an unsafe manner.
- Lack of universality of standards. Not all facilities are accredited as the process is a voluntary one. Furthermore, different accreditation bodies may adopt inconsistent standards.
- Voluntary accreditation may not be a transparent process and may not adequately inform the public.
- The loss or lack of accreditation may not be a commercially significant event as some hospitals and many day procedure centres currently manage to function without the need for accreditation.
- Potential increase in costs to consumers if they wish to seek out a higher quality service. This could occur as the standards imposed by the health insurance industry and ACHS may be above the minimum legislative standard.

Major potential benefits of third party accreditation include:

- Elimination of regulatory costs associated with administering the licensing system. Minimum cost savings of administration would be approximately \$110,000 per year.
- Reduction in compliance costs to private health care facility providers.
- More flexible than statutory regulation and are more adaptive to changing circumstances.
- Consumers may experience a higher standard of care than under the licensing regime as accreditation authorities are more able to develop

optimum standards that reflect contemporary consumer views and clinical and management practices.

- Facilities that are already accredited would not incur any additional costs of having to be licensed.
- Complaints could be made to the Health Care Complaints Commission regarding the nature of care provided and related concerns regarding standards of clinical practice.

Again, it is difficult to measure quantitatively these potential costs and benefits because of the lack of available data, and some of these potential costs and benefits are qualitative in nature.

The Assessment Team finds on balance the major potential costs of third party accreditation to outweigh the major potential benefits. In particular, in unregulated private health care environment, this option is inadequate in protecting consumers from physical and financial harm, and in protecting consumer's health and safety.

Option 3: Mandatory third party accreditation

Under this option, the regulatory licensing regime is maintained but the prescribed specific licensing standards are replaced with the standards as set out by a third party accreditation authority. A private health care proprietor must satisfy these accredited standards in order to operate a private health care facility.

The major potential costs of this option are a combination of costs under the licensing and third party accreditation regimes. Other major potential costs include:

- the possibility of higher compliance costs than under the existing licensing regime because accreditation standards are often based upon optimum rather than minimum standards;
- the accreditation authority may use its power to raise entry barriers or exclude parties in an anti-competitive manner which may in the long run create an oligopolistic industry;
- there is a risk that specific powerful interest groups may exert their influence over the accreditation authority to protect commercial interest.
- Consumers may view the accreditation process administered by the industry as less independent and transparent than a Government-administered process.

The major potential benefits of this option are a combination of benefits derived under the licensing and third party accreditation regimes. Other major potential benefits include:

- elimination of direct regulatory costs of the State inspecting and monitoring specific prescribed standards;
- retaining accountability and transparency aspects of the licensing system;
- removal of duplication for the large number of facilities that have already gained accreditation;
- continuation of fitness and probity checks of applicants for licences by the Department;

- retaining the complaint handling and monitoring role; and
- loss of accreditation would result in licence removal.

Again, the reasons for not being able to quantify these major potential costs and benefits are similar to that under the previous option.

The Assessment Team finds this option does not produce a net public benefit as there is a real possibility that it may restrict further entry rather than encourage entry into the private health care industry.

Option 4: Negative licensing

Under this option, minimum standards are imposed on private health care facilities, they are able to offer health care services until being excluded. Exclusion occurs when consumers or other parties complaint about the quality of service. Complaints can be made to the NSW Health Care Complaints Commission.

The negative licensing scheme operates in a similar manner to the self regulation model where any person is free to set up a private health care facility and is not subject to the stringent standards that are imposed under the licensing arrangement. The establishment of a private health care facility will be subject to other legislation such as the Fair Trading Act; the Trade Practices Act; the Local Government Act; and other public health legislation, etc.

To illustrate, Tables 5 shows the number of complaints received for private hospitals and day procedures centres in NSW. Table 6 shows the category of complaints received.

