# HEALTH SERVICES POLICY REVIEW FINAL REPORT

# GOVERNMENT RESPONSE

## BACKGROUND TO THE REVIEW

The Health Services Policy Review was initially commissioned by the previous Government in order to meet Victoria's commitments under National Competition Policy to review significant legislation which may restrict competition. The Review was conducted by a small team of consultants led by Professor Stephen Duckett, Dean of the Faculty of Health Sciences at Latrobe University.

The consultants were asked to undertake a 'big picture' review of the *Health Services Act 1988* (the Act) from a competition policy perspective.

The Act is the regulatory framework governing public and private sector health services in Victoria. It provides for the governance of metropolitan health services, public hospitals and community health services. It also provides for the regulation of non-funded private sector supported residential services providing 'special or personal care' to residents. Residents of supported residential services may include aged persons, people with disabilities and marginalised individuals who need assistance with daily living or management of medication.

A Discussion Paper for the review was released in March 1999. Following consideration of 75 public submissions, the consultants produced a Final Report containing 33 recommendations. The Government received the Final Report earlier this year and now provides its response.

The Government considers that the Final Report contains many valuable ideas for improving health services in Victoria. It has accepted the overwhelming majority of the recommendations of the Review.

## SUMMARY OF GOVERNMENT RESPONSE

**Regulatory issues affecting hospitals**

The Government agrees to -

- remove the private hospital bed cap and beds to population ratio (thereby eliminating the 'market' for the transfer of private hospital beds);
- not reintroduce a bed cap applicable to day procedure centres upon the expiry of the current 'moratorium';
- retain regulation and enhance regulation designed to ensure fitness of operators and safety in private hospitals and day procedure centres; and
- aim to achieve equivalent minimum standards of safety and quality apply in both the public and private hospital sectors.

**Structural change and 'level playing field' issues**

- The Government will not pursue competitive purchasing models or models which would enable the private and public sectors to compete for the right to operate existing public hospitals or constellations of public health care services.

- Public hospitals will not be required to charge full cost for the treatment of private patients at this time, but the costs and benefits of this approach will be explored if the Commonwealth enables private patients in public hospitals to access second tier benefits.

- The Government will not take any steps to remove existing tax exemptions and concessions applicable to not for profit providers of health services (both public statutory bodies and 'private' charitable providers).

**Measures to empower consumers and enhance quality**

The Government -

- supports in principle the establishment of a health call centre on a pilot basis for 5 years, subject to satisfactory resolution of its role, funding source and the need to ensure effective integration with the Commonwealth's Carelink program;

- supports the development of performance indicators and publication of aggregate data on hospital performance, once the indicators have been tested and found to be satisfactory;

- supports in principle the establishment of mechanisms designed to ensure a systems approach to quality across the hospital sector, subject to further consultation with stakeholders on detail; and

- will give patients a legislative right of access to health records held by public and private sector organisations and individual practitioners.

**Supported residential services**

The Government agrees to remove the statutory distributional controls applicable to private sector supported residential services (SRS), and will retain all existing regulation aimed at protecting vulnerable SRS residents.

## Regulatory issues affecting hospitals

**The private hospital and day procedure centre bed cap**

The Act requires the Department of Human Services (DHS), in considering applications for registration or variation of registration to enable a private hospital or day procedure centre development, to consider whether granting the application would result in *more than adequate health services of any kind becoming available in an area*. Guidelines provide criteria for determining adequacy of health services as required by the Act. Registration under the Act stipulates the permitted number of beds in a facility.

Guidelines currently being applied state that a regional acute (public and private) bed to population ratio of between a minimum of 2/1000 and a maximum of 4.1/1000 is deemed to provide an adequate level of services. This effectively requires applicants for private hospital developments to acquire registered beds from existing private hospital proprietors as DHS does not register any additional private beds or allow the transfer of beds from the public to the private sector. This provision has operated as a bed cap in the private hospital market. The guidelines are not applied to the public hospital sector.

