Health Services Policy Review

Final Report

November 1999

prepared by

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and

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This Final Report is derived from a Discussion Paper of which Alan Rassaby of Phillips Fox Lawyers was a co-author.

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(015 1299)

The Hon. John Thwaites
Minister for Health

Dear Minister

We were commissioned in 1998 by the Department of Human Services with the agreement of the then Minister For Health, The Hon. Robert Knowles, to review the Health Services Act 1988 in order to meet Victoria's obligations under the National Competition Policy Agreements. Those Agreements require all Australian Governments to review legislation that may restrict competition by the year 2000. Legislation must be assessed against the guiding legislative principle which provides that:

> *Legislation should not restrict competition unless it can be demonstrated that:*
>
> - *the benefits of the restriction to the community as a whole outweigh the costs; and*
> - *the objectives of the legislation can only be achieved by restricting competition.*

Our Review was shaped by specific terms of reference and informed by the Guidelines for the Review of Legislative Restrictions on Competition (Department of Premier and Cabinet, Victoria, 1996).

We reviewed the Act together with the Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 and the Health Services (Residential Care) Regulations 1991 which contain legislative restrictions on competition in the public and private markets for health care. We produced a Discussion Paper outlining our findings and sought submissions from interested parties.

We have now had the opportunity to review the submissions and to reassess our previous recommendations in the production of this Final Report.

In this process we have had regard not only to the importance of facilitating fair competition between the public and private sectors, but also to the shape of the health system and the framework for legislation for the next five years. Our projection is for a health system which:

- *maintains the strengths of the existing system in terms of quality, efficiency and equity;*
- *provides an opportunity to learn from experimentation of different types of service provision;*
- *enables fairer competition between the public and private sectors;*
- *recognises and quantifies the returns to the community from the charitable, not-for-profit health sector; and*

- *provides better information to allow consumers to make more informed decisions.*

Although this Report was commissioned by the former Government, we believe that it contains information and recommendations which are relevant for the future operation of the health system in Victoria.

We commend this report to you.

Stephen Duckett *Lucy Hunter*

November 1999

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ACRONYMS AND ABBREVIATIONS USED

ADA Victoria	Australian Dental Association Victorian Branch
AHC	Australian Hospital Care Limited
AMA Victoria	Australian Medical Association Victorian Branch
BCA	Building Code of Australia
CCPHA	Church and Charitable Private Hospitals Association Ltd
CPI	Consumer Price Index
DHS	Department of Human Services
DHSV	Dental Health Services Victoria
DP Rec	Discussion Paper Recommendation
FID	Financial Institutions Duty
GST	Goods and Services Tax
HBC	Health Benefits Council of Victoria
HIA	Health Improvement Agency
HPPA	Hospital Purchaser Provider Agreement
HVPH	Hunter Valley Private Hospital (NSW)
MBS	Medicare Benefits Schedule
MRHAG	Ministerial Rural Health Advisory Group
MUMSS	Melbourne University Medical Students' Society
NCWV	National Council of Women of Victoria Inc
NHS	National Health Service
PBS	Pharmaceutical Benefits Scheme
PHACS	Primary Health and Community Services
PHAV	Private Hospitals Association of Victoria
RACP	Royal Australasian College of Physicians, Victorian State Committee
RACS	Royal Australasian College of Surgeons
RANZCOG	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Victorian State Committee
RMO	Resident Medical Officer
VAC/GMHC	Victorian AIDS Council/Gay Men's Health Centre
VCHC	Victorian Catholic Health Care
VHA	The Victorian Healthcare Association Ltd
VICCAG	Victorian Community Advisory Group on Mental Health
VIMD	Victorian Inpatient Minimum Dataset
WIES	Weighted Inlier Equivalent Separations

SUMMARY OF FINAL RECOMMENDATIONS

Final Recommendation 1

The objectives in section 9 of the Health Services Act should be expanded to recognise the differences in delivery of health care in different parts of the State and the critical importance of clinical research and the teaching and training of health professionals. We suggest the following words be added:

[The objectives of this Act are to make provision to ensure that …]:

- health care agencies are structured and funded in the most appropriate manner to meet the needs of the community they serve;
- clinical research and teaching and training of health professionals is facilitated.

Final Recommendation 2

Measures should be developed to enhance the capacity and accountability of boards of all public statutory bodies, including articulation of governance principles.