Table 5: Number of complaints received for the financial year 1997 to 1999

Year	Private Hospitals	Day Procedure Centres
1/7/1997 – 30/6/1998	55	5
1/7/1998 – 30/6/1999	44	2
1/7/1999 – 31/12/99	25	2
Total	124	9

Source: NSW Health Care Complaints Commission

Table 6: Categories of complaints received for the financial year 1997 to 1999

Year	Private Hospitals	Day Procedure Centres
Clinical Standards	64	4
Other Ethical Improper Conduct	1	0
Miscellaneous	2	0
Waiting List	1	0
Patient Rights	5	0
Prescribing Drugs	2	0
Quality of Care	37	3
Illness Related	1	0
Business Practices	10	2
Character	1	0
Total	124	9

Source: NSW Health Care Complaints Commission

Most of the major potential costs associated with self regulation also apply to negative licensing. Other major potential costs include:

- as no positive screening occurs, the number of inappropriate private health care operators initially entering the industry may be higher than under a licensing or accredited system;
- some sub-standard operators may be able to operate undetected or act inappropriately before they are detected. That is, licence removal will only occur after the detection of a breach. This is potentially a significant cost given the importance of private health care services; and
- enforcement activities may need to be increased, hence, increasing monitoring costs.

The major potential benefits associated with negative licensing include:

- lower compliance costs as it imposes fewer costs on private health care operators which may result in lower prices for consumers;
- lower administrative costs. While the Government would still incur some continuing administrative costs under negative licensing, it would pick up a small net savings relative to the costs incurred in running a system of positive licensing;
- lower entry barriers as the costs of entry are lower; and
- the threat of licence cancellation may be enough to provide private health care operators with the incentive to provide high quality service.

Again due to inadequate data and the qualitative nature of most of these costs and benefits, it is not possible to provide a quantitative assessment.

The Assessment Team finds on balance negative licensing is a reactive system, that is, private health care providers are punished only after detection of a misconduct has occurred. Therefore, the Assessment Team considers the major potential costs associated with negative licensing, mainly relating to information asymmetry and externalities, to significantly outweigh the major potential benefits of lower compliance and administrative costs.

4.1.5 Conclusion and Recommendation

The Assessment Team finds the licensing system to be an efficient means in achieving the objectives of the licensing restriction. Moreover, the four alternative options analysed above are not adequate in addressing the same results as the licensing restriction, especially in relation to protecting public health and safety, and to reducing physical and financial risks to consumers.

The Assessment Team considers on balance the major benefits of the licensing restriction to outweigh the major costs, and hence produces a net public benefit. In contrast, the Assessment Team finds on balance the major potential costs of each of the four alternative options to outweigh the major potential benefits. Consequently, the Assessment Team recommends *the retention of the requirement in the Act that private hospitals and day procedure centres be licensed*.

Recommendation 1: The Assessment Team recommends the retention of the requirement in the Act that private hospitals and day procedure centres be licensed. This restriction is considered to produce a net public benefit.

5 ASSESSMENT OF RESTRICTION ON PATIENT CAPACITY

Having identified the objectives of the restriction on patient capacity in Section 3.2, the Assessment Team will now assess whether the current *legislation and administrative practices that impose limits on private hospital capacity* are the most efficient means of achieving these objectives. In the process, the Assessment Team will also explore a range of major alternative options for achieving the same outcomes which meet the objectives of the restriction. Section 5.1 briefly describes the present practices that impose limits on patient capacity. It also investigates the major costs and benefits of the existing system, and assesses whether the current restriction produces a net public benefit. Section 5.2 considers the range of alternative approaches to achieve the same results as the restriction. Section 5.3 presents the Assessment Team’s recommendation.

5.1 The current system of limiting patient capacity

As noted earlier, under the current Act, the Director-General of the Department may refuse an application for a licence where the approval would result in the total number of patients who may be accommodated overnight at private hospitals in NSW will be increased. As stated in the Department’s Issues Paper:

Not only may this impose restrictions upon new entrants into the field, but it has also created a de facto market in private hospital “beds” which favours existing operators, with “beds” which are no longer in use held “in reserve” by operators and traded on the open market (p.33).

Under present Departmental policy with regard to “new” patient capacity for a new facility or the extension of an existing facility without purchasing existing or reserve beds on the open market, the Director-General will consider the approval for an increase in overall patient capacity if one of the following four criteria is satisfied:

- there is an identifiable demographic, geographic or other need for the increase in the number of private hospital beds;
- the service offered by the applicant is a meritorious, innovative clinical service;
- a service that has been the subject of a Department sponsored tender process generally as part of a co-location arrangement with a public hospital; and
- the applicant has purchased on the market existing bed capacity or bed capacity recognised by the Department as being in reserve.

In recent times, the Department has placed conditions upon any new capacity which is granted, in particular, new beds granted cannot be transferred to another facility or held in reserve. This has reduced the potential for new beds to be traded on the open market. In addition, the restriction on patient capacity applies only to private hospital developments, there are no similar restrictions placed upon the growth in day procedure centres.

