PUBLIC BENEFIT TEST REPORT
PRIVATE HEALTH FACILITIES BILL 1999

CONTENTS

INTRODUCTION

Private hospitals and day hospitals ("private health facilities") are regulated under Division 4 of Part 3 of the *Health Act 1937* and the *Health (Private Hospitals) Regulation 1978.*

The legislation, by virtue of the fact that it establishes a licensing system and is therefore, prima facie, anti-competitive, is required to be reviewed under National Competition Policy (NCP). NCP requires that legislation should not restrict competition unless it can be shown that the benefits of the restriction to the community as a whole outweigh the cost of the restriction (known as the "Public Benefit Test"(PBT)) and the objectives of the legislation can only be achieved by restricting competition.

As proposals have been developed for new legislation for private health facilities which will retain certain restrictions on competition, a PBT assessment, as presented in this report, has been undertaken using the methodology endorsed by Queensland Treasury.

Review Background/Process

In 1994, a review of the legislation was commenced as part of the Government's Business Regulation Review Program. Major deficiencies in the legislation (eg. lack of criteria for licensing decisions, absence of appeal rights), which were causing problems with its administration, also dictated that the legislation should be reviewed and updated to meet current legislative drafting standards.

The NCP review of the legislation was commenced in January 1997 by Queensland Health's Legislative Projects Unit. As a result of the ongoing difficulties in the administration of the legislation and the scheduled expiry of the Regulation on 1 July 1999, the scope of the review included all aspects of the legislation and was not confined solely to NCP issues.

Terms of Reference for the review and a PBT Plan were approved by Queensland Treasury in April 1997.

The review has been overseen by a Departmental Steering Committee, comprising representatives of Queensland Health and Queensland Treasury's NCP Unit. The review has also had input from a Stakeholder Reference Group comprising representatives of key bodies affected by the legislation including:

- Private Hospitals' Association of Queensland (PHAQ)
- Australian Medical Association (AMA)
- Australian Council on Healthcare Standards (ACHS)
- Health Care of Australia
- MBF
- Medibank Private

- Health Rights Commission (representing the concerns of users of private health facilities).

Research was conducted into the regulation of private health facilities in other Australian jurisdictions, and international literature was also examined.

Meetings were held with the Steering Committee and the Stakeholder Reference Group during 1997 to obtain input from those groups in relation to the development of proposals for a policy framework for private health facilities. In addition, the PHAQ was consulted directly on key review issues.

EXECUTIVE SUMMARY

Policy Objective (Section 1)

Patients receiving health services provided at private health facilities are exposed to the risk of harm through the occurrence of an adverse patient outcome. This risk arises due to factors such as the patients' health status and the nature of the treatment provided. A recent study indicated that approximately 230,000 preventable adverse patient outcomes occurred annually in Australian hospitals.

The objective therefore is to protect the health and well-being of patients receiving services at private health facilities by minimising the risk of adverse patient outcomes occurring through ensuring that appropriate standards of care are provided at those facilities.

Possible Ways of Achieving Objective (Section 2)

A range of options were considered for achieving the above policy objective, namely:

- self-regulation

- three forms of licensing whereby licensing is conditional upon the health facility:
  - being accredited by ACHS or other quality assurance body; or
  - meeting statutory quality standards; or
  - meeting statutory quality standards and being accredited by ACHS or other quality assurance body

- four non-licensing models namely:
  - statutory standards with penalties for non-compliance
  - certification/registration
  - "negative licensing"
  - a combination of certification/registration and negative licensing.

The self-regulation option is not supported on the grounds that some statutory mechanism is required whereby the government is able to prevent health services

being provided at private health facilities which fail to maintain minimum quality standards and therefore expose the public to an unacceptable risk of harm.

Of the non-licensing models, the "negative licensing" model has the most merit in that it involves minimal costs to industry but provides a mechanism for the closure of facilities which fail to meet minimum quality standards. However, all of the non-licensing models are "reactive" models in that they only allow for intervention after a failure to meet minimum standards has been detected (eg. through the occurrence of an adverse patient outcome). Therefore, they have only a limited capacity to achieve the policy objective.

The licensing model requiring statutory standards and accreditation requirements to be met is the preferred model overall as it provides the greatest degree of protection to the public, and most effectively achieves the policy objective, by:

- providing a means by which operators can be prevented from entering the market or remaining in the market unless they have effective measures in place to ensure minimum quality standards are met
- incorporating the benefits flowing from the on-going quality improvement activities associated with accreditation processes.

Current Regulatory Arrangements (Section 3)

The key provisions in the current legislation which have been identified as being actual or potential restrictions on competition are those which:

- prohibit a person from erecting or operating a private health facility unless licensed by the Chief Health Officer (CHO)
- restrict the categories of persons who may hold licences
- restrict the issues of licences to certain types of health facilities eg. general private hospitals, maternity hospitals, day hospitals etc.
- require licensees to comply with physical, clinical and operational standards.

These provisions are regarded as being anti-competitive on the basis that they:

- limit participation in the private health care market to those individuals or corporations that meet defined standards or qualifications
- impose requirements for prescribed quality standards other than those that apply generally in regard to public/workplace health and safety
- impose restrictions on the conduct of business at private health facilities
- prescribe different requirements for the private sector *vis a vis* the public sector which has the effect of conferring a benefit on the public sector.

The most significant restriction on competition in the private health care industry has occurred through the imposition of "planning controls" which can constitute an absolute barrier to market entry. Controls of this nature, aimed at preventing oversupply, were applied administratively by Queensland Health between 1994 and

1996 and effectively allowed the number of private hospital beds to be "capped" (based on a ratio of 3.5 beds per 1000 head of population).

Market Structure of Private Healthcare Industry (Sections 4 and 5)

The main features of the market structure of the private health facilities industry in Queensland are that:

- as at July 1998 there were 76 licensed private health facilities operating, comprising 51 private hospitals and 25 day procedure centres
- ownership of facilities is not concentrated and there are similar levels of corporate and independent ownership
- the number of for-profit and not-for-profit facilities are roughly the same
- slightly more than 50% of facilities are located outside Brisbane.

Significant changes which have occurred within the market in recent years, and which are expected to continue in the foreseeable future, include:

- a significant increase in the number of day procedure centres (both free-standing and within acute hospitals)
- an increase in the range and complexity of services provided at private health facilities through the establishment of specialised units (eg. cardiac surgery, intensive care and accident and emergency)
- a greater presence in the market by large health corporations(eg. Health Care of Australia) which is likely to lead to ownership becoming concentrated within a few large corporate groups
- an increase in private health facility charges and in the cost of private health insurance
- the emergence of contracting between health insurers and private health facilities potentially producing more competitive pricing arrangements between those bodies
- the development of private health facilities in collocation with public health facilities.

Proposed Model ("With Change State")(Section 6)

Based on the conclusions reached in section 2, policy proposals have been developed for the framework for the Private Health Facilities Bill, the features of which include:

- the retention of a licensing system for private health facilities
- the setting of clear criteria by which licensing applications must be determined (eg. ability to meet relevant standards, financial capacity)
- a requirement that all licences issued be subject to conditions that the facility is accredited and the relevant standards are complied with
- a wider range of day facilities to be covered by licensing requirements (eg. to include any facilities performing procedures involving the use of anaesthesia or sedation which prevent continuous rational communication with the patient)

- provision for new standards to be set for licensed private health facilities dealing with the areas of clinical environment; patient care; equipment, furnishing and fittings; information management; and minimum patient throughput for specified services
- a right of appeal to the District Court from licensing decisions
- a comprehensive range of monitoring and enforcement powers.

Market Structure under "With Change" State (Section 7)

Under proposed licensing model

The market changes likely to occur under the proposed licensing model are not expected to differ significantly from the changes likely to occur under the "without change" state as outlined in sections 4 and 5 (eg. growth of day facilities, more concentrated ownership structure).

Under "negative licensing" model

Likely features of the market under this model are:

- an initial increase in market size due to the absence of entry barriers but this may be limited mainly to the larger established groups (who are better placed to negotiate contracts with health funds) and independently-owned day facilities (which have less dependence on private health insurance)
- a subsequent decline in market size as a result of market fallout caused by competitive forces and other factors such as the possible loss of consumer confidence in an unregulated industry and the continuing decline in the levels of private health insurance
- some downward pressure on prices resulting from increased competition but this may be limited given the recent trend for health insurers to increase premiums as a result of factors such as rising hospital costs and declining membership of health insurance funds.

Major Impacts of Moving from "Without Change" State to "With Change" State (Sections 9, 10 and 11)

The impacts (cost and benefits) that are likely/possible as a result of moving from the "without change" state to (a) the proposed licensing model and (b) a "negative licensing" model, are outlined below. As regards the estimated size of the impacts, those shown in bold are large, those in italics are medium, and the remainder are small. The majority of impacts cannot be valued in monetary terms.

Proposed Licensing Model

<u>Costs</u>

- increased licensing compliance costs for existing operators of facilities not currently required to be licensed
- increase in the cost of private health care as a flow on from increased licensing costs
- costs to government in establishing new licensing framework

Benefits

- *reduction in social and economic costs to consumers through by reduced rate of adverse patient outcomes as a result of application of new quality standards and extended coverage of legislation*
- cost savings to operators resulting from a reduction in the rate of adverse patient outcomes and from greater clarity as to the entry/on-going requirements to be met by licensees
- increased profits arising from increased utilisation of private health facilities flowing from increase in consumer confidence in standards at facilities
- lower administration costs for government resulting from increased transparency/clarity of new legislation.
- increase in public confidence in the government's ability to protect consumers through improved oversight of standards in private health facilities
- lower legal costs and insurance premiums/payouts for health professionals and professional indemnity insurers respectively resulting from reduction in the rate of adverse patient outcomes
- lower insurance and Medicare payouts by health insurers and the Health Insurance Commission respectively resulting from reduction in the rate of adverse patient outcomes
- increased income for accreditation bodies, and consultants providing services to health facilities preparing for accreditation.

It is expected that the proposed licensing model will have a nil net impact on government and have net benefits for the other stakeholder groups namely, consumers, industry, health professionals/professional indemnity insurers, health insurers/Health Insurance Commission and accreditation bodies.