Final Recommendation 3

All agencies receiving a requisite level of funding from the Department of Human Services should be issued with a certificate of registration under the Health Services Act. A central registration unit should be re-established by the Department of Human Services.

Final Recommendation 4

Sections 83(1)(b) and 71(1)(a)(iii) of the Health Services Act should be repealed. The Secretary of the Department of Human Services should no longer be able to take into account adequacy of health services in an area when considering applications for approval in principle or registration of new private hospital developments. The Department should remove the bed cap by withdrawing the existing Guidelines for the Development of Acute Hospital Beds.

Final Recommendation 5

Building standards for hospitals should be incorporated into the Victorian Building Regulations. Once this occurs, the Department of Human Services should no longer approve the design and construction of private hospital premises.

The sole criterion for approval in principle and registration under sections 71 and 83 of the Health Services Act should be whether the applicant is a fit and proper person to operate, or be a director of, a private hospital.

The Secretary of the Department of Human Services should retain the power to set conditions under section 85.

Criteria for renewal under section 89 should be fitness and propriety of the principal, conformity with the law and compliance with conditions of registration.

The Department should retain the power to inspect premises pursuant to section 147 to determine compliance with the Act and Regulations.

Final Recommendation 6

Exemption from input taxes represents a competitive advantage which not-for-profit private hospitals have over their for-profit counterparts in the private patient market. Government should establish a working party to quantify the benefits of the tax exemption to the public. These benefits should then be made explicit in a 'Community Charitable Return' for not-for-profit hospitals. The Community Charitable Return should not be less than the tax revenue forgone.

The issue of input tax exemptions should be re-visited in the light of the working party's conclusions.

Final Recommendation 7

The State Government should no longer prescribe fees for private patients in public hospitals and should not set targets for private patient activity. Targets for public patient activity should be retained. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income received by public hospitals should be retained by them and the State should cease to make WIES payments in connection with those services.

Final Recommendation 8

The State should negotiate with the Commonwealth to ensure that:

- private inpatients of public hospitals are not disadvantaged in comparison to private hospital inpatients in accessing subsidised pharmaceuticals; and
- public and private hospitals are treated equivalently for health insurance purposes.

Final Recommendation 9

Input taxes create an unlevel playing field between public and for-profit hospitals in the private patient market. Given that we have recommended that public hospitals set fees for private patients in accordance with normal commercial practices it is appropriate that this difference be eliminated. However, there are complex interactions involved in implementation and as a first step a levy equivalent to payroll tax should be imputed to reflect private patient and other commercial activity of public hospitals.

Final Recommendation 10

The Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 should be reviewed for relevance and reformulated to also apply to public hospitals. Regulatory standards affecting quality of patient care should, as a general principle, be common standards which apply to public and private hospitals.

Final Recommendation 11

Day procedure centres should continue to be registered by the Department of Human Services but the current definition of a day procedure centre should be amended to delete any reference to the volume of activity. Consultation should take place as to the most appropriate manner of determining what procedures should be prescribed.

Final Recommendation 12

The bed cap should not apply to day procedure centres. The necessary steps should be taken to remove the bed cap, pending the repeal of sections 71(1)(a)(iii) and 83(1)(b) of the Health Services Act.

Final Recommendation 13

The Department of Human Services should review the proximity requirement for day procedure centres in the context of any available data on the number of patients who require emergency transfer from a day procedure centre to a proximate hospital.

Final Recommendation 14

The registration process for day procedure centres should be the same as the process described in Recommendation 5 for private hospitals.

Final Recommendation 15

The Department of Human Services should not pursue development of models that involve competitive purchasers at this stage, but should revisit this issue if the scope of services encompassed by a purchaser is expanded to include key primary care services such as MBS and PBS.

Final Recommendation 16

We have recommended that competitive purchasing models not be introduced at this stage. However, if they are introduced, consideration should be given to whether purchasers should also be disallowed from engaging in direct service provision.

Final Recommendation 17

The status quo provides the capacity for a significant level of competition in public patient services between the public and private sectors. Further efficiencies may be achieved by allowing the two sectors to compete for the right to operate existing public hospitals or constellations of services, however these efficiencies need to be demonstrated. Evaluation of outcomes at privately operated hospitals should therefore occur before proceeding with further implementation of this model.

Final Recommendation 18

Subject to developing robust measures of quality of training and research (which should be pilot tested in the public sector), Training and Development Grants should be available to the private sector.