5.1.1 Costs Higher prices for beds and services

As mentioned above, limiting patient capacity has created a de facto market for existing private hospital beds where existing beds which are no longer in use are either held “in reserve” or are traded on the open market.

The NSW Private Hospital Association commented that:

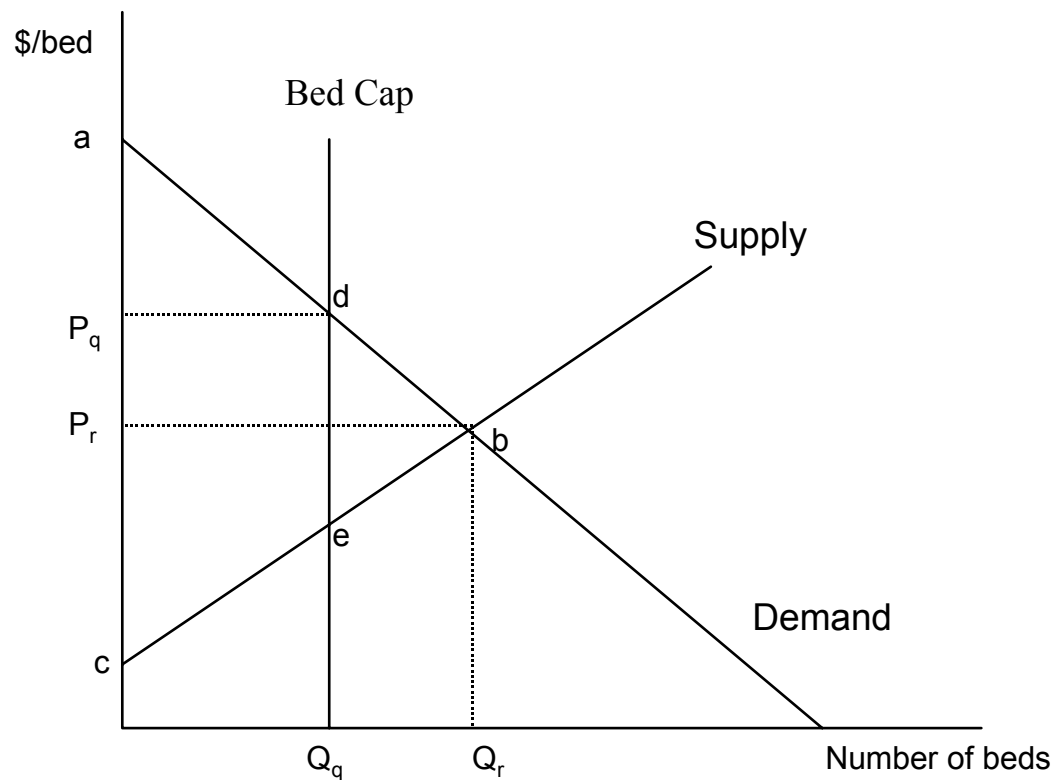
some private hospitals have paid about \$50,000 per bed.

Higher prices for private hospital beds may lead to higher prices for private health care services offered by private hospitals as they may pass on the costs to consumers.

Costs of economic efficiency

Limiting patient capacity acts as a barrier to entry into the industry. It also hinders competition and innovation in the industry. In addition, limiting patient capacity via the “bed cap” imposes a significant cost on society as it reduces net social welfare by imposing costs on both consumers and suppliers. The argument is presented in Figure 3.

Figure 3: Demand and supply for private hospital beds



In Figure 3, the demand schedule for private hospital beds shows the number of beds that are demanded at various prices for private hospital beds. The demand for private hospital beds is a derived demand because it is dependent on the consumers' demand for private hospital services. The supply schedule for private hospital beds shows the number of beds that suppliers are willing and able to supply at different prices for private hospital beds. Economic efficiency occurs at point *b* where the number of beds demanded is equal to the number of beds supplied, in this case, at Q_r no of beds with a corresponding price of $\$P_r/\text{bed}$. In this situation, net social welfare is maximised and is represented by the area of the triangle *abc*.

Now suppose the “bed cap” is set at Q_q number of beds with a corresponding price of $\$P_q/\text{bed}$. At the price of $\$P_q/\text{bed}$, purchasers who were willing and able to buy private hospital beds at the price of $\$P_r/\text{bed}$ are now no longer able to afford the beds. In addition, due to the “bed cap”, suppliers who were willing to supply Q_r number of beds are no longer able to do so. Social welfare is now represented by the area *adec*, and the loss in welfare resulting from the “bed cap” is represented by the area of the triangle *dbe*.