In relation to day procedure beds (beds registered for 'day procedures' where the patient is reasonably expected to be admitted and discharged on the same day, whether in private hospitals or stand alone day procedure centres), a Governor in Council Order was made in 1997 effectively removing the bed cap temporarily (known as a 'moratorium' on the need to acquire day procedure beds from the existing pool). The Order was initially expressed to apply for two years and was extended for a further 12 months in 1999. It expires on 22 July 2000.

The 'moratorium' was introduced when the problem of unregistered day procedure centres emerged. Some proprietors, frustrated at the need to pay others high prices to enable the transfer of beds, chose to operate unregistered facilities. DHS did not wish to prosecute or close down facilities that were providing an acceptable health service and the then Government implemented the moratorium to enable them to be brought within the regulatory framework

The Review has recommended immediate withdrawal of the guidelines imposing the bed cap and beds to population ratio and the repeal of the statutory requirement to consider whether there are more than adequate services in an area for both private hospitals and day procedure centres. The Review considers that the bed cap, which can be traced back to the 1970s, is a barrier to market entry and has long ceased to perform a useful policy role.

Regardless of National Competition Policy, the Review makes a convincing case for removing the bed cap. In view of changing technologies, shorter length of hospital stay and far greater utilisation of day procedure services, a more flexible approach is now required which recognises that a beds to population ratio is no longer a meaningful way of assessing community need for health services.

The Government accepts the Review's recommendation to remove the bed cap and will therefore replace the current guidelines with a new guide for assessing applications for registration of both private hospital and day procedure developments under the Act. The new guide will take effect on 22 July 2000. It will introduce new criteria for determining adequacy and will remove the requirement to source beds from the existing pool.

Many stakeholders consider that the statutory provisions about adequacy of services have the potential to be a useful planning mechanism. It is therefore not proposed to amend the Health Services Act to remove them at this time. Instead, the Government will evaluate the impact of the new criteria for assessing adequacy once they have operated for a sufficient period to enable an assessment of their effectiveness.

**The regulatory framework for hospitals**

Under the Act, private hospitals and day procedure centres are required to be registered in order to carry on business lawfully. To provide certainty for proponents of new developments, the Act provides a mechanism for the granting of approval in principle for registration at initial planning stage. Registration criteria include suitability of the design and construction of the premises for the intended use, fitness of the proprietor and associates, compliance with any distributional guidelines

(see above), ongoing compliance with minimum standards of safety and quality set out in the Act and relevant regulations, and compliance with any conditions imposed on registration.

Regulations made under the Act set minimum standards aimed primarily at patient safety and cover issues such as minimum staffing ratios, patients rights, record keeping. The regulations only apply to the private hospital sector, but equivalent minimum standards are expected of public hospitals.

The Review has recommended that:

- building standards for hospitals should be incorporated into the Victoria Building Regulations. Once this occurs, DHS should no longer approve the design and construction of private hospital premises;

- the statutory registration framework, including the approval in principle process, assessment of fitness and propriety of applicants and capacity to impose conditions on registration and inspect premises should be retained; and

- regulations under the Act should be reviewed for relevance and reformulated to apply also to public hospitals. The proximity requirement for day procedure centres which is contained in guidelines should also be reviewed.

The statutory registration framework is considered essential to ensure minimum standards of patient safety in public hospitals. The Government will retain this framework, however consideration will be given to whether current statutory definitions are adequate in light of safety concerns. A review of the regulations as proposed in the Report has commenced to ensure that they remain relevant and achieve their objectives effectively and efficiently.

The principle of equivalent minimum standards for public and private hospitals is accepted and will be addressed in the context of the current regulation review, which will analyse and assess costs and benefits and competition implications of any regulatory proposals via a regulatory impact statement. It is proposed that consultation will take place between DHS and the Building Control Commission to examine the feasibility of incorporating building standards into the Victoria Building Regulations.

## Structural change and 'level playing field' issues

### Purchasing models and competition for public health care services

The Review examined some models for structural change which could increase competition among the public and private health sectors including area based and competitive purchasing models, and models which would enable the private and public sectors to compete for the right to operate existing public hospitals or constellations of public health care services (franchising models).

These strategies are not consistent with Government policy. The Review recommended against proceeding with them, given the way in which Australia's health system is currently organised. These recommendations were supported by the overwhelming majority of those who made submissions to the review, most of whom were opposed in principle to such approaches. As

required under National Competition Policy, a convincing case has been made for not adopting such approaches.