Final Recommendation 19

The outcomes of the PHACS redevelopment and review processes should be evaluated before any competitive elements are implemented in this area.

Final Recommendation 20

Consideration should be given to enabling designated agencies funded for provision of public services (including public hospitals, PHACS agencies and other relevant agencies) to establish data integration mechanisms. Such mechanisms should ensure appropriate protection of consumers' rights to privacy and access to services.

Final Recommendation 21

A 24 hour call centre should be established in Victoria on a pilot basis for a 5 year period to assist consumers to be better informed about health care, health care providers and health choices. Measures should be taken to ensure confidentiality of information identifying any consumer.

Final Recommendation 22

The pilot call centre should receive information from each public hospital waiting list and advise patients of waiting times at alternative locations. The centre should also maintain and release data on accreditation status of public and private hospitals, the private health insurers with whom the hospitals have contracts, and the relative performance of public and private hospitals on the indicators developed pursuant to Final Recommendation 24.

Final Recommendation 23

The pilot call centre scheme should be subject to evaluation. If the pilot is successful, and the call centre established on a non-pilot basis, section 141 of the Health Services Act should be amended to impose a statutory obligation of confidentiality on staff of call centres.

Final Recommendation 24

The Commonwealth and the States should collaborate to develop by 1 July 2001 a set of indicators of organisation and management of care including risk-adjusted clinical performance indicators which are comprehensive, consumer focused and current. Hospitals and day procedure centres should have one year to validate the indicators and review their performance. From 1 July 2002, the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres. In the absence of an agreed national set of indicators, Victoria should develop and publish its own set.

Final Recommendation 25

The Health Services Act should be amended to require health providers regulated under the Act to provide information to enable the Department of Human Services to measure performance against the specified indicators.

Final Recommendation 26

Legislation should be enacted to enable consumers of health services to have an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner (medical or otherwise). The scope of the legislation should be similar to the Health Records (Privacy and Access) Act 1997 (ACT). Appeals should lie to the Victorian Civil and Administrative Appeals Tribunal against a refusal to provide access.

Recommendation 27

Legislation should not be introduced to create a legally enforceable patient charter. The Department should review the existing patient charter to take account of the suggestions raised in submissions to this Review. The proposed call centre should publicise the existence of the patient charter.

Final Recommendation 28

There should be a formal review of the operation of quality assurance committees declared under section 139 of the Health Services Act, with the reviewer given authority by legislation to examine relevant documents, including documents generated by those committees.

Final Recommendation 29

Section 139 of the Health Services Act should be amended to require health agencies which have committees declared under that section to report to a new peak quality committee established by the Department. Reporting details should include:

- actions arising out of the quality assurance process, both agency-wide and on a unit basis; and
- information on units or individuals whose performance is below average and the steps taken for improvement.

Consideration should also be given to imposing a statutory duty of quality improvement on (at least) public sector health care providers.

The Secretary should have the power to direct a specific committee (or specified like classes of committees) to review data or investigate a matter referred by the Secretary and to report to him/her on the outcomes of their deliberations or proposed actions. The Secretary should also be empowered to call on a specific committee or committees to supply data to him/her.

Final Recommendation 30

The Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in supported accommodation. This process should involve some form of public consultation.

Final Recommendation 31

The Secretary of the Department of Human Services should not be able to take into account the adequacy of services in an area when considering applications for approval in principle and registration of supported residential services. Sections 71(1)(a)(iii), 71(1)(c)(iii) and 83(1)(b) of the Health Services Act should therefore not apply to supported residential services.

Final Recommendation 32

Residents of supported residential services are particularly vulnerable (unlike patients of a private hospital or day procedure centre). The criteria set out in sections 71 and 83, other than those specified in Final Recommendation 31, should therefore be retained in relation to applications for approval in principle and registration of supported residential services. Section 89 should be retained in full for supported residential services.

Final Recommendation 33

Consideration should be given to developing outcome-based controls in relation to the supported accommodation sector to supplement and, where appropriate, replace input controls.

1. OVERVIEW

1.1 Establishment of the Review

The Department of Human Services is the largest Department in the Victorian Government sector, accounting for 39% of all Government expenditure. The *Health Services Act 1988*, one of the many Acts administered by the Department, is the primary vehicle through which the Department regulates its relationship with the health service bodies which it funds. The Act also provides for the regulation of private hospitals and supported residential services. Clearly this is one of the more important reviews of legislation undertaken by the Victorian Government in order to fulfil its commitments under the National Competition Principles Agreement.