Another major cost of the “bed cap” is that it may provide an incentive for private hospitals to hoard private hospital beds in order to push up the price for hospital beds. As illustrated in Figure 3, hoarding will raise the price for a private hospital bed above $\$P_q/\text{bed}$, which will lead to higher social welfare loss. The current occupancy rate for private hospital beds in NSW is around 60%. However, as previously mentioned, the practice to trade new beds is not permitted due to recent Departmental practices.

Distorts resource allocation and dynamic inefficiency

In addition to the restriction on patient capacity for private hospitals, the market in private hospital beds is also being eroded by the shift of some medical procedures previously performed in private hospitals to day procedure centres that have no restrictions on patient capacity. This is due mainly to advances in technology and improved medical techniques that have enabled complex procedures to be performed at day procedure centres where patients can be discharged on the same day as the procedure is performed.

This uneven playing field may skew the market in favour of day procedure centres and is therefore a cost on private hospitals of doing business which their competitor, day procedure centres, don't have. This may lead to dynamic inefficiency in the allocation of society's scarce resources.

Administrative costs

The current restriction on patient capacity imposes administrative costs on the Department in managing the “bed cap” regime. This includes:

- determination of the bed quota;
- granting approval for new bed licences; and
- issuance of new bed licences, etc.

Given the lack of detailed disaggregated data, it is difficult to estimate the cost of administering the “bed cap” regime. However, the Department notes:

the cost of administering the “bed cap” currently is negligible but could possibly be attached to the 2 staff and the database for administering the licensing regime of approximately \$110,000 per year.

Cost of forecasting error

Another cost associated with the “bed cap” arrangement relates to forecasting error. That is, in determining the bed quota for each period, the Department must estimate the number of private hospital beds that are required for each period. As illustrated in Figure 3, the magnitude of the welfare loss to society depends on how far away the bed quota is set from the efficient level of private hospital beds. Therefore, if the “bed cap” is significantly below the efficient level due mainly to forecasting error, then society will incur a higher social cost.

5.1.2 Benefits

Limiting patient capacity is a method of planning controls. As mentioned, it's objectives are to:

- control over-investment in private hospitals;
- achieve more even distribution of private hospital services; and
- protect the patient from supplier induced demand.

Each of these benefits are discussed in turn below.

To control over-investment in private hospitals

The major potential benefit of limiting patient capacity is to control unfettered and unplanned increase of private hospitals, and to avoid unnecessary duplication of costly facilities.

However, the Victorian Department of Human Services (Vic H&CS) notes:

An objective of orderly development implies that the public would not be well served by an environment where competition might result in some private hospitals closing due to poor financial viability or new hospitals opening to compete with existing hospitals. Moreover, it assumes that government has the capacity to judge the optimum size of the private hospital market and to refuse entry to prospective new proprietors once that limit has been reached. The development of a market in bed licenses provides strong evidence of the failure of government to determine the optimum size of the private hospital market (The Role of Government in Regulating Private Hospitals, A Discussion Paper, November, 1995).

To achieve more even distribution of private hospital services

It is argued that one of the benefits of limiting patient capacity is to enable the Government to re-direct private hospital beds from areas of “over supply” to areas of “under supply”. The argument assumes that the Government can identify better than the marketplace areas of “over supply” and “under supply” and encourage redistribution of beds from “over supply” to “under supply” areas.

Table 7 presents the distribution of private hospital beds in rural and urban areas in NSW.

Table 7: Distribution of private hospital beds in rural and urban areas in NSW

Health Area	Rural/Urban	Private Hospitals	Private Hospital beds
Far West	R		
Greater Murray	R	2	182
Macquarie	R	1	58
Mid North Coast	R	6	412
Mid West	R	4	116
New England	R	2	91
Northern Rivers	R	1	105
Southern	R		
Total			964
Central Coast	U	3	300
Central Sydney	U	9	762
Hunter	U	7	496
Illawarra	U	4	287
Northern Sydney	U	23	1643
South Eastern	U	12	832
South West Sydney	U	4	275
Wentworth	U	3	292
Western Sydney	U	5	371
Total			5,258

To protect the patient from supplier induced demand

One of the major objectives of limiting patient capacity is to minimise the supplier-induced demand effect. The supplier-induced demand phenomenon is a situation whereby a health care provider, usually a physician, influences a person's demand for health care services due to information asymmetry between the health care provider and the health care recipient. It is argued that if the Government does not limit patient capacity, then the supplier-induced demand phenomenon may arise where the physician, given the existence of information asymmetry, will insist the patient to stay overnight at a private hospital, even though the patient's condition may not warrant an overnight stay.