Negative Licensing Model

Costs

- *increased costs/lower profits for operators due to:*
  - *increased competition and consequential loss of market share*
  - *lower levels of usage as a result of reduced consumer confidence in industry*
  - *increase in legal and other costs arising from litigation and government intervention resulting from likely increase in rate of adverse patient outcomes*

  - ♦ costs of developing industry-based standards, if required, in addition to accreditation standards
- ***increase in rate of adverse patient outcomes in absence of licensing standards resulting in social and economic costs to consumers***
- increase in health insurance premiums resulting from increased supply of services by unlicensed facilities
- *increased public waiting lists arising from loss of public confidence in unlicensed private market*
- *increased costs to government (eg. handling increased volume of consumer complaints*)
- *decrease in public confidence in government's ability to protect health consumers*
- *increased legal costs and insurance premiums/payouts for health professionals and professional indemnity insurers respectively resulting from possible increase in the rate of adverse patient outcomes*
- increased insurance and Medicare payouts by health insurers and the Health Insurance Commission respectively resulting from possible increase in the rate of adverse patient outcomes

- increased costs for HIC and health insurers in determining whether a facility is eligible for the payment of benefits

Benefits

- *removal of licensing compliance costs to industry*
- *removal of costs to government of administering licensing regime (annual savings estimated at $165,000)*
- *unrestricted entry to the market for potential operators*
- lower cost of private health care and increased choice of private health services through increased competition
- increase in income for health professionals through increase choice of facilities
- increase in profits due to health insurers having an increased choice of facilities with which to contract
- increased income for accreditation bodies and consultants providing services to health facilities preparing for accreditation.

It is expected that a negative licensing model will produce a net benefit to accreditation bodies but result in costs to the other stakeholders.

Consultation/Interstate Developments (Sections 12 and 13)

Consultation has been undertaken primarily through a Stakeholder Reference Group comprising representatives of key bodies affected by the legislation (eg. Private Hospitals' Association of Queensland (PHAQ), AMA, major health insurers, and the Health Rights Commission (representing the interests of consumers). There has also been direct consultation with the PHAQ and its members.

All parties consulted strongly support licensing of private health facilities and the

overall policy framework for the PHFB.

All other Australian jurisdictions currently regulate private health facilities by way of licensing while most impose planning controls in some form. Most jurisdictions are currently conducting NCP reviews of their legislation. While there is no suggestion that licensing of private health facilities will not continue in all jurisdictions, there are serious doubts whether the retention of planning controls will be justifiable under a PBT assessment. Victoria has already proposed that such controls be abolished.

Conclusion (Section 14)

As the majority of the impacts for the proposed licensing model and a negative licensing model cannot be valued, the net public benefit/cost of the respective models cannot be assessed by aggregating such impacts.

Given that the policy objective of regulating private health facilities is to protect the health and well-being of users of private health facilities by minimising the risk of adverse patient outcomes occurring, it follows that, when assessing the net public benefit/cost of the respective models, the greatest weight should be given to the consumer impacts relating to the incidence of adverse patient outcomes. These impacts directly relate to the health and safety of patients at private health facilities and therefore provide the most significant indicator as to the extent to which the policy objective could be achieved.

While the existing licensing system offers a significant degree of protection to users of licensed private health facilities, the proposed licensing model contains new features which will potentially improve the quality of care at those facilities and thereby reduce the likelihood of adverse patient outcomes occurring. The combination of this benefit to consumers, the net benefits to the industry and the negligible impact on government, produce a clear net public benefit.

In contrast, the negative licensing model does not include the protective elements of the proposed licensing model (eg. entry requirements, setting of licensing standards) and will potentially result in an increase in the incidence of adverse patient outcomes. This will produce a significant overall net cost to the public.

In the circumstances, the proposed licensing model is the preferred regulatory model for private health facilities. Other factors which lend support to this conclusion are that:

- while the model is more restrictive than the current model (to the extent that the scope of licensing of day facilities is broadened), it does not significantly restrict competition in that the licensing requirements are quality-focussed and do not allow for the application of "planning controls" in any form
- the model is supported by all stakeholders consulted during the review

- a similar licensing model is currently adopted by all other Australian States and Territories and is likely to be retained after NCP legislative reviews have been conducted in those jurisdictions.

1 POLICY OBJECTIVE

All health care interventions expose patients to the risk of harm through the occurrence of an adverse patient outcome. This is primarily because:

- patients receiving health care services are generally suffering from an illness or injury which involves risks or complications arising for that illness or injury

- the nature of the treatment provided to patients exposes the patient to risk eg. surgical or other invasive procedures or procedures involving the use of general anaesthetic.

The nature and prevalence of the risks associated with health care interventions is highlighted by the findings of the Quality in Australian Health Care (QAHC) Study which was commissioned by the Commonwealth in an attempt to estimate the incidence and costs of adverse patient outcomes in the Australian hospital system. The Study involved the examination of medical records relating to patients treated in a selection of public and private hospitals in New South Wales and South Australia in 1992.

The results of the QAHC Study[1] indicate that, in 1992, approximately 230,000 patients admitted to public and private hospitals in Australia would have had a preventable adverse event including approximately 30,000 patients suffering a permanent disability of some kind and 10,000 to 14,000 deaths.

Therefore, in relation to the provision of health services at private health facilities, the objective is to protect the health and wellbeing of patients receiving services at those facilities by minimising the risk of adverse patient outcomes occurring through ensuring that appropriate standards of care are provided at those facilities.

2 POSSIBLE WAYS OF ACHIEVING OBJECTIVE

Options

The PBT Plan identified 4 possible options for achieving the above objective:

Option 1.

Self-regulation. Under this approach, the maintenance of quality standards would depend on the industry participating in non-legislative quality assurance processes such as accreditation.

Option 2.

[1] Reported in PIR Final Report, p.20 (see footnote no.8 on p. 32)

Licensing conditional upon the licensed facility meeting minimum quality standards prescribed in the legislation (this would largely mirror the current regulatory arrangements).

Option 3.

Licensing conditional upon the licensed facility being accredited by ACHS or other recognised quality assurance body.

Option 4.

Licensing conditional upon the licensed facility:

- meeting minimum quality standards prescribed in, or made under, the legislation; and
- being accredited by ACHS or other recognised quality assurance body.

Other regulatory Options which were subsequently identified during the course of the review are:

Option 5. Statutory standards with penalty provisions

While not imposing licensing requirements, the legislation would specify minimum standards to be maintained at private health facilities, with appropriate penalties for non-compliance.

Option 6 Certification/Registration

Under this model there would be a legislative requirement that all private health facilities provide Queensland Health with prescribed information eg. qualifications and experience of persons owning/managing the facility, details of quality assurance processes in place, types of services to be provided. The offence provisions in Option 5 would also apply.

Option 7 "Negative Licensing"

Under this model there would be no statutory licensing of private health facilities. However, Queensland Health, upon receipt of complaints or information indicating that the health and safety of any person may be at risk, would have statutory power to enter and inspect any private health facility and, where necessary, issue remedial notices. If an operator failed to comply with a remedial notice, Queensland Health could prosecute the operator and/or apply to the Court for an order for the closure of a facility.

Option 8. Certification/Registration & Negative Licensing

This would be a combination Options 6 and 7.

Merits of Respective Options

Option 1

The self-regulation option (Option 1) was dismissed at an early stage of the review as not being a feasible option for serious consideration, primarily on the grounds that some form of statutory regulation is necessary to enable government to meet its obligations to provide the basis safeguards necessary to protect the health of the public.

As highlighted in section 1, the health status of persons receiving services at private health facilities and the nature of the health services provided at those facilities expose patients to a risk of harm through the occurrence of an adverse patient outcome. The health risks to patients can be minimised by ensuring that minimum quality standards are maintained in private health facilities. Some mechanism is required whereby the government is able to prevent health services being provided at private health facilities which fail to maintain minimum quality standards and therefore expose the public to excessive risks. Such a mechanism can only be provided by some form of statutory regulation.

A further ground for regulation is to prevent "market failure". Economic theory suggests that, in most cases, unrestricted competition through an unregulated market will produce "allocative efficiency", whereby the cost of providing a good or service equals the amount that consumers are willing to pay for that good or service. In this regard, the competitive market model assumes that consumers have easy access to information about the price and quality of goods and services. However, in relation to the provision of health services, information asymmetry exists between consumers and health providers in that consumers are generally not equipped to assess the quality of, and need for, health services before purchasing those services. This results in allocative inefficiency or "market failure".

Given the inability of consumers to assess the quality of health services provided at private health facilities, consumers must rely on government to ensure that private health facilities are safe to use and meet minimum quality standards.

Non-licensing options

Options 5-8 are essentially "reactive" models in that they do not establish barriers to entry to the market but allow government to intervene where minimum standards are not being met to either prosecute the operator of the facility (Options 5 and 6) and/or seek an order from the Court for the closure of the facility (Options 7 and 8).

Options 7 and 8 are preferable to Options 5 and 6 on the grounds they give a greater degree of protection to the public by providing a mechanism which can result in the prevention of health services being provided at facilities at which minimum standards are not complied with.

Option 7 is preferable to Option 8 on the basis that the collection and management of information under a certification/registration system under Option 8 would involve significant costs to government and industry but such a system would not significantly increase the degree of protection to the public provided by a "negative licensing" model.

Licensing options

Of the licensing models under Options 2 to 4, Option 3 (licensing conditional upon accreditation) has the disadvantage that it does not provide a mechanism for standards to be enforced during the period between when a facility commences to operate and when it is assessed for accreditation purposes. This period is usually not less than 12 months. In contrast, the licensing model under Option 4 requires facilities to meet minimum quality standards before they commence operating and enables standards to be enforced from the time the facility commences to operate. In addition, the requirement to meet the minimum prescribed standards is reinforced by the accreditation requirements.

Conclusion

As indicated above, Option 4 is the preferred licensing model while Option 7 is the preferred non-licensing model.

The disadvantage of Option 7 is that it adopts a reactive approach which allows for intervention only after non-compliance with minimum standards has been detected, by which stage the health and safety of patients may have been placed at serious risk. It does not provide a mechanism to prevent operators entering the market who are not suitable to operate a facility or do not have effective measures in place to ensure the maintenance of minimum standards. By contrast, the licensing model under Option 4 provides a greater degree of protection to the public and reduces the level of risk to patients in that it provides a means by which such operators can be prevented from entering the market or, where appropriate, have such conditions imposed on their licence as may be necessary to ensure that minimum standards are met.