The Health Services Policy Review was set up by the Victorian Government in March 1998. The task of the Review was to analyse the impact of the Health Services Act, the Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 and the Health Services (Residential Care) Regulations 1991 on the market, having regard to the Government's obligations under the National Competition Principles Agreement. A copy of the Terms of Reference for the Review is in appendix 1. The relevant guiding principle states that legislation should not restrict competition unless it can be demonstrated that:

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

Our methodology was developed in consultation with the Project Steering Committee, chaired by the Secretary to the Department of Human Services, Mr Warren McCann. Membership of that Committee is listed in appendix 2.

1.2 The Review process

At the outset of the Review we set out to identify the various markets affected by the Health Services Act, noting that the Act is about the regulation of agencies providing health services. We identified two broad markets – a health care market and a residential care market. We also identified several sub-markets within the broader health care market – a public patient market, a private patient market, and a primary health and community services (PHACS) market.

Our Review comprised seven stages:

- ***Stage 1*** involved analysis of the Victorian health industry by market type and analysis of the relevant legislation.
- ***Stage 2*** involved identification and analysis of restrictions on competition, such as barriers to entry, tax benefits and over-regulation.
- ***Stage 3*** consisted of a detailed literature review, focusing in particular on European, North American and New Zealand jurisdictions.
- ***Stage 4*** involved a series of interviews with multi-state and single-state stakeholders regarding their perceptions about restrictions to the efficient provision of health and residential care services within Victoria. This enabled us to explore these perceptions with key industry players and generated further ideas for consideration.
- ***Stage 5*** involved the exploration of alternative competitive models and an analysis of costs and benefits of each model, including transition and transaction costs.
- ***Stage 6*** saw the release of a Discussion Paper which thoroughly explored the information we gathered during stages 1 to 5 and contained our recommendations for changes to the Health Services Act, Health Services (Private Hospitals and Day Procedure Centres) Regulations and the Health Services (Residential Care) Regulations.
- ***Stage 7*** is now complete. It involved a re-examination of our findings and recommendations in light of submissions made in response to our Discussion Paper. This Final Report contains our recommendations based on this re-analysis.

1.3 Release of the Discussion Paper

In March 1999 the *Health Services Policy Review Discussion Paper* (the Discussion Paper) was released to stimulate discussion and canvass views regarding legislative restrictions on competition in the public and private markets for health care in Victoria. It is clear that the Discussion Paper successfully achieved its objective: 3000 copies were distributed, the web site received hundreds of 'hits' and 75 written submissions in response were received from a broad range of interested parties.

In the Discussion Paper we took a relatively conservative approach to the opening of the health market to further competition. We did not, for instance, recommend there should be multiple competing purchasers of public patient services, or that the right to provide public patient services at metropolitan hospital networks should be opened to private sector competition at periodic intervals.

Our research revealed that health systems throughout the world are undergoing significant change. Contemporary reform directions are generally in line with the Australian National Competition Principles (more consumer choice, opening up markets). In Australia, experimentation with fund holding (an element of any approach to purchaser competition) is occurring in the coordinated care trials. Overseas, the United States' health system is in the midst of a revolutionary change through the expansion of managed care for both public and private coverage. A natural experiment is also occurring throughout Australia in terms of private provision of public services, most notably in the health sector through the development of privately operated public hospitals.

We pointed out there are significant technical issues in the expansion of the role of the private sector in areas previously the sole preserve of the public sector. Expansion of private sector roles means a change in the form of regulation and control, from bureaucratic process to arms' length contractual relations. It has been suggested that this form of control can improve quality of provision and responsiveness to consumers (and purchasers). However, a *sine qua non* of a contract is a clear definition of the product being purchased. Poor product definition can vitiate the ability of contracts to ensure standards are met.

On the provider front, at the time the Discussion Paper was written Victoria was expanding private provision of public hospital services as envisaged in the 1996 Metropolitan Health Services Plan. We suggested in the Discussion Paper that the sensible and cautious thing to do is to evaluate the projects realised in accordance with the Plan before further opening up the system.

On the purchaser front we adopted a similarly cautious approach. The development of competitive purchasers requires the specification of a capitation payment to purchasers. We have almost no experience of this in Australia. We suggested there was a need for skill development, and observation of and learning from the overseas experience, before embarking on such a policy.