To protect investments in public hospitals

As private hospitals are in direct competition with public hospitals, governments can protect their own investments in public health facilities by limiting patient capacity. Table 8 presents government and non-government investments in public and private hospitals.

Table 8: Government and non-government investments in public and private hospitals, current prices, 1995-96

	Government Sector		Non-Government Sector	Total Expenditure
Major area of expenditure	Commonwealth	State and Local		
Public acute care hospitals	\$5,197	\$5,043	\$1,025	\$11,265
Private hospitals	\$295	-----	\$2,888	\$3,183

Source: Australia's Health 1998, sixth biennial health report of the Australian Institute of Health and Welfare, p.167.

The potential benefits of limiting patient capacity is difficult to quantify because of the lack of available data, and most of these potential benefits are qualitative in nature.

5.1.3 Assessment of the current restriction

The Assessment Team considers the costs of the restriction on patient capacity to significantly outweigh the benefits and hence produces a net cost to society. The current method is an ineffective means of achieving the desired objectives of the restriction, in particular, it is an inappropriate approach in dealing the supplier induced demand problem.

5.2 Alternative approaches

Having assessed the costs and benefits of the current legislation and administrative practices of limiting patient capacity, the Assessment Team now turns to consider the four major alternative options for achieving the same results as the restriction. These alternative approaches were considered in the discussion paper circulated by Vic H&CS.

Option 1: Deregulation

Under this option, the Department would no longer limit patient capacity in NSW. The number of private beds would be determined entirely by market forces as illustrated in Figure 3.

The major potential costs associated with the deregulation of patient capacity are discussed below.

Costs

Value of “bed cap” license

It is argued that the removal of the bed licence may impact on the value of the bed licences held by the private hospitals. However, the Productivity Commission and Vic H&CS argued that the adverse consequences of deregulation of hospital beds for a small minority would outweigh the benefits to the broader community. In particular, the Productivity Commission argued that greater competition will lead to lower prices for consumers because private hospital proprietors no longer need to factor the cost of licences in setting their prices. Moreover, recent Departmental practice has prohibited the trade of new beds which would over time have the effect of eroding the existing value of the market in beds.

Supplier induced demand problem

Limiting patient capacity via the “bed cap” is not a cost effective and efficient method to deal with the supplier induced demand phenomenon. The discussion paper circulated by Vic H&CS argued that:

Certainly a small number of studies undertaken in Australian public hospitals have uncovered evidence, suggesting about 5 to 10 per cent of hospital episodes are inappropriate. Prima facie, similar levels of unnecessary hospitalisation may be occurring in private hospitals. However, ultimately, the use of planning guidelines to control bed numbers

*is a very blunt and ineffectual approach to reducing over servicing and unnecessary hospitalisation.*¹¹⁶

An alternative approach to address the information asymmetry problem may be to conduct a consumer awareness campaign and to disseminate relevant information on the Internet such as the case in the United States and the United Kingdom.

The major potential benefits associated with deregulation of patient capacity are outlined below.

Benefits

Elimination of administrative costs

Elimination of regulatory costs in administering the ‘bed cap’ arrangement. The additional resource may be used in a more productive area.

Economic efficiency

The private hospital proprietors are more likely to undertake sophisticated demand assessment, marketing, financial viability analyses prior to multi-million dollar investments in the private hospital industry. Market forces will equate the number of private hospital beds demanded with the number of private hospital beds supplied. This will maximise the net social benefit as society’s scarce resources are used efficiently. By placing restriction upon patient capacity, this assumes that the Government knows more about the appropriate volume and location of private hospital services than consumers and private hospital operators.

Hospital profitability and planning

Planning controls, such as the limitations placed upon patient capacity, assume that the Government has more knowledge about the financial structure of the facilities than the operators. Several private hospitals in Victoria, for example, folded in the early 1990s largely due to supply controls. These controls also hinder the restructuring of private hospitals, in particular, those hospitals that wish to develop economies of scale by increasing the number of facilities and services they offer.