Accordingly, Option 4 is the preferred approach.

3 CURRENT REGULATORY ARRANGEMENTS ("WITHOUT CHANGE" STATE)

Anti-competitive provisions

The key provisions in the current legislation which have been identified as being actual or potential restrictions on competition are those which:

- prohibits a person from erecting or operating a private health facility unless licensed by the Chief Health Officer (CHO)

- restrict the categories of persons who may hold licences to medical practitioners, registered nurses, a religious body or order, or a society or body corporate approved by the CHO

- restrict the issues of licences to certain types of health facilities eg. general private hospitals; maternity hospitals; hospitals for the reception and care of mental health patients; hospitals for mothers and infants; day hospitals.

- limit the term for which licences may remain in force

- authorise the CHO to impose conditions on licences eg. as to the:

    - maximum numbers of the various classes of patients that a licensee is authorised to accommodate in a licensed private health facility

    - number, qualifications and experience of staff required to be employed in the facility

- authorise the CHO to suspend or cancel a licence on a range of grounds eg. if not satisfied that the facility is fit for the care or treatment of patients, or that the licensee is not a fit and proper person.

- require licensees to comply with physical, clinical and operational standards

- requires any plans for additions/alterations to premises to be approved by the CHO.

These provisions are regarded as being anti-competitive on the basis that they:

- limit participation in the private health care market to those individuals or corporations that meet defined standards or qualifications

- impose requirements for prescribed quality standards to be observed other than those that apply generally in regard to public/workplace health and safety

- impose restrictions on the conduct of business at private health facilities

- prescribe different requirements for the private sector *vis a vis* the public sector which has the effect of conferring a benefit on the public sector.

Additional requirements relating to quality standards are also imposed through draft regulations and administrative guidelines.

Planning controls

The most significant restriction on competition in the private health care industry has occurred through the imposition of "planning controls" as part of the licensing system. Such controls were applied administratively by Queensland Health between 1994 and 1996. These controls, which were aimed at preventing oversupply, enabled the CHO to refuse an application for a licence if the applicant could not demonstrate that:

- that the proposed private health facility was compatible with an overall strategic framework for health service needs (a ratio of 3.5 public and private hospital beds:1000 head of population was specified to be an adequate service level for a region)

- there was a "community need" for the proposed facility, based on factors such as geographical location, access to existing services, mix and complexity of existing services and levels of private health insurance.

The imposition of a cap on the number of private hospital beds in this manner can constitute an absolute barrier to entry to the private health care market.

4 MARKET STRUCTURE OF PRIVATE HEALTHCARE INDUSTRY

Types of Facility/Services

The market structure of the private healthcare industry comprises two main categories of facilities:

- acute and psychiatric hospitals which provide services for patients requiring overnight stay *and*, in many cases, same-day services in day theatres/centres for patients who do not require overnight accommodation

- free standing day hospitals which provide same-day services only, eg. do not provide overnight accommodation.

Private health facilities provide a range of health services eg. surgical, medical, psychiatric, rehabilitative, obstetrics. A notable trend in the private healthcare market has been the recent increase in services provided by way of free-standing day facilities (discussed below). In addition, private health facilities, in particular the larger private hospitals, have in recent years started to provide a wider range and complexity of services through the establishment of specialised units (eg. cardiac surgery, intensive care, accident and emergency). Traditionally, services of this nature have generally only been available in public sector hospitals.

National Market - Number and Growth of Private Health Facilities

ABS figures released in November 1997 indicate that, throughout Australia during 1995-96, there were 463 private health facilities comprising:

- 323 acute and psychiatric hospitals (of which 156 also had day theatres); and

- 140 free-standing day hospital facilities.

The figures indicated that, while the number of acute and psychiatric hospitals had not increased significantly in recent years (319 in 1991-92; 323 in 1995-96), the number of day surgeries, theatres etc. within those hospitals had increased by around 20%, eg. from 125 in 1991-92 to 156 in 1995-96.

Similarly, the number of free-standing day hospitals almost doubled, from 72 in 1991-92 to 140 in 1995-96.

Of the 140 free-standing day hospitals operating in Australia in 1995-96, 73 were in New South Wales, 23 in Victoria, 17 in Queensland, and the remaining 27 were in other States and Territories (the number of free-standing day hospitals in Queensland had increased to 26 by July 1998).

The basis for the popularity of day procedure centres has been attributed to the fact that

> *only minor and elective surgery, and routine diagnostic procedures are performed in these facilities, so major investments in infrastructure and the maintenance of excess capacity to cater for emergency services are unnecessary. Costs do not need to be spread across a large number of hospital beds in order to ensure profitability*[2]

Number and Location of Licensed Facilities in Queensland

As at July 1998, there were 77 licensed private health facilities in Queensland, comprising:

- 51 hospitals (of which 27 also have day surgery facilities), accounting for 5375 beds and 74 neonatal cots
- 26 free-standing day hospitals

ABS statistics from November 1997 indicate that Queensland had the smallest variation in bed supply (based on available beds per 1,000 population) between Australian capital cities. This reflects Queensland's strong regional population base, as demonstrated in Table 1 below which shows that at July 1998, 43 private health facilities were located outside the Brisbane metropolitan area, compared to 34 located within the Brisbane area.

Table 1: Regional location of private facilities in Queensland @ July 1998

Regional location	No/type of facilities

[2] (Victorian Office of Regulation Reform, *Impact Assessment Study on the Role of Government in Regulating Private Hospitals*, February 1996, p.10).

Regional location	No/type of facilities
Gold Coast	4 hospitals 4 day hospitals
Toowoomba	8 hospitals 1 day hospital
Sunshine Coast	5 hospitals 2 day hospitals
Cairns	3 hospitals 2 day hospitals
Townsville	1 hospital 1 day hospital
Mackay	2 hospitals 1 day hospital
Rockhampton/Yeppoon	4 hospitals
Bundaberg/Kingaroy/Maryborough	4 hospitals
Birdsville	1 hospital
Total facilities located outside the Brisbane metropolitan area	32 hospitals 11 day hospitals 43 private health facilities
Facilities located within the Brisbane metropolitan area	19 hospitals 15 day hospitals 34 private health facilities
TOTALS	77 facilities (51 hospitals, 26 day hospitals)

(Sourced from information provided by Private Health Establishments Advisory and Licensing Unit, Office of the Chief Health Officer, Queensland Health)

Patient Separations from Private Health Facilities

The 1997 ABS report states that, in 1995-96 there were 1,661,100 patient separations from private hospitals throughout Australia, comprising

- 1,452,300 from acute and psychiatric hospitals
- 208,800 from free-standing day hospital facilities.

These figures represent a 26% increase over the five years to 1995-96, including an 8% increase between 1994-95 and 1995-96, of which Queensland hospitals account for 37% (the privatisation of a Commonwealth Hospital (Greenslopes) in 1995 contributed significantly to the large increase in patient separations in Queensland).

Of the 1,452,300 patient separations from private acute and psychiatric hospitals during 1995-96, 41% were same-day (this compares to 35% in 1994-95 and 30% in 1993-94), again reflecting strong development in the day-only market.

Free-standing day hospitals in Australia accounted for 13% of all patient separations in 1995-96, compared to 10% of all separations five years ago.

Bed Capacity/Occupancy Rates

Although the number of hospitals (as opposed to day hospitals) in Australia has not increased significantly since 1991-92, those hospitals have increased their bed capacity by around 10% and in 1995-96 accounted for 22,757 hospital beds. Free-standing day hospital facilities (which do not provide overnight accommodation) account for an additional 1,023 beds, chairs, recliners, etc. Over the five year period to 1995-96, Queensland recorded the largest increase (872 beds) in bed supply.

Bed occupancy rates, which provide an indication of the usage of available facilities and services in private hospitals, stood at 70% nationally (an increase from 67% for each of the four previous years) in 1995-96. Statistically adjusted data indicated that the occupancy rate in Queensland was even higher, at 74%.

The ABS report in November 1997 noted that, generally, occupancy rates are higher in larger hospitals, with occupancy rates around 59% for hospitals with 26-50 beds and 81% for hospitals with over 200 beds.

Ownership of Private Health Facilities

There are two main categories of private facility ownership: *for profit* and *not-for-profit*. The latter category comprises religious/charitable hospitals, community hospitals, and bush nursing hospitals. In 1993-94, ABS figures indicated that the national averages of private hospital ownership in Australia were around 53% for-profit and 47% not-for-profit. The current ownership profile for private health facilities in Queensland is contained in Table 2 below.

The largest for-profit ownership group in Queensland is Health Care of Australia (HCoA), with 5 hospitals (4 of which are located in Brisbane, 1 on the Gold Coast).

The major ownership groups in the not-for-profit sector are those which fall within the umbrella of the Catholic Church (11 hospitals, of which 5 are located in Brisbane) and the Uniting/Presbyterian Church (8 hospitals, of which only 1 is located in Brisbane).

All but two of the 26 free-standing day hospitals in Queensland are independently owned, with half of that number located in Brisbane.

Table 2: Ownership profile of private health facilities in Queensland

Ownership group	**No of facilities: hospitals/day hospitals**
For-Profit (FP):	
Health Care of Australia	5 hospitals
Independent owners	8 hospitals, 24 day hospitals
Private Hospital Services	3 hospitals
Australian Health Care Group	2 hospitals, 1 day hospital
Medical Benefits Fund	2 hospitals
Ramsay Health Care Group	2 hospitals
Community Private Hospital Services	1 hospital
Moran Health Care Group	1 hospital

Ownership group	**No of facilities: hospitals/day hospitals**
Total For-Profit facilities:	***24 hospitals, 25 day hospitals***
Not-for-Profit (NFP):	
Catholic Church	11 hospitals
Uniting Church	8 hospitals, 1 day hospital
Independent (community-based)	7 hospitals
Queensland Cancer Fund	1 hospital
Total Not-for-Profit facilities	***27 hospitals, 1 day hospital***
Total private health facilities:	**51 hospitals (24FP, 27 NFP)** **26 day hospitals 25FP, 1NFP)**

(Sourced from information provided by Private Health Establishments Advisory and Licensing Unit, Office of the Chief Health Officer, Queensland Health)

Public/Private Relationship

In Queensland, as in other Australian States, the private sector competes with the public sector for the provision of health services to private patients. The private sector's market share in Queensland has been increasing in recent years relative to the public sector share (from 72.82% in March 1990 to 78.28 % in March 1995 : Source: Queensland Health Discussion Paper, *Private Health Insurance Reforms*, January 1997, p.10.).