Wherever competition does exist, it should operate within a fair and even-handed regulatory and tax environment. To that end, we made recommendations for the development of a common regulatory and taxing approach to public and private health providers in competition with each other.

We were much less conservative in our approach to consumer empowerment in the health market. A necessary corollary of a competitive system is an informed consumer. Our recommendations for a 24 hour call centre, management of statewide waiting list information, reporting of risk-adjusted clinical performance indicators

and the enactment of a statutory right by patients of access to their health records were all designed to further empower consumers.

1.4 Development of the Final Report

We greatly appreciate the time and obvious effort put in by the individuals and organisations who responded to our Discussion Paper. As well as considering the 75 written submissions, we met with a special committee of the Victorian Healthcare Association (VHA) and listened to their views on our recommendations. We also met with the Ministerial Rural Health Advisory Group (MRHAG) chaired by The Hon Peter Hall MLC, and gave presentations to, and considered matters raised by, the:

- Australian College of Health Service Executives (Victorian Branch);
- joint symposium of the Murdoch Institute and Australian Institute of Health Law and Ethics;
- annual conference of the Australian Institute of Health Law and Ethics; and
- annual conference of the Australian College of Nurse Management.

We also took into account comments made by officers of the Acute Health and Aged, Community and Mental Health Divisions of the Department of Human Services (the Department) and officers of the Departments of Premier and Cabinet and Treasury and Finance. We also considered recent developments in health impacting upon our recommendations.

As a result of our analysis of this information, we deleted two of our original recommendations, made substantive changes to seventeen, and re-worded six to clarify their meaning. We also suggested one new recommendation regarding the objectives of the Act. This Report outlines our rationale for adding, retaining, amending or deleting each. (A table highlighting the comparison between our Discussion Paper Recommendations and our Final Recommendations is in appendix 3.)

For the purposes of ensuring this Report is a manageable size, we have not repeated the detailed information that is contained in the Discussion Paper. However, in some cases we have found it necessary to restate our views and key arguments in order to ensure the rationale for our final recommendations to Government is fully understood. The Discussion Paper contains explanatory material about the Health Services Act, commentary on Victoria's health system, comparisons with overseas experience and more detailed analyses of options for enhancing competition which are not reproduced in this Report. For completeness, this Report should be read together with the Discussion Paper.

1.5 Responses to the Discussion Paper

The responses to our Discussion Paper came from a variety of interested parties, including professional bodies, not-for-profit and for-profit private hospitals, public hospitals and metropolitan hospital networks, individual medical practitioners, individual consumers, consumer organisations, learned Colleges, peak bodies representing various interest groups and government agencies. (A list of individuals and organisations providing written submissions is in appendix 4.)

Given the breadth of the issues contained in the Discussion Paper, the submissions did not necessarily express an opinion about each proposal. Instead, most authors commented in detail upon particular findings and recommendations. The issues raised in the Discussion Paper provoking the most vigorous response were:

- the recommendation that the cap on private hospital bed licences be removed so there will no longer be a barrier to entry into the private patient market;
- the recommended removal of unfair advantages in relation to the provision of private patient services between the for-profit and not-for-profit sectors;
- the recommendation that the development of models involving competitive purchasers not be pursued at this stage;
- the finding that the status quo allows for a significant level of competition in public patient services between the for-profit and not-for-profit sectors and the recommendation that outcomes at privately operated hospitals be evaluated before proceeding further;
- the recommendation that the outcomes of the PHACS redevelopment process be evaluated before further competitive elements are introduced or contestability principles applied;
- the proposal that a 24 hour call centre be established on a pilot basis to assist consumers to be better informed about health care, health care providers and health choices;
- the recommended introduction of clinical performance indicators for public and private hospitals and day procedure centres which are comprehensive, consumer focused, current and published annually;
- the recommendation that consumers be given an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner;
- the recommendation that a formal review be established to assess quality assurance committees to determine whether the object of peer review on a multidisciplinary basis has been achieved; and

- the recommendations relating to supported residential services, in particular the recommendation that Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in the supported residential sector.

In this Report we have attempted to distil the essence of the submissions and comments we received and to respond to the key arguments and underlying themes raised.

1.6 Recent developments in health impacting on the Review

Legislative changes have occurred since the release of the Discussion Paper.