**Charging for private patients in public hospitals**

The Review has recommended that the State should cease to prescribe fees for private patients in public hospitals and should not set targets for private patient activity. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income should be retained by the hospitals and the State should cease to make WIES (Casemix) payments in connection with those services.

This is a complex issue and implementation is difficult. Policy options are constrained by Commonwealth policy on access by private patients in public hospitals to default benefits and the behaviour of private health insurance funds.

The expansion of the private hospital market has seen declining numbers of private patients being treated in public hospitals over the past 10 years. In view of this and the difficulties associated with implementation, it is questionable whether the costs of moving to a policy of full cost recovery for private patients would outweigh the benefits. It is not proposed to explore the costs and benefits until such time as the Commonwealth takes the necessary first step towards feasibility by making second tier benefits available to private patients in public hospitals.

**Taxation exemptions available to the public and charitable sectors**

As public benevolent institutions, both public hospitals and 'private' charitable hospitals are exempt from a range of State and Federal taxes. The Review considers that this gives them a competitive advantage where they are in competition with for profit private sector hospitals in relation to the 'private patient' market.

The Review considered that, by providing services to the needy and disadvantaged, the charitable sector performs a valuable and valued role and that such activities merit Government and community support. Given this, the key National Competition Policy issue is whether the best means of supporting such activities is indirectly via taxation exemptions and concessions or via direct transfers from Government and the community. The Review has recommended that a working party be established to quantify the public benefits of these tax exemptions and suggested that the benefits could then be made explicit in a community charitable return for not for profit hospitals. It noted that such a review would need to be undertaken co-operatively at both State and Federal levels.

The benefits of taxation exemptions and concessions enjoyed by the charitable hospital sector will be reduced as a consequence of FBT and GST changes. Such an inquiry would need to encompass all charitable organisations as it would not be justifiable to confine it to hospitals. It would also need to involve the Commonwealth, which has already announced its intention to maintain concessional treatment of charitable organisations for FBT purposes. As the sector is currently undergoing considerable change, and given the difficulties inherent in undertaking such an inquiry, it is not proposed to pursue this approach.

In relation to public hospitals, the Review has pointed out that their main activity is a public benefit and the concept of a community charitable return is therefore not relevant. It has therefore recommended that input tax exemptions available to public hospitals should be eliminated, but has noted that there are complex interactions involved in implementation. It has proposed that, as a first step, a levy equivalent to payroll tax should be imputed to reflect private patient and other

commercial activity. (The Review considers that in principle, the financial impact of this change should be fed back into the public hospital system in the form of enhanced payments).

It is not proposed to move towards implementation of this recommendation at this time. Private patient activity is partly subsidised by the public sector and this provides some public benefits. Care is needed to ensure that any change does not result in private patients being out of pocket or actively discourage private patient activity. This change would require substantial change to hospital financing systems at a time when the public hospital sector is also facing adjustment to accommodate GST and FBT changes.

## Measures to empower consumers and enhance quality

The Review made various recommendations designed to enhance competition and consumer choice by redressing the imbalance of information between health care providers and consumers. These are:

- the establishment of a call centre on a pilot basis;
- the development by the Commonwealth and States by 1 July 2001 of a set of indicators of organisation and management of care including risk adjusted clinical performance indicators. It is proposed that hospitals would have 1 year to validate the indicators;
- amendment of the Health Services Act to require hospitals to require health service providers to provide information to enable DHS to measure performance against the specified indicators;
- the establishment of an overarching quality body with the power to compel the production of data from a wide range of sources including public and private hospitals and other relevant bodies such as consultative councils established under the Health Act; and
- the enactment of legislation to enable consumers to have access to their health records, whether the provider is public or private.

The Government supports the above recommendations. A strategy for the development of indicators is currently being prepared to ensure that, as a minimum, a set of Victorian indicators will be available for trial from 1 July 2001. Legislation to amend the Health Services Act will be necessary to provide a framework for the production of data and to support the proposed new overarching quality body. Draft legislative proposals will be developed in tandem with implementation strategies.