The Industry Commission[3] estimated that private admissions in public hospitals fell by 42% between 1989/90 and 1995/96.

Cost of Services provided at Private Health Facilities

Over 80% of patients receiving services at private health facilities are privately insured. For patients in this category, the cost of these services is met through the payment of insurance premiums and any out of pocket expenses eg. where insurance benefits only partially cover the hospital/medical costs.

Private health insurance premiums have been rising rapidly in recent years. This led to a inquiry by the Industry Commission which found that the main contributing factors to the increases were:

- a substantial rise in the proportion of fund members using private rather than public hospitals
- an increase in average private hospital admission charges
- an increase in average hospital admissions, partly reflecting a change in fund composition towards older and sicker members as community coverage dwindles.

The Commission noted that a significant factor in the rising private hospital admission charges was the increase in expenditure by private health facilities (ABS data

[3] *Private Health Insurance*, February 1997, pp.196, 208

indicates that total operating expenditure for all private acute and psychiatric hospitals in Australia increased by 44% between 1991/92 and 1995/96). The Commission attributed this mainly to the increasing complexity of procedures now being undertaken in private health facilities and noted that:

Increasing complexity might mean higher spending on drug, medical and surgical supplies. In addition, more complex procedures mean more high-tech equipment and more highly qualified (and better paid) nursing staff - all of which affect hospital expenditure[4].

In 1995, the Commonwealth initiated reforms to the health insurance industry aimed at reducing the cost of private health insurance and private hospitalisation. Amendments to the *Health Insurance Act 1973* (Cwlth) permitted health funds to negotiate contracts with private health facilities and medical practitioners. The significance of this to consumers is that such contracts can allow health funds to provide 100% cover for hospital and medical costs thereby eliminating out of pocket expenses.

The Industry Commission noted that the reforms

encourage funds to shop around, using their bargaining power to negotiate lower prices and more comprehensive services with their preferred hospital and medical providers by establishing the total cost of an episode of treatment[5].
A major NSW health fund stated, in its submission to the Commission, that the rate of increase of private hospitals charges in NSW had slowed considerably since it started negotiating charges and benefit levels with private hospitals and attributed this to the contracting arrangements.

The Commission noted that while a high percentage of private health facilities have entered into contracts with health funds, there has been very limited progress in respect of contracts between health funds and medical practitioners.

Collocated Facilities

Collocations involve the sharing (to a greater or lesser extent) between the private sector and the public sector of some common facilities (eg. physical site, surgical amenities, equipment, staff). Such arrangements are a relatively new development, but already exist in some other Australian States (eg. NSW, Victoria).

There are currently two existing collocated private hospitals which share facilities with the public sector in Queensland at Gladstone and Caboolture, and there are proposals for a further seven facilities at various locations.

Conclusion

[4] *Private Health Insurance*, February 1997, pp.223-224.
[5] Ibid. pp.73-74

In summary, the above outline of the market structure of the private health facilities industry in Queensland indicates that:

- ownership is not concentrated and there are similar levels of corporate and independent ownership
- the number of for-profit and not-for-profit facilities are roughly the same
- slightly more than 50% of facilities are located outside Brisbane.

The most significant developments in recent years have been:

- the growth in the relative significance of day procedure centres (both free-standing and within acute hospitals)
- the increase in range and complexity of services provided at private health facilities
- the increased presence in the market of larger health corporations, eg. HCoA
- the ability for health funds to negotiate contracts with private health facilities.

5 LIKELY FUTURE CHANGES IN MARKET STRUCTURE

In 1995 it was suggested that up to 60% of all hospital separations in Australia - twice the current level - could be on a same day basis (source: ABS/Australian Institute of Health & Welfare, *Hospitals Australia* 1991-92, May 1995, p.9). Similarly, a British Report in 1994 suggested that, by 2004, 70% of surgical operations in the UK will be carried out by minimally invasive techniques (Cushieri Report, reported in *Acute Futures*, 1996, p. 133).

The role of technology will be significant in continuing the changes to what is done in private health establishments, and how it is done. A UK study in 1996 stated that:

> *changes in hospital services have been largely driven by changes in medical technology which have increased the range of what [hospitals] can do and reducing the cost of some procedures. In addition, technological development in support services, from information handling to meal preparation, has also allowed costs to be reduced and thereby improved the overall competitiveness of the hospital.* (*Acute Futures*, 1996, p. 133)

The UK study concluded that further implementation of existing technology will have a major impact on hospital services and the scope for increased use of day surgery is apparent. It also foresaw a future transformation in the way that medical and other human resources are used within hospitals, eg increased substitution of nurses and other health personnel for doctors. This forecast reflects US practices in which 65% of all anaesthetics administered in the US are the responsibility of nurses, and US government assessments that advanced practice nurses can meet the needs of 50-90% of patients receiving care outside the hospital (*Acute Futures*, 1996, pp. 138-146).

There is no reason why similar influences will not be evident in the Australian market. Thus it would appear that the current trend in Australia towards increased use of day procedures, whether performed in free-standing hospitals or in day theatres located within acute hospitals, will continue during the next decade. Similarly, the length of inpatient stays in acute hospitals will probably continue to decline in line with technological advances in surgical procedures. The trend for private health facilities to provide a wider range and complexity of services is also expected to continue.

Increased utilisation of private health facilities and rising expenditure associated with the increasing complexity of services are likely to maintain upward pressure on insurance premiums and hospital charges. This means that the extent to which contracting between insurers and hospitals is effective in containing hospital charges is likely to be increasingly significant.

The fact that hospitals which are part of large corporatised groups (whether for-profit or not-for-profit) are likely to have more leverage in negotiations with insurers than do smaller, independently owned hospitals may increasingly become a major incentive for the grouping of hospitals. In this regard, a recent health journal (HealthCover, v.7(3), June/July 1997) predicted that the future of the private hospital industry would be

> *a significant movement of smaller stand-alone groups into the hands of large corporate players; by the year 2000 hospitals will have no role unless they are totally differentiated (though there may be high-risk opportunities for niche players), and price competition... will continue.*

One major player in the industry, Health Care of Australia (HCoA) has signalled an increasingly aggressive approach to the market, planning to be strategically located in main population centres throughout Australia, and to vertically integrate with diagnostic services (pathology, radiology) and medical centres (*HealthCover*, October-November 1996, p.53).

An HCoA executive commented (*HealthCover,* October-November 1996, p.53) that corporate groups are able to undertake greater service innovation and have the capacity to :

- undertake more complex projects, such as joint ventures with the public sector
- consider export of hospital expertise to Asia (which many large groups are now doing) and
- develop new service types and experiment, for instance, with ambulatory care, home care, diagnostic services, medical centres and occupational health and safety - services which may not be financially viable in the first instance, but which create a more diversified base which takes into account changes in health care delivery where the emphasis is increasingly shifting away from inpatient delivery, while also diversifying the revenue base away from total dependence on health insurance for inpatient care.

While large corporatised groups may be better placed in the future to negotiate contracts with health insurers, independently owned day procedure centres (usually owned by medical practitioners either as individuals or as a group practice) which are less dependent on private health insurance for their profitability, are likely to continue to have a strong presence in the market.

It is anticipated that the future market structure may be significantly influenced by the continuing development of collocated private health facilities with public sector facilities. The successful tenderers for these facilities may have better opportunities than the proprietors of other (non-collocated facilities) to secure a market advantage. It is probable that successful collocation tenderers are likely to be the larger corporate operators.

Conclusion

In summary, the most likely changes in the future market structure of private health facilities are expected to be:

- continuing significant development of day procedure centres (both free-standing and day theatres/surgeries within acute hospitals)
- continuing increase in the range and complexity of services provided by private health facilities
- the increasing corporatisation of private health facilities ownership within a few large corporate groups
- continuing increase in the cost of private health insurance and private health facility charges, and in the significance of contracting between health funds and private health facilities
- continuing development of private health facilities in collocations with public health facilities.

6 PROPOSED MODEL ("WITH CHANGE" STATE)

Based on the conclusion reached in section 3, policy proposals have been developed for the framework for the Private Health Facilities Bill (the *PHFB*). The key features of the *PHFB* are outlined below:

Licensing process

A licensing system for private health facilities is to be retained under the *PHFB*.

Under the current licensing system, an operator of a private health facility must obtain from the CHO:

- an approval to establish the facility for the provision of specified services (this is an administrative requirement and is not reflected in the current legislation);

- a licence to erect (which essentially involves approval of the plans for the facility); and
- a licence to use.

Under the *PHFB*, the process will be streamlined to include only the approval stage and the licence to use stage. The Integrated Development Approval System (IDAS) under the *Integrated Planning Act 1997* will remove the need for the issuing of licences to erect. Under IDAS, Queensland Health will have the capacity to be a Referral Agency whereby the relevant local authority or private certifier, before deciding whether building approval for a private health facility should be granted, will be required to ensure that Queensland Health's requirements as to the design and layout of the facility are met.

Criteria for granting approvals/licences

The *PHFB* will require the CHO, when deciding an application for an approval, to consider specific matters including:

- whether the applicant has the ability, including any relevant experience, and financial capacity to operate a private health facility
- the applicant's previous record as a licensee in any jurisdiction
- any criminal history relevant to the applicant's suitability
- whether the applicant has the ability to comply with the required Standards for the services proposed to be provided at the facility.

The criteria for granting a licence will include whether:

- the applicant is an approval holder
- any material change of circumstances has occurred since the approval was granted
- the facility meets the relevant physical Standards made by the CHO (see below)
- a Certificate of Classification under the Standard Building Law has been issued for the facility.

There will be no restriction on the categories of persons/corporations who may hold approvals or licences. In addition, the PHFB will not impose "planning controls" in that the criteria for approvals/licences will not include a requirement to demonstrate "community need" for the proposed service/facility or compatibility with a strategic plan for the delivery of health services (eg. capping of bed numbers).