The first relates to the funding of mental health agencies separately under the *Mental Health Act 1986*. We recommended that Division 3 of Part 6 of the Mental Health Act should be deleted and mental health agencies funded under the Health Services Act. This has now occurred through the enactment of the *Mental Health (Amendment) Act 1999*.

The more major change relates to freedom of information. The *Freedom of Information (Amendment) Act 1999* amended the *Freedom of Information Act 1982*. This amendment requires that a document not be released to an applicant if it contains names or identifying information unless the applicant already knows (or ought reasonably to know) the identity of those persons. Agencies can release documents if identifying information (such as names and addresses) is deleted. If a person wishes to obtain access to the full document, he or she needs to apply to the Victorian Civil and Administrative Tribunal for an order granting access.

We consider this amendment operates to diminish the rights of patients to access their medical records held in the public sector (ie those held by metropolitan hospital networks, public hospitals, multi purpose services and community health centres). At the time of writing it was announced that legislation would be introduced into Parliament to overturn this amendment. Nevertheless, we believe that legislation should be developed which gives all health consumers equal rights of access to their own health records, regardless of whether they receive health services from a public or private sector provider. This is discussed further in chapter 7 of this Report.

A further legislative change affecting our recommendations relates to fundraising appeals. The *Fundraising Appeals Act 1998* replaced the earlier 1984 Act and established a regime in Part 3 whereby fundraising appeals must be authorised by the Minister administering the Act, who may consent to the appeal, direct that it not be conducted or permit it to be conducted subject to conditions. Penalties are

imposed for conducting an unauthorised appeal. Part 3 also sets out certain requirements for banking of funds, keeping of records and accounts, and audit of accounts.

The Act exempts certain organisations from the requirement to obtain ministerial authorisation for an appeal. Registered funded agencies within the meaning of the Health Services Act are specifically exempt from the provisions of Part 3 of the Fundraising Appeals Act. This means metropolitan hospital networks, public hospitals, community health centres and any agency registered under Division 2 of Part 3 of the Health Services Act are exempt. The exemption does not extend to multi purpose services as they are not, nor are they deemed to be, registered funded agencies. We consider it is important that sound administrative processes are in place within the Department for ensuring statutory functions are appropriately managed in order to assist citizens who may be required to comply with legislation to seek accurate and timely information about their obligations. This reinforces our recommendation that a central registration unit should be re-established by the Department of Human Services. This is discussed in chapter 2 of this report.

1.7 Conclusions

The health market is one of the most complex of markets. The market being regulated by Government is currently the health *care* market. From the consumer's perspective the health care market is characterised by information asymmetry.

Because of this information asymmetry, traditional forms of market regulation do not work. The market does not operate perfectly and policy makers need to regulate the market in various ways. There are good reasons to develop a regulatory framework in the health care market to protect consumers. Aside from the importance of consumer protection, regulation of the public patient market is also necessary to protect the State's investment and interest in this sector. The State has obligations to fulfil under the Australian Health Care Agreement. It must ensure that providers of public patient services comply with the principles contained in the Agreement and recognised by section 17AA of the Health Services Act as guidelines for the delivery of public hospital services in the State. However, regulation has also developed for reasons other than these which, *prima facie*, is anti-competitive.

In accordance with the principles of competition reviews, it was necessary for us to establish whether the benefits of this form of regulation outweigh the costs.

Competition Policy is not a crusade founded on a belief that competition should be elevated above public good. Nor does the Policy equate competition with public good. Rather, it requires a rational

articulation of the objectives of anti-competitive measures, and an analysis of alternative means of achieving those objectives.

The objectives of the Act as currently expressed are set out in sections 9 (health market) and 10 (residential care market). Those objectives remain relevant today. However, underlying the objectives is a vision which we think reflects the legitimate aspirations of the Victorian public. That vision is for a service delivery system which:

- provides high quality care, including a seamless integrated continuum of care;
- provides for consumer choice based on informed decisions;
- ensures that patients receive the most appropriate health service irrespective of who funds that service;
- is capable of responding to changing technologies, demographics and consumer preferences;
- facilitates high quality clinical research and teaching and training of health professionals;
- is fair as between public and private health providers;
- is efficient; and
- protects the vulnerable.

In this Final Report we make 33 recommendations we believe will help this vision to be achieved.