Legislation is being prepared for introduction in the Spring Session of Parliament that will give patients the right of access to their health information held by public and private sector organisations and individual practitioners. The legislation will also establish privacy standards for health information.

The recommendation to establish an overarching quality body is particularly important as it is designed to provide, for the first time, a system wide approach to quality improvement across the hospital sector. The objective is to ensure that "systemic issues are addressed, lessons learned with broad application are disseminated widely among health care agencies, and that action is taken to deal with identified issues of concern". It will not duplicate the work of existing bodies. Instead, it will act as a conduit to ensure that system wide quality issues are recognised and that appropriate

action is being taken by the boards and chief executives of health care agencies, other responsible bodies, and by DHS.

The proposed new body will include consumer, professional and managerial representation. Such representation will ensure that any information accessed by the committee will be interpreted correctly and appropriate conclusions drawn. Similarly, public reporting of its findings will facilitate community understanding of quality issues within health service provision.

The Review has proposed that health service boards should be required to report to the new body on units or individuals with less than average performance, so that it can monitor whether necessary action has been taken by the appropriate bodies. This approach is only supported in part. This body should have information at the unit or specialty level if necessary as it would have an interest in the systemic issues. However, this does not require individual identifying data. Access to individual identifying information is also likely be strongly opposed by professional organisations.

The Review also proposes that the Secretary of DHS should have the capacity to direct a quality committee, or committees, to either review data or investigate specific issues or to supply data for analysis. This data would not identify individual patients or professionals. The idea is to provide another mechanism by which it can be assured that institutional quality committees are evaluating and acting upon the data available to them. At present, DHS has various mechanisms, including health service agreements and the annual Policy and Funding Guidelines, through which providers can be encouraged, but ultimately not legally required, to provide performance information to it. This recommendation is accepted in principle, but requires further consideration to ensure that there is no overlap with the role of the new quality body.

## Supported residential services

Like private hospitals and day procedure centres, supported residential services (SRS) are required to be registered in order to carry on business lawfully. Similar statutory provisions apply such as assessment of suitability of the design and construction of premises for the intended use, fitness of the proprietor and associates, ongoing compliance with minimum standards of safety and quality set out in the Act and relevant regulations, and compliance with any conditions on registration. The Act requires DHS to assess whether an applicant for registration has and is likely to continue to have the financial capacity to carry on the establishment.

There are additional offences which apply to SRS proprietors which are aimed at protecting vulnerable residents. These include not providing health care when needed, failure to maintain residents' personal hygiene, failure to provide suitable nutrition, failure to maintain cleanliness of the premises and failure to properly account for residents' finances. Regulations also set minimum standards and cover issues such as minimum staffing requirements and record keeping.

The Review has emphasised that SRS residents are especially vulnerable and their vulnerability is usually lifelong. Statutory registration criteria such as the requirement to assess viability are especially important in the SRS context, as the closure of a facility is likely to leave residents homeless. The Review has therefore recommended retaining all of the current statutory registration criteria. This recommendation is supported, and no legislative change is proposed in this area.

The Act also enables distributional controls to apply to SRS (in a similar manner to private hospitals). However, no such controls have ever been applied. The problem in the SRS arena is undersupply of suitable accommodation to meet demand. The Review has recommended the repeal of these statutory provisions on the basis that distribution has always been determined by the market

and that this will inevitably continue. This recommendation is supported. As no distributional controls currently apply to SRS, implementation of this recommendation is not a high priority

The Review suggests that a broad review of regulation and policy covering all sorts of supported accommodation types (not just SRS), is desirable. It argues that different service types have evolved along separate paths and there is no coherent framework encompassing all the services. He has acknowledged that different forms of regulation in the supported accommodation sector tailored to different circumstances (eg. funded sector versus private sector) may be justifiable, despite competition policy.

Extreme care is needed to ensure that regulation does not make marginal private sector facilities unviable as this could lead to increased homelessness. Instead, the Government will undertake discrete reviews of regulation governing SRS, the care needs of SRS residents, standards in funded accommodation for people with intellectual disabilities, appropriate State role in relation to the regulation of nursing homes and hostels and related issues to ensure that regulatory regimes reflect Government policy. These reviews will involve stakeholder consultation.