Other licensing issues

All licences will be subject to specified conditions which will include that:

- only those services specified in the licence may be provided at the facility
- the licensee must comply with all relevant Standards
- the facility must, within 90 days after the issue of the licence, be entered into an accreditation program with an accreditation body prescribed under a regulation
- the facility must be accredited within 3 years after the issue of the licence
- the licensee must notify the CHO of any change of circumstances relevant to the licence (eg. a change of corporate structure).

Other significant features of licences are that:

- they may be granted for a renewable term of up to 3 years where the facility is accredited, and up to 1 year in all other cases
- the CHO may, on application of the licensee, vary the licence (eg. as to the type of services provided or conditions imposed) or transfer the licence to another person who meets the relevant licensing criteria
- the CHO may, after complying with "show cause" requirements, suspend or cancel a licence if specified grounds exist (eg. breach of a condition on the licence), or may immediately suspend a licence if of the opinion that there is a risk of serious harm to the health and well-being of any person.

Scope of the proposed legislation

The current licensing system covers the various types of private hospitals (eg. medical, surgical, maternity, psychiatric) and "day hospitals" (excluding GP treatment rooms). While private hospitals will continue to be specifically covered under the *PHFB* together with any other facility which provides overnight nursing care (excluding nursing homes etc.), the range of day facilities to be covered by the licensing requirements under the PHFB will be extended to include any day hospital which provides:

- procedures involving the use of anaesthesia or sedation which prevent continuous rational communication with the patient
- termination of pregnancy, IVF or other infertility treatment, dialysis, cardiac catheterisation, chemotherapy or cardiac rehabilitation
- any medical/psychiatric/rehabilitation procedure or treatment prescribed by regulation.

Standards

Standards that currently apply to licensed private health facilities are located in a number of sources (eg. the Regulation, draft Regulations, administrative guidelines and policies). Some stakeholders noted that this situation has made it difficult for licensees and licence applicants to be entirely clear as to what standards must be met.

The Standards that the CHO will be authorised to make under the *PHFB* will not be legislation but will be required to be approved by regulation. The Standards will be required to be tabled in Parliament with the approving regulation and be made available by Queensland Health for inspection and copying. This will ensure that the Standards are subject to an appropriate level of scrutiny and readily accessible to licensees and licence applicants.

Standards will be able to be made in relation to the following matters:

- clinical environment (eg. as to minimum levels of clinical support services to be available in respect of specific health services)
- patient care (eg. admission /discharge procedures)
- equipment, furnishings and fittings (eg. resuscitation equipment in operating rooms)
- information management (eg. keeping of clinical records, reporting of statistical data to CHO)
- minimum patient throughput for specified services (eg. cardiac surgery) which require a minimum volume of patients to maintain the clinical skills of the personnel providing those services.

Accountability Measures

Unlike the current legislation which contains no review or appeal rights, the *PHFB* will make provision for appeals from licensing to be made the District Court, allow certain matters to be reviewable by the CHO and require the CHO to provide a written statement of reasons for licensing decisions.

Monitoring and Enforcement

The *PHFB* will contain a comprehensive range of powers for inspectors which will be consistent with modern legislative drafting practices. Inspectors will have appropriate powers of entry, search and seizure. If an inspector finds that a licensee is not complying with the legislation or the Standards, the inspector may serve a compliance notice requiring the licensee to take remedial action. Failure to comply with a compliance notice will be grounds for the cancellation or suspension of the licence.

In addition, monitoring (eg. of the rate of adverse patient outcomes) will be possible through the collection of data from licensed facilities under the Standard relating to information management.

7 MARKET STRUCTURE UNDER "WITH CHANGE" STATE

A. Under proposed licensing model

The market changes likely to occur under the proposed licensing model are not expected to differ significantly from the changes likely to occur under the "without change" state as outlined in section 4 above (eg. growth of day facilities, more concentrated ownership structure).

B. Under "negative licensing"

Under this model, the removal of the entry requirements under the current licensing system will potentially provide greater scope for new operators to enter the market eg. those who would have been unable to meet the criteria for licensing.

However, any increase in the size of the market may be limited by factors such as the declining levels of private health insurance, the ability of the health funds to contract only with selected private health facilities and the shortage of specialist medical staff.

The capacity for health funds to contract only with selected facilities could result in any market growth being mainly limited to expansion by the larger established groups (who are better placed to negotiate contracts with health funds) and a continuing increase in the number of independently-owned day facilities (which have less dependence on private health insurance).

Any initial increase in the size of the industry would be likely to decline as a result of market fallout caused by competitive forces and other factors such as the possible loss of consumer confidence in an unregulated industry and the continuing decline in the levels of private health insurance. Ownership of facilities by large groups may increase as smaller operators may not be able to compete with the larger competitors.

The extent to which consumers may benefit from any increase in competition eg. by way of lower health insurance premiums may be limited given the recent trend for health funds to increase premiums as a result of factors such as rising hospital costs and declining membership of funds.

8 MAJOR IMPACTS OF MOVING FROM "WITHOUT CHANGE" STATE TO "WITH CHANGE" STATE

Table 3 below identifies the impacts (costs and benefits) that are likely/possible as a consequence of moving from the "without change" state to:

- the proposed licensing model
- a "negative licensing" model.

Size of Impacts

The size classification of the impacts is indicated in the Table. Large impacts are shown in bold, medium impacts are shown in italics and the remainder are small. Given that the policy objective is to protect the health and well-being of patients receiving health services at private health facilities by minimising the risk of adverse patient outcomes occurring, it follows that the most significant impacts are those related to potential changes in the incidence of adverse patient outcomes under the respective regulatory models.

Table 3

IMPACT GROUP	IMPACT DESCRIPTION *PROPOSED LICENSING MODEL*	IMPACT DESCRIPTION *NEGATIVE LICENSING MODEL*
INDUSTRY: **Existing operators**	***Costs:*** • Increased costs in meeting licensing requirements (for operators of day facilities not currently required to be licensed) ***Benefits:*** • Cost savings resulting from potential reduction in the rate of adverse patient outcomes as a consequence of industry compliance with new licensing requirements and extended coverage of legislation • Cost savings resulting from greater clarity as to the on-going requirements to be met by licensees • Increased profits arising from potential increased utilisation rates flowing from increased consumer confidence in industry	***Costs:*** • *Lower profits due to potential loss of market share and reduced consumer confidence in an unregulated industry* • *Increase in legal and other costs arising from litigation and government intervention resulting from likely increase in rate of adverse patient outcomes* • Costs of developing industry-based standards, if required, in addition to existing (eg. ACHS) standards. ***Benefits:*** • *Removal of licensing compliance costs*

IMPACT GROUP	IMPACT DESCRIPTION *PROPOSED LICENSING MODEL*	IMPACT DESCRIPTION *NEGATIVE LICENSING MODEL*
Potential operators	***Costs:*** • Nil ***Benefits:*** • Cost savings due to greater transparency/clarity of entry requirements • Increased profits arising from potential increased utilisation rates flowing from increased consumer confidence in industry	***Costs:*** • *Increase in legal and other costs arising from litigation and government intervention resulting from likely increase in rate of adverse patient outcomes* • Costs of developing industry-based standards, if required, in addition to existing (eg. ACHS) standards. ***Benefits:*** • *Increased capacity for potential operators to enter the market* • *Entry costs related to licensing would be removed*
COMMUNITY/ CONSUMERS	***Costs:*** • Increase in the cost of private health care as a flow-on from increased licensing costs ***Benefits:*** • *Reduction in the rate of adverse patient outcomes as a result of application of new quality standards and extended coverage of legislation.*	***Costs:*** • **Increase in rate of adverse patient outcomes due to lack of requirement for private health facilities to comply with licensing standards** • Increase in health insurance premiums resulting from increased supply of services by unlicensed facilities • *Increased public waiting lists arising from loss of public confidence in unlicensed private market* ***Benefits:*** • Lower cost of private health care and increased choice of private health services as a result of increased competition in an unlicensed market and removal of licensing costs
GOVERNMENT	***Costs:*** • Costs associated with the establishment of new licensing framework (these costs would not be ongoing)	***Costs:*** • Loss of revenue through abolition of licensing fees • *Increased costs associated with:* * *establishing/administering a negative licensing framework.*

IMPACT GROUP	IMPACT DESCRIPTION *PROPOSED LICENSING MODEL*	IMPACT DESCRIPTION *NEGATIVE LICENSING MODEL*
	Benefits • Lower administration costs resulting from increased transparency/clarity of new legislation. • Increase in public confidence in the government's ability to protect consumers through improved oversight of standards in private health facilities.	* *handling/investigating likely increased volume of consumer complaints about private health facilities* * *taking action against private health facilities when public health/safety is considered to be at risk* • *Increased public waiting lists which may arise from loss of public confidence in unlicensed private market* • *Lower public confidence in government's ability to protect health consumers* ***Benefits:*** • Removal of costs of administering licensing regime.
HEALTH PROFESSIONALS /PROFESSIONAL INDEMNITY INSURERS	***Costs:*** Nil ***Benefits*** • *Lower legal costs premiums/payouts resulting from possible reduction in rate of adverse patient outcomes*	***Costs:*** • *Increased legal costs, premiums and payouts resulting from potential increased rate of adverse patient outcomes* ***Benefits:*** • Increased income for health professionals (salaried or with visiting rights)
PRIVATE HEALTH INSURANCE FUNDS/HEALTH INSURANCE COMMISSION	***Costs:*** Nil ***Benefits:***	***Costs:*** • Increase in insurance payouts and Medicare payments resulting from possible reduction in rate of adverse patient outcomes • Increased costs for HIC and health insurers in determining whether a facility is eligible for the payment of benefits. ***Benefits:***

IMPACT GROUP	IMPACT DESCRIPTION *PROPOSED LICENSING MODEL*	IMPACT DESCRIPTION *NEGATIVE LICENSING MODEL*
	• Reduction in insurance payouts and Medicare payments resulting from possible reduction in rate of adverse patient outcomes	• Potential increase in profits due to health insurers having a greater choice of facilities with which to contract
ACCREDITATION BODIES & CONSULTANTS	*Costs:* Nil *Benefits:* • Increased income for ACHS and other accreditation bodies, and for consultants providing services to health facilities preparing for accreditation.	*Costs:* Nil *Benefits:* • Increased income for ACHS and other accreditation bodies, and for consultants providing services to health facilities preparing for accreditation

9 VALUATION OF IMPACTS

In relation to the above impacts, the following are capable of being valued:

A. Proposed Licensing Model

Increased costs in meeting licensing requirements

The most obvious costs associated with licensing are licence fees and other compliance costs eg. those involving the preparation of licence applications, compliance with reporting requirements etc. There is no data available in relation to the latter category of costs. The significance of accreditation costs also needs to be considered.