These recommendations must be viewed in the context of the division in responsibility between the Commonwealth and the State for health funding. Both Governments fund health care through a multitude of programs, each operating within its own set of parameters. This division means that some reforms cannot be achieved simply through re-engineering a State funded service, let alone by amending a State Act of Parliament. We believe our recommendations take into account the options available at this point of time, and recognise the increased efficiency in the public hospital sector partially resulting from the application of competitive neutrality principles to non-clinical services.

Eleven of our recommendations relate to the private patient market and address the competitive advantages of the various sectors. For example, we recommend the removal of the bed cap on private hospital and day procedure development, thus opening the market. We also recommend common regulatory standards for the public and private hospital sector. We also suggest that Government should establish a working party to quantify the benefits which the not-for-profit sector obtains from various input tax exemptions which could then be made explicit as a Community Charitable Return. Public hospitals also have a competitive advantage in the private patient market due to input tax

exemptions. In the interests of competition and fairness, we believe it is desirable that this advantage be abolished. However, because of the complex interactions that would be involved in implementation, we recommend that, as a first step, a levy equivalent to payroll tax should be imputed to reflect the private patient and other commercial activity of public hospitals.

We suggest any further development of competition for the right to provide public patient services should await an evaluation of the operation of the privately operated hospital experiment. Training and Development Grants should be available to the private sector once robust measures of quality of training and research are developed.

In relation to the PHACS market, we recommend that any initiative to promote competition be delayed until the current re-development and review processes are concluded.

In the residential care market, we recommend the Government review the existing policy and regulatory framework in the supported residential market to determine whether there is an appropriate level of protection for vulnerable people paying for personal care services.

Finally, we believe that a good health system must redress information asymmetry. Consumer empowerment is not an alternative to a competitive system. Rather, it is the foundation stone of competition. An informed consumer will promote competition by choosing products which are of a high standard, this will then lead to improved quality and efficiency in the health care market. A number of our recommendations are aimed at achieving this.

With this Review we are essentially developing a framework for legislation to apply for the next five years. The health sector is changing rapidly and we think a new look at the legislation will be required after five years. Such a timeframe is also consistent with our 'watchful waiting' approach to the existing level of experimentation in the system.

We stand by the projection of the shape of the health system (and thus the basis for new legislation) we outlined in the Discussion Paper. That is, we propose as a system which:

- maintains the strength of the existing system in terms of quality, efficiency and equity;
- provides an environment and opportunity to learn from experimentation;
- enables fairer competition between the public and private sectors;
- allows for quantification of the benefits which accrue to the community from the activities of the not-for-profit sector; and

- provides better information to allow consumers to make more informed decisions.

2. THE LEGISLATION IN CONTEXT – REGULATION OF AGENCIES UNDER THE ACT

2.1 Overview

In chapters 2 and 3 of the Discussion Paper we provided an overview and analysis of the history, content, origins, objectives, performance and structure of the Health Services Act. We concluded that overall the health system has performed relatively well in efficiency terms and has achieved a high level of patient satisfaction. It is not possible, however, to determine the extent to which the legislation and legislative framework have contributed to that performance.

We found that despite amendments that have been made over the past 10 years, the basic structure of the Health Services Act remains sound and the Act continues to provide a reasonable platform to support health policy.

As we said in the Discussion Paper, the Health Services Act reflects the diversity of arrangements that exist for purchasing public health care services. The Act provides both the funding and contracting models for service provision, creates three types of public statutory corporations (metropolitan hospital networks, public hospitals and multi purpose services) and provides for the governance of community health centres. The Act also regulates private providers of health services via a licensing regime.

The Health Services Act provides a framework for the governance, control and funding of numerous organisations. The specific controls which pertain to a particular organisation will depend on how it is classified. Different controls apply to metropolitan hospital networks, public hospitals, denominational hospitals, privately operated hospitals, private hospitals, day procedure centres, multi purpose services, community health centres and registered funded agencies. In the Discussion Paper we described how the Health Services Act is really about three types of agency: public statutory bodies, charities and private for-profit organisations. (We describe each of these further later in this chapter.)

The submissions we received commented principally on the following issues covered in chapters 2 and 3 of the Discussion Paper:

- the objectives of the Act;
- governance and control mechanisms;
- the role of the Department of Human Services; and

- registration and funding arrangements.

We discuss each of these issues in turn.