Level playing field and dynamic efficiency

Private hospitals are no longer restricted in terms of patient capacity to compete with day procedures centres. Dynamic efficiency would result as society’s resources would be allocated efficiently over time.

Again due to inadequate data and the qualitative nature of most of these costs and benefits, it is not possible to provide a quantitative assessment.

The Assessment Team considers on balance this option produces a net public benefit because it significantly reduces the costs associated with the current system. In addition, limiting patient capacity is not adequate in addressing the supplier induced demand problem. Option 1 also encourages the development of new approaches to deal more effectively with the supplier induced demand problem.

¹¹⁶ The Role of Government in Regulating Private Hospitals, A Discussion Paper, The Department of Human Services, November 1995.

Option 2: Government issue by public tender of new bed licenses

Under this option, a staged release of a certain percentage of the existing beds on a six monthly basis would occur until no further bids were received.

Costs

The major potential costs include:

- the direct participation of government in the actual trade of bed licenses would give support to the existing trade among hospital proprietors;
- higher prices for beds and hence higher prices for private hospital services;
- costs of economic efficiency;
- uneven “playing field” in favour of day procedure centres which may lead to an inefficient allocation of society’s scarce resources;
- costs of administration which may be significantly higher than the current system because the Government has to prepare and stage the auctioning process.

Benefits

The major potential benefits include:

- applicability across the State;
- the successful developers are not subject to any other planning criteria issued by the Department;
- the licenses could be issued for specific geographic areas or types of services;
- allowing the government to test the unmet demand for growth in the private hospital industry and therefore the likely impact of deregulation; and
- the revenue raised by the public tender would be retained by the Government.

The Assessment Team finds on balance this option does not produce a net public benefit because it does not reduce the major potential costs but adds further administrative costs to the current system. In addition, this course of action would encourage the trade in beds - a practice which the Government is attempting to revert. As Vic H&CS argued:

such a scheme would make it more difficult to abandon the existing bed license system and this option is therefore not supported.

Option 3: Buy one, get one free policy

Under this option, potential hospital proprietors would only have to purchase half the number of required bed licenses compared with the existing situation.

The major potential costs would be a combination of costs under Option 2 and the current system. The major potential benefits would be similar to that under the current system. However, this option would allow existing hospital proprietors an

opportunity to recover some of the value of their licenses by permitting the continuation of trade in bed licenses, although at diminished values.

Although this option would be preferred to Option 2 because the Government is not directly involved in the trade in bed licenses, it still encourages the practice of trade in beds. If the main objective were to completely remove the “bed cap” arrangement, then this option does not send the appropriate signals to potential proprietors as it relies upon a continued trade in bed licenses. On balance, the Assessment Team considers this option does not produce a net public benefit.

Option 4: No “bed cap” for specific services and/or in nominated geographic areas

Under this option, the Department may waive the requirement for bed licenses in certain “under supply” areas.

The major potential costs would be similar to that under the current system. Additional potential costs include:

- failure to recognise the substitutability of markets for different types and locations of private hospital and day procedure centre beds;
- difficulty with implementation as prospective hospital proprietors all seek to claim that their situation should be included under selective waivers of bed licenses; and
- If the Government were to move towards deregulation at a later date, then it would be likely that trade in bed licenses in the non-exempted areas would slow substantially, in anticipation of the final move to complete deregulation.

The major potential benefits would be similar to that under the current system. An additional potential benefit is that it may encourage more beds to be provided in “under supply” areas,

The Assessment Team finds this option to be an inefficient method to achieve the desired objectives of the restriction on patient capacity because the additional potential costs outweigh the additional potential benefits. Vic H&CS also did not support this alternative option.

5.3 Conclusions and Recommendation

The Assessment Team finds the current legislation and administrative practices that impose limits on private hospital capacity to be an inefficient means of achieving the desired objectives, because the costs significantly outweigh the benefits. In addition, the current system is inadequate and ineffective in addressing one of major objectives that it was designed to achieve i.e. to control the supplier induced demand effect.

Among the four major alternative options, the Assessment Team considers Option 1 (deregulation) to be the most efficient alternative. It reduces significantly the costs of the current regime such as: higher prices for beds and services; costs of economic efficiency; distortion of resource allocation; administrative costs; and measurement errors. At the same time, it allows new approaches to be developed to deal more effectively with the supplier induced demand problem.