Licence Fees

It is assumed that the licence fee levels under the "without change" and "with change" states will be equivalent on the basis that fee increases would have been made in any event under the "without change" state to achieve greater cost recovery. A licence fee structure negotiated with the PHAQ in 1993, but not proceeded with legislatively, provides an indicator of the possible level of fees under the proposed model eg. -

- licence application fee - $1400 (day facility), $4000 (100 bed hospital) - currently $446 for all facilities
- annual licence fee - $100 (day facility), $500 (100 bed hospital) - currently $ 57 for all facilities.

The only operators who would incur increased costs (through licence fees) as a direct result of the proposed model are operators of facilities which will be required to be licensed (for the first time) as a result of the proposed extended coverage of the

legislation. It is estimated that this will initially involve approximately 15 day facilities. Based on the above fee levels, the total fees payable for these facilities would be $21,000 for licence application fees and $1500 per annum for annual licence fees.

Accreditation costs

The accreditation requirements under the proposed licensing model will not have an impact on potential operators as licence applicants under the existing licensing model are already subject to equivalent requirements (which are imposed administratively).

The only facilities that will potentially be effected by will be those licensed facilities that are not accredited and the 15 day facilities likely to be affected by the extended coverage of the legislation.

However, the extent of the impact of mandatory accreditation under the proposed licensing model is affected by various factors such as:

- the increasing levels of voluntary participation - currently 65% of all licensed private health facilities (80% of private hospitals and 40% of day facilities) are ACHS accredited or have applied for ACHS accreditation, an increase of 15% since 1995
- the recent requirements imposed by the major health insurers, under their contracts with health facilities, that facilities must be accredited as a condition of payment of insurance benefits
- the PHAQ requirement that its members must be accredited (85% of private hospitals in Queensland are PHAQ members).

As a result of these factors, it is estimated that the number of licensed private health facilities not participating in accreditation programs would be negligible by the time new legislation mandating accreditation came into force. The accreditation requirements will therefore, in effect, simply give legislative force to a practice already occurring within the private health care industry. In the circumstances, accreditation costs should not be regarded as a component of licensing compliance costs under the proposed model.

B. Negative Licensing Model

Loss of revenue through abolition of licensing fees / Removal of costs of administering licensing regime

The abolition of the current licensing model would, on one hand, result in revenue loss for Queensland Health through the non-collection of licence fees and, on the other hand, avoid the costs to Queensland Health in administering the licensing regime. The net effect of these two impacts is an estimated annual saving to Queensland Health calculated as follows:

Table 4

Annual administration costs (based on operational costs of Queensland Health's Private Health Establishment Advisory & Licensing Unit (based on 1997/8 budget)	$200,000
Licence fees[6] collected annually (calculated on the basis of 76 existing licensed facilities and an additional 6 licences being issued by 31 December 1998)	$45,000
Net savings	$165,000

These savings would be offset by the administrative costs associated with the operation of the "negative licensing" model (see discussion of this impact in section 10 below).

10 ASSESSMENT AND QUANTIFICATION OF NON-VALUED IMPACTS

A. *PROPOSED LICENSING MODEL*

Industry (Existing & potential operators)

Cost savings resulting from a reduction in the rate of adverse patient outcomes, as a consequence of industry compliance with new quality standards, and extended coverage of legislation.

In 1994/5, a Commonwealth review into compensation and professional indemnity in health care (the Professional Indemnity Review (PIR)) concluded that *the best way to minimise the human and financial costs of adverse patient outcomes is to implement effective quality assurance and risk management strategies.*[7]

Measures contained in the proposed licensing model which could potentially reduce the rate of adverse patient outcomes in private health facilities include:

- provisions enabling more comprehensive and clearer quality standards to be made for licensed private health facilities
- mandatory accreditation
- reporting requirements which will enable the CHO to monitor the rate of adverse patient outcomes, and to intervene where the reported data indicates that a facility may not be complying with clinical quality standards
- extended coverage of the licensing regime to facilities not currently licensed (eg pregnancy termination clinics).

[6] Based on increased fee levels as outlined in A above.

[7] Commonwealth Department of Human Services and Health, *Compensation and Professional Indemnity in Health Care: A Final Report*, November 1995, p.89.

As noted in section 2, the results of the QAHC Study[8] indicate that, in 1992, around 230,000 patients admitted to public and private hospitals in Australia would have had a preventable adverse event including approximately 30,000 patients suffering a permanent disability of some kind and 10,000 to 14,000 deaths. The Study estimated that, in 1992, 3.3 million hospital bed days in Australia were attributable to adverse patient outcomes (eg. through increased length of stay). For preventable adverse patient events, it was estimated that this amounted to around $650 million in hospital costs.

On the basis that one in every four days of hospitalisation are provided by private hospitals and that Queensland has roughly 20% of the nation's private hospitals, the results of the QAHC Study suggest that approximately 11,500 preventable adverse patient outcomes would have occurred in Queensland private hospitals in 1992 resulting in $32.5 million in hospital costs. The bulk of these costs would have been be borne initially by the health insurers but ultimately all of these costs would be met by consumers either by direct payment or through health insurance premiums (see consumer/health insurer impacts discussed below).

It is reasonable to assume that a significant number of the adverse patient outcomes which occur in private health facilities lead to damages claims (eg. in negligence) being brought against private hospitals (eg. where the adverse outcome resulted from an unsafe physical/clinical environment in the hospital). Therefore, a reduction in the rate of adverse patient outcomes in private health facilities could potentially reduce the likelihood of facilities being exposed to damages claims and incurring consequential costs (eg. through uninsured losses, increased insurance premiums).

Cost savings from increased clarity of licensing requirements

Under the current legislation the licensing criteria are not specified and the standards which must be met by licensed private health facilities are set out in range of legislative and administrative formats. This can result in potential and existing operators incurring costs associated with unproductive activity eg. seeking clarification/advice from Queensland health as to entry/ongoing requirements for licensing, providing additional information, amending applications etc.

These costs will largely be avoided under the proposed licensing model as the criteria which must be satisfied by licence applicants are clearly set out and the proposed new Standards will clearly specify what minimum quality standards must be met at licensed facilities.

Increased profits arising from increased utilisation of private health facilities flowing from increase in consumer confidence in industry

Consumer confidence in private health facilities could potentially increase if consumers perceive that the new licensing model will improve the quality and safety

[8] Reported in PIR Final Report, p.20

of services provided in private health facilities. This may lead to increased utilisation of private health facilities and a consequential increase in profits for operators.

Community/Consumers

Increase in the cost of private health care as a flow-on from increased licensing costs

The potential increased costs to industry in complying with licensing requirements under the proposed model were outlined in Table 4 above. As noted, the impact will mainly affect day facilities, and the additional costs will largely comprise non-recurrent accreditation costs which (as previously discussed) need to be heavily discounted. It is not considered that these increased costs will have any significant effect on the price of health services for consumers given the small number of facilities involved and that the costs would represent a very small component of the facilities' operating expenditure. In addition, contracting arrangements between health funds and private health facilities could also severely restrict the capacity for facilities to increase their charges.

Increase in consumer protection as a result of application of new quality standards and extended coverage of legislation

The results of the QAHC Study, as noted above, suggest that significant rates of preventable adverse patient outcomes occur in private health facilities. Such outcomes can result in a wide range of social and economic costs. The social costs include the permanent disability/death of a patient and the impact of this on the patient's family/carers while the economic costs to consumers include additional hospital/medical costs incurred as a consequence of extended hospital stay or re-admission and loss of income/earning capacity. The hospital costs, at $32.5 million per annum estimated for Queensland private hospitals, based on the results of the QAHC Study, are borne by consumers either directly or through payment of health insurance premiums.

As noted previously, the proposed licensing model contains measures which will potentially improve the quality of services provided to patients and reduce the rate of adverse patient outcomes. These include the requirement for licensed facilities to comply with the new quality Standards to be developed under the proposed model and the proposed extended coverage of licensing requirements to a wider range of day facilities.

Government

Costs associated with the establishment of new licensing framework

The development of a new licensing framework under the proposed model will involve certain costs to government associated with:

- policy development and consultation processes

- the drafting of new legislation, and the necessary Cabinet and Parliamentary processes (some costs would also be incurred by the introduction of a negative licensing framework)
- the development of new quality Standards (external consultants may need to be engaged by Queensland Health to advise on certain aspects of the standards)
- establishing new administrative processes necessary for the operation of the licensing system
- implementation of the new licensing system

These costs will be non-recurrent with the exception of costs incurred in the periodic amendment of the legislation and the Standards.

Lower administration costs resulting from increased transparency/clarity of new legislation.

The new legislation will provide greater clarity than the existing legislation, particularly as the criteria for assessing licence applications and as to the minimum quality Standards to be met by licensees. This may result in lower administrative costs to Queensland Health by potentially reducing its resources used in:

- processing applications that are refused for failure to satisfy/address licensing Standards
- advising applicants and potential applicants as to licensing requirements.

Increase in public confidence in the government's ability to protect consumers through improved oversight of standards in private health facilities.

The public may initially view the proposed new licensing model, with its greater focus on quality standards, and its extended coverage of facilities, as a measure by which the government is striving to increase/maintain the quality of private health care and to provide greater protection to users of private health services. The extent to which this impact would continue may be dependent upon the extent to which the government can effectively administer and enforce the new legislation.

Health Professionals/Professional Indemnity Insurers

Lower costs resulting from possible reduction in the rate of adverse patient outcomes

Adverse patient outcomes at private health facilities can, in addition to resulting in legal actions against operators of facilities, result in legal actions and/or disciplinary action against individual health professionals providing services in the facility. Such actions can arise directly or indirectly from licensing-related matters. For example, an adverse outcome resulting from an unsafe physical or clinical environment may result in a claim against the health practitioner as well as the operator of the facility. A reduction in the rate of adverse patient outcomes could potentially reduce:

- legal costs or professional indemnity premiums for health professionals
- legal costs/insurance payouts for professional indemnity insurers.

An indication of the costs incurred by professional indemnity insurers as a result of adverse patient outcomes was given in the PIR[9] which noted that insurance payouts made by Australian Medical Defence Organisations (which provide professional indemnity insurance cover for the medical profession) rose from less than $22 million in 1987 to more than $37 million in 1991.

Private Health Insurance Funds/Health Insurance Commission

Reduction in insurance payouts/Medicare payments

As noted above, it is estimated that, based on the results of the QAHC Study, $32.5 million in hospitals costs are incurred annually in Queensland as a result of preventable adverse patient outcomes (eg. through increased length of stay). These costs, when translated into hospital charges, are borne largely by private health insurers through insurance payouts, although ultimately they are met by consumers through health insurance premiums.

Another significant cost attributable to adverse patient outcomes is the Medicare payments made for medical costs for treatment provided to patients as a result of the adverse outcome.

The proposed licensing model could, as mentioned above, potentially result in a reduction in the rate of adverse patient outcomes and thereby reduce these costs.

Increased income for accreditation bodies, and consultants providing services to health facilities preparing for accreditation

Any increased participation in accreditation programs as a result of the accreditation requirements under the proposed model would result in additional income for accreditation bodies as well as consultants providing services to health facilities preparing for accreditation. However, given the external factors affecting the level of participation in accreditation programs (see p.31), the amount of income that would be generated as a result of the accreditation requirements would be negligible.

B. *NEGATIVE LICENSING MODEL*

Industry

Lower profits due to potential loss of market share and reduced consumer confidence in industry

[9] PIR Interim Report, p.18

As a consequence of the removal of the market entry barriers established under the current licensing regime, the size of the market may increase initially (there is no available data to indicate the extent to which this might occur). This may result in reduced market share for existing operators and, as a consequence, lower profits.

In the longer term, any untoward growth in the market is likely to stabilise as a result of competitive forces. As noted in section 7, additional factors which could limit the extent to which the market could expand include further decline in the levels of private health insurance, shortage of medical specialists and the ability of health insurers to contract only with selected operators.

In the absence of licensing, there may be reduced consumer confidence in the quality of services provided at private health facilities. This could result in lower utilisation of private health facilities and therefore lower profits for operators.

Increase in legal and other costs arising from litigation and government intervention resulting from likely increase in rate of adverse patient outcomes

Under the "negative licensing" model, operators will be expected to voluntarily comply with any industry-based/accreditation standards. There would potentially be a greater likelihood of non-compliance with standards by operators, particularly of new facilities, given that accreditation bodies would not ordinarily assess whether a new facility meets accreditation standards until at least 12 months after the facility commences to operate.

The QAHC Study highlights that significant rates of preventable adverse patient outcomes exist in private health facilities, notwithstanding the licensing of such facilities. The removal of the licensing system may lead to in an increase in the rate of adverse patient outcomes resulting in increased legal and other costs for operators through consequent involvement in civil litigation or other means of dispute resolution, or by responding to intervention by Queensland Health.

Costs of developing industry-based standards, if required, in addition to existing (eg. ACHS) standards.

In the absence of licensing standards, industry would presumably wish to establish standards/codes of practice with which all industry participants are expected to comply. Existing accreditation standards (eg. ACHS) could, to a large degree serve this purpose. However, ACHS standards assume the existence of a licensing regime, and that minimum standards will have been met as a consequence of a facility being licensed. If minimum standards are to be set for industry, existing accreditation standards may need to be expanded or supplemented by other standards to achieve this. This will result in costs to industry.

Unrestricted entry to the market for potential operators

The removal of licensing will allow unrestricted entry to the market for new operators. As mentioned above, there is no available data to indicate the level to which the market may grow. The effects of this potential growth in the market (eg. market fallout) were outlined above.

Community/Consumers

Increase in rate of adverse patient outcomes due to lack of requirement for private health facilities to comply with licensing standards

The potential for an increase in the rate of adverse patient outcomes in the absence of licensing standards has been discussed above (eg. in so far as that may impact on industry). Adverse patient outcomes can result in a range of significant social and economic costs for the patients concerned and the wider community (eg. death or permanent disability, hospital/medical costs, loss of income/earning capacity).

Increase in health insurance premiums resulting from increased supply of services by unlicensed facilities

Proponents of "supplier induced demand" theory argue that an unrestricted supply of private health facilities (without licensing) will lead to a greater demand for services and subsequent higher overall payouts by health insurers, who will increase premiums as a consequence (this theory is not accepted by all economists)[10]. The Industry Commission[11] noted that increasing hospital utilisation ranked near the bottom as a source of premium increases. In addition, the extent of this potential impact may be minimised by health insurers in effect capping supply by only contracting with selected operators and by increasing levels of self-insurance in the community.

Increased public waiting lists arising from loss of public confidence in unlicensed private market

As mentioned above, the public may consider that the removal of licensing will result in lower quality standards in private health facilities. This loss of public confidence may result in increased demand for public sector health services and longer waiting lists for treatment in public sector facilities.

Lower cost of private health care and increased choice of private health services

As noted on page 10, economic theory maintains that, in most cases, free competition yields the most efficient outcomes for consumers eg. lower prices, better range of services. The removal of barriers to market entry could result in an increase in the

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[10] See, for example, John Logan, *Competition in Health: An Economic Perspective,* Centre for Independent Studies, circa 1996; and Brian Ferguson, *Supplier-Induced Demand: A Review of Some Non-Evidence",* CIS Working Paper in Health and Welfare, Centre for Independent Studies, September 1989.

[11] Industry Commission Report, *Private Health Insurance,* February 1997. p 253.

size of the market thereby increasing competition and providing consumers with access to a greater range of services.

While there is no available data to indicate the extent to which increased competition will occur, the factors which are likely to limit market growth and restrict the ability of operators/health funds to reduce charges/premiums have been noted in section 10 above.

It is unlikely that the removal of licensing costs, given that they represent a very small percentage of the operating expenditure of private health facilities, would have a significant impact on the cost of private health care.

Government

Increased costs associated with establishing/administering a negative licensing framework.

The establishment of the negative licensing framework will involve costs to government in relation to:

- the repeal of the licensing legislation and the development of new legislation conferring powers for the CHO to intervene where public health/safety is considered to be at risk
- handling/investigating likely increased volume of consumer complaints about private health facilities
- taking action enforcement against private health facilities where necessary.

As mentioned above, it is likely that there will be an increase in the rate of adverse patient outcomes under a negative licensing framework. This is likely to result in a corresponding increase in the volume of consumer complaints against private health facilities.

There no data available to predict the extent of this increase. However, the volume of consumer complaints under the current licensing framework has been relatively low. The Annual Reports of the Health Rights Commission indicate that, during the four year period from 1992-1996, 39 consumer complaints about private hospitals were received by the Commission while 43 complaints were received in 1996/7. In percentage terms, private hospitals represented 10% of all consumer complaints to the Commission in the years 1992-1996, and 10.8% in 1996-97. It should be noted that not all consumer complaints concern issues related to adverse patient outcomes, or even to treatment issues (eg. some complaints are about costs or management issues).

Complaints about private health facilities can overlap with complaints against health professionals, eg. where a procedure preformed competently by a medical practitioner results in an adverse patient outcome as a result of an unsafe physical or clinical environment existing in the facility. As a consequence, complaints of this nature can

involve costs to other government agencies such the Health Rights Commission and the Health Practitioner Registration Boards

Increased public waiting lists which may arise from loss of public confidence in unlicensed private market; decrease in public confidence in government's ability to protect health consumers

As noted above, the replacement of the current licensing system with a negative licensing system, and any consequential increase in the rate of adverse patient outcomes, may reduce public confidence in the government's ability to ensure that private health facilities meet appropriate quality standards and are safe to attend. Diminished public confidence in this regard could cause significant political damage to the government and contribute to an increase in utilisation of public sector health services thereby increasing public hospital waiting lists.

Health Professionals/Professional Indemnity Insurers

Higher legal costs/premiums/payouts resulting from possible reduction in the rate of adverse patient outcomes

This impact is the direct opposite to the potential benefits (discussed above) for these groups resulting from the proposed licensing model.

Increase in income for health professionals

As noted above, the removal of the market entry barrier established under the current licensing regime may be likely, in the short term, to increase the size of the market. An increase in the number of private health facilities would potentially provide greater employment opportunities for health professionals (salaried or with visiting rights) and increase the demand for their services. This would place health professionals in a better position to demand higher salaries or charge higher fees for their services.

Private Health Insurance Funds/Health Insurance Commission (HIC)

Increase in insurance payouts and Medicare payments

As noted above, the abolition of licensing is likely to result in an increase in the rate of adverse patient outcomes. The QAHC Study highlights the costs attributable to increased length of stay or re-admissions due to preventable adverse patient outcomes. These costs include hospital costs, which for patients in private health facilities would be borne largely by the health insurance funds (ultimately met by health fund members), and medical costs through Medicare payments (ultimately met by the public through the Medicare levy).

A further factor which could lead to an increase in insurance payouts by health funds and Medicare payments is that there may be an increase in the size of the private healthcare market under a negative licensing model which could result in excessive

demand and overservicing. This argument is based on the "supplier induced demand" theory which has been widely challenged[12]. In any event, the extent of this impact may be minimal given that various factors (eg. competitive forces, possible loss of consumer confidence in unlicensed facilities) are likely to limit any untoward growth in the market.

Increased costs for HIC and health insurers in determining whether a facility is eligible for the payment of benefits

The payment of Medicare benefits for services provided in private hospitals is dependent on the relevant hospital being 'declared' as a private hospital under the Commonwealth *Health Insurance Act 1973*. The holding of a State or Territory licence is a prerequisite to the declaration of a private hospital, presumably on the basis that the holding of a licence indicates that minimum quality standards are met in the facility. Similarly, the holding of a licence is generally a prerequisite to facilities contracting with private health insurers.