On balance, the Assessment Team recommends *that the current practice of restricting bed capacity be abolished and be replaced by a deregulated market for private hospital beds.*

Recommendation 2: The Assessment Team recommends the removal of the current “bed cap” restriction which imposes limits on private hospital capacity. The costs of this restriction are considered to outweigh the benefits and hence produce a net cost to society.

Appendix A: Consultation

Members of the Assessment Team met with the following organisations:

The NSW Department of Health

Australian Consumers Association

Commonwealth Department of Health and Aged Care

Health Care Complaints Commission

Medical Benefits Fund Ltd

NSW Health Funds Association

NSW Private Hospitals Association

Australian Health Insurance Association

Appendix B: Reviews undertaken in other States

This Appendix presents a brief summary of the relevant reviews undertaken in other states in Australia.

Victoria

Part 4 of the *Health Services Act 1988*, the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991*, and Guidelines for the Development of Acute Hospitals Services 1990 made under section 12 of the *Health Services Act 1988* provide for the regulation of private hospitals in Victoria.

A review of the *Health Services Act* and associated regulations is currently underway. The review was scheduled for completion by December 1997, however, it has been delayed due to a wider review of the relevant policy framework. An issues paper has recently been released to promote discussion among stakeholders on issues concerning the development of new regulations. The paper presents a number of options and issues for consideration in developing the new regulations. Among other things it considers:

- whether day procedure centres should continue to be regulated by the Department of Human Services, and the current definition of a day procedure centre should be amended to remove any reference to the volume of activity;
- whether any new regulations need to be flexible enough to capture new and emerging medical techniques;
- whether the regulations should incorporate more detailed requirements for the provision of information to patients;
- the costs and benefits of mandatory accreditation with an approved body for both private hospitals and day procedure centres;
- the potential use of performance and clinical indicators to provide more readily accessible information about the industry; and
- the most appropriate means by which to encourage best practice.

Western Australia

The *Hospitals and Health Services Act 1927* and *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987* provide for the regulation of private hospitals and day procedure centres in Western Australia.

In November 1998 the Health Department of Western Australia (HDWA) released a report for discussion. The report identified several weaknesses of the current regime including:

- the over involvement of the HDWA in facilities standards which generated unnecessary government accountability;
- the lack of documented standard relating to service quality and patient care; and
- problems related to private operators not conforming with conditions and requirements.

The report also identified and explored five options for the future licensing of private hospitals:

- full deregulation;
- increasing resources for existing licensing activities;
- full cost recovery for existing licensing activities from the private sector;
- outsource licensing; and
- a random inspection and program accreditation.

The findings of the report were that random inspection and program accreditation was the most favourable option. This option would involve the public sector providing resources to improve patient care standards, and private sector professionals would assess and certify compliance with these standards.

Tasmania

The Hospitals Act 1918 provides for the regulation and control of private hospitals in Tasmania.

A review of the legislation has begun with the release of regulatory impact statement on option for future regulation. A final report is yet to be presented to the government.

The review investigated six potential options for reform including:

- full deregulation;
- self regulation;
- regulation by Ombudsman/Health Complaints Commissioner;
- negative licensing
- licensing for quality with Government as the regulator; and
- Licensing for quality with an independent regulator.

The review favoured the final alternative as the preferred option, as it provides the greatest benefits with the least costs. This alternative is seen to separate the regulatory and service delivery roles of government. This review also notes that this option would remove prescriptive bed controls except for some specialty services.

Queensland

Until December 1999, *the Health Act 1937* provided for the licensing and control of these facilities, whilst *the Health (Private Hospitals) Regulations 1978* provided for their safety and quality control. *The Private Health Facilities Act 1999* was passed in December 1999 and is currently undergoing a six month implementation phase. It is expected that regulations will be developed during this time for private hospitals and day procedure centres.

The new legislative framework shifted the focus of the regulatory regime administrative matters and building requirements to promoting patient care through the provision of quality services.

South Australia

The South Australian Health Commission Act 1975 and *South Australian Health Commission (Private Hospitals) Regulations 1985* provide for the regulation of

private hospitals in South Australia. However, the Act and Regulations do not relate to day procedure centres which are currently unregulated.

A review of the relevant legislation has been undertaken by the South Australian Health Commission. The final report of this review recommends deregulation of the private hospital sector. A default systems would replace regulation whereby facilities would only be inspected following a complaint to the relevant authority. This option is seriously being considered in South Australia, however, the Minister for Human Services is yet to make a determination on this issue.