In the absence of licensing, the HIC and private health insurers would need to rely on other means of satisfying themselves as to whether a facility meets appropriate quality standards. This could involve costs to those parties (eg. carrying out inspections, consultancy costs) particularly in the case of new facilities where accreditation status could be used as a criterion in this regard.

Increase in profits due to health insurers having a greater choice of facilities with which to contract

As noted above, the abolition of licensing could result in an increase in the size of the market which would provide health insurers with a greater choice of facilities with which to contract. Insurers will therefore be in a better position to negotiate contracts which are more financially attractive for them and which will result in increased profits.. However, the extent of this impact will be limited by the rate of market growth which, for the reasons outlined in section 7, may be minimal.

Increased income for accreditation bodies and consultants providing services to health facilities preparing for accreditation

Any increase in the size of the market resulting from the abolition of licensing may produce increased income for accreditation bodies and consultants providing services to health facilities preparing for accreditation. The amount of such income would depend on the extent to which market growth occurred. As noted in section 7, this may be limited.

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[12] See footnote no.6

11 NET EFFECT OF IMPACTS

In relation to the impacts described/quantified in sections 9 and 10 above, the net effect on each of the relevant stakeholder groups can be summarised as follows:

Under Proposed Licensing Model

Existing operators

Increased costs (by way of licensing fees) are likely to be incurred by relatively few operators namely, day facilities not currently required to be licensed.

Given that the benefits (potentially lower costs through reduced risk of litigation and increased clarity of licensing requirements, higher profits as a result of increased utilisation) will apply to all operators, it is considered that there will an overall net benefit to operators.

Potential operators

There will no significant costs but there is expected to be benefits, namely, potentially lower costs through reduced risk of litigation and increased clarity of licensing requirements (entry and on-going).

Consumers

The potential for the cost of private healthcare to increase as a flow-on from increased licensing costs is minimal. However, the potential increased consumer protection (through a reduction in the rate of adverse patient outcomes) represents a clear net benefit.

Government

The initial costs involved with establishing the proposed new licensing system (eg. developing standards, education) could, to a large extent, be offset by potential savings made in the administration of the legislation due to its increased clarity/transparency. As the possible extent of the other benefit (increased public confidence in the government's ability to protect consumers) may be minimal, it is estimated that the net effect of the impacts would be essentially nil.

Health Professionals/Professional Indemnity Insurers

Benefits to these groups could accrue through cost savings flowing from potentially lower levels of litigation against health professionals providing services at private health facilities.

Private Health Insurance Funds/Health Insurance Commission

Benefits to these groups could accrue through the potential reduction in insurance payouts and Medicare payments attributable to adverse patient outcomes.

Accreditation bodies and consultants

The benefits to these groups are likely to be negligible.

Under Negative Licensing Model

Existing operators

While operators will no longer have licensing costs, it is possible that this benefit would be lost or substantially reduced as a result of the potential increase in litigation/insurance costs resulting from the likely increase in the rate of adverse patient outcomes. This factor, coupled with the potential loss of market share without licensing, suggest that there will be a net cost to existing operators under this model.

Potential operators

As with existing operators, savings from the removal of licensing costs may be roughly equivalent to the potential increase in litigation/insurance costs resulting from the likely increase in the rate of adverse patient outcomes. The absence of restrictions on entry to the market may result in a net benefit to potential operators. However, in the longer term, some new entrants may exit the industry as a result of competitive forces.

Consumers

The most significant impact on consumers is the potential increase in the rate of adverse patient outcomes in the absence of licensing. It is considered that the social and economic costs associated with this impact, as highlighted by the QAHC Study, whilst not quantifiable in monetary terms, would far outweigh the potential benefits to for consumers resulting from any increased competition in an unlicensed market.

Government

It is likely that the costs savings achievable through the abolition of the current licensing regime (estimated at $165,000 per annum) would be substantially offset by the costs associated with the likely increase in consumer complaints under the negative licensing model. However, it is considered that the potential costs of a reduction in public confidence in the government's ability to ensure the protection of the public (eg. adverse political consequences, increased public waiting lists), while not quantifiable in monetary terms, would be sufficiently significant to outweigh the relatively minor cost saving as a result of the abolition of licensing.

Health Professionals/Professional Indemnity Insurers

The potential exposure of these groups to costs arising from damages claims brought as a result of a likely increase in adverse patient outcomes could be significant and on-going. It is estimated that this would be likely to outweigh the potential benefits from employment-opportunities for health professionals which may be minimal given the factors that would limit market growth.

Private Health Insurance Funds/Health Insurance Commission

While these groups could incur significant additional costs through increased insurance payouts and Medicare payments attributable to a likely increase in the rate of adverse patient outcomes, these costs would ultimately be met by health fund members and the public respectively. The effect of the impact is therefore likely to be negligible.

Accreditation bodies and consultants

The benefits to these groups are likely to be minimal.

12 CONSULTATION

As noted in the Introduction, consultation has been undertaken with a Stakeholder Reference Group and the PHAQ. Both support the overall policy framework for the PHFB.

The Stakeholder Reference Group considered the 4 possible regulatory models (see page 9) identified as options in the PBT Plan and did not support self regulation (Option 1) on the grounds that such an approach would not offer sufficient protection to the public. The Group was of the view that having regard to the nature of the health services provided at private health facilities some form of licensing system was necessary to ensure that only operators who can meet minimum quality standards should be allowed to enter into or remain in the market. The Group supported Option 4 (the proposed licensing model).

The PHAQ initially proposed that "planning controls" should be included in the legislation but has recently indicated it no longer supported controls on "bed numbers" and accepts that "planning controls" would have a major impact on competition.

The range of day facilities within the scope of the proposed licensing model could potentially include some dental clinics and GP treatment rooms. There is clearly no intention for the legislation to apply to GP rooms used for normal consultation purposes. However, there is a widespread concern among stakeholders that there are some procedures undertaken in GP treatment rooms and dental clinics (eg. those involving the use of general anaesthetic) which warrant the licensing of those facilities.

Consultation on this issue will be undertaken with the medical and dental professions, and other relevant stakeholders in parallel with the drafting of the PHFB.

The Department of Local Government and Planning has been consulted and has advised that, as the approvals and licences proposed under the PHFB are of a "personal" nature involving an assessment of matters such as the applicant's experience and ability, they are not suitable to be dealt with under the Integrated Development Approval System (IDAS) under the *Integrated Planning Act 1997.*

The Business Environment Unit has been consulted and endorses the overall policy framework for the PHFB but is of the view that licences should be able to be issued for an unlimited term rather than, as is proposed, for a maximum renewable term of 3 years. However, the granting of licences for a finite period is an essential part of the licensing process as it provides a mechanism for the periodic re-assessment of whether licensing standards are being met and also facilitates on-going compliance with those standards. The 3 year term is consistent with the accreditation process (for ACHS) which operates on a 3 year cycle.

13 INTERSTATE DEVELOPMENTS

All other Australian jurisdictions currently require private hospitals to be licensed while only New South Wales, Victoria and Western Australia require day hospitals to be licensed. Planning controls are contained in legislation, or applied administratively, in most interstate jurisdictions.

Most jurisdictions are in the course of conducting NCP reviews. There has been on-going consultation with other jurisdictions as to the progress of their reviews and there is no suggestion that private hospitals will not continue to be licensed in these jurisdictions. The key licensing issue seems to be the extent to which licensing should apply to day hospitals.

Most jurisdictions are reviewing planning controls in the context of their NCP reviews. There is doubt as to whether such controls will be able to be justified under a PBT assessment.

In Victoria, planning controls have been recently reviewed separately and it is proposed that they be abolished. In this regard, the Victorian Office of Regulation Reform found that

the removal of the bed cap and most of the planning controls will facilitate entry and exit from the industry as well as the expansion and reduction of existing hospital facilities[13].

[13] Victorian Office of Regulation Reform, *Impact Assessment Study on the Role of Government in Regulating Private Hospitals*, February 1996, p.vii.

This indicates that planning controls, rather than quality based licensing requirements, have been the major anti-competitive factor in the private health care market.

14 CONCLUSION

As indicated above, it is estimated that the proposed licensing model will have a nil impact on government but produce net benefits to the other stakeholder groups while the negative licensing model is likely to produce net benefits to potential operators and accreditation bodies/consultants but result in costs to the other stakeholder groups. However, as the majority of the impacts cannot be valued, it is not possible to aggregate such impacts for the purpose of assessing the net public benefit/cost of the respective models.

Given that the policy objective of regulating private health facilities is to protect the health and well-being of users of private health facilities, it follows that, in assessing the net public benefit/cost of the respective models, the greatest weight should be given to the consumer impacts relating to the incidence of adverse patient outcomes. These impacts directly effect the health and safety of patients at private health facilities and provide the most significant indicator as to the extent to which the policy objective could be achieved. This approach is supported by the results of the QAHC Study (see p.32 above) which suggest that the rate of preventable adverse patient outcomes in private health facilities is quite significant and highlight the major social and economic costs to the community that flow from such outcomes.

In this regard, the proposed licensing model contains new features with the potential to improve the quality of care at private health facilities and thereby reduce the likelihood of adverse patient outcomes occurring. The combination of this major benefit to consumers, the net benefits to the industry and the negligible impact on government, produce a significant overall net public benefit.

In contrast, the negative licensing model, through the absence of entry requirements or minimum standards, will potentially result in an increase in the incidence of adverse patient outcomes. While there may be some benefits to industry under this model (eg. minimal costs savings, unrestricted entry to the market for potential operators) it is considered that the costs to consumers resulting from the potential increased risk of harm through the negative licensing model outweigh the benefits to industry and produce an overall net cost to the public.

In the circumstances, the proposed licensing model is the preferred regulatory model for private health facilities. Other relevant factors which support this conclusion are that:

- while the model is more restrictive than the current model (to the extent that the scope of licensing of day facilities is broadened), the model does not significantly restrict competition, in that the licensing requirements are quality-focussed and do not allow for the application of planning controls in any form

- the licensing of private health facilities is supported by all stakeholders consulted during the review

- a similar licensing model is currently adopted by all other Australian States and Territories and is likely to be retained after NCP legislative reviews have been conducted in those jurisdictions.