2.2 Objectives of the Act

Part 1 contains the objectives of the Act insofar as they affect the health market, namely:

> (a) health services provided by health care agencies are of high quality; and
>
> (b) an adequate range of essential health services is available to all persons resident in Victoria irrespective of where they live or whatever their social or economic status; and
>
> (c) public funds
>
> (i) are used effectively by health care agencies; and
>
> (ii) are allocated according to need; and
>
> (d) health care agencies are accountable to the public; and
>
> (e) users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about health care; and
>
> (f) health care workers are able to participate in decisions affecting their work environment; and
>
> (g) users of health services are able to choose the type of health care most appropriate to their needs.

In the Discussion Paper we expressed the view that these objectives remain relevant today, but there may be different views on how they are implemented.

Our view about the continuing relevance of the statutory objectives is supported by the submissions which specifically comment on them. For instance, the Health Services Commissioner, Ms Beth Wilson, comments that the objectives specified in sections 9 and 10 are still relevant, and are complemented by the guiding principles of health care set out in the *Health Services (Conciliation and Review) Act 1987*. Ms Wilson states that 'seamless care', consumer choice, informed consent, protection of the vulnerable, and the provision of services in a responsive manner and with fairness and efficiency are also important. Asymmetry of information is also a significant problem which needs to be addressed in her view.

Other comments on the objectives of the Health Services Act include:

- the Act should specify requirements to ensure informed decision making by consumers;
- the requirement of and specifications providing for informed consent to treatment should be included in the Act;
- the objectives should acknowledge the differing requirements of rural and metropolitan health services; and
- teaching and training of health professionals and the importance of clinical research should be included as objectives of the Act as they are fundamental to the functioning of the entire system.

In relation to informed decision making by consumers, we believe the current objective is adequate and that our recommendations in chapter 7 which address information asymmetry are a more appropriate way to implement that objective.

We do not agree with the suggestion that the principles of informed consent should be included in the Act. The common law in this area is expanding. Any attempt to codify the legal requirements for informed consent is unnecessary and could limit the development of the law in this area.

In relation to the differences between rural public hospitals, provincial public hospitals and metropolitan hospital networks, two of the objectives in the Act (b and g) are designed to ensure that all residents of Victoria have access to a range of adequate health services from which to choose the care most appropriate to their needs, irrespective of where they live. The first of these objectives picks up one of the three principles agreed to by Victoria in the Australian Health Care Agreement:

> Eligible persons should have equitable access to public hospital services regardless of their geographical location.

This and other principles are picked up by section 17AA of the Health Services Act and established as guidelines for the delivery of public hospital services in the State. We recognise that public hospitals and multi purpose services outside the metropolitan area and provincial cities do provide a different health care service, however, often combining primary health services, aged care, and community health and support services. The different funding model in place for some of these agencies attests to the flexibility of the Act in catering for different types of services. We see no reason why an objective should not be articulated, however, which recognises the different needs of, and services provided by, health care agencies in different parts of the State.

We also agree that clinical research and the teaching and training of health professionals are important features of Victoria's public health system. This is implicit in the way our system currently operates. To reflect this, we believe a specific objective regarding these should also be included in the Act. We therefore make the following recommendation.

Final Recommendation 1

The objectives in section 9 of the Health Services Act should be expanded to recognise the differences in delivery of health care in different parts of the State and the critical importance of clinical research and the teaching and training of health professionals. We suggest the following words be added:

[The objectives of this Act are to make provision to ensure that ...]:

- **health care agencies are structured and funded in the most appropriate manner to meet the needs of the community they serve;**
- **clinical research and teaching and training of health professionals is facilitated.**

2.3 Governance and control mechanisms

2.3.1 Public statutory bodies

We use the term public statutory bodies to describe any agency in which all or the majority of board members are appointed by Government. Currently these include metropolitan hospital networks, non-metropolitan public hospitals and multi purpose services. As a result of recent amendments to the Act, community health centres also fall into this category.

Public statutory bodies are subject to the highest level of Government control, including the power to remove board members or directors from office. In the Discussion Paper we noted that significant attention was paid to governance issues when the metropolitan hospital networks were established. For example, directors are responsible under the Act for establishing the network's objects and organisational structure, appointing senior staff, developing a business plan and

budget to ensure the provision of health services and the network's long term viability, and monitoring the performance of the network and its chief executive officer. We took the view it is important that best practice applies to the governance of all public bodies, and we considered that other public statutory bodies could also benefit from similar measures to enhance the capacity and accountability of boards. We therefore recommended that:

> Consideration should be given to the development of measures to enhance the capacity and accountability of boards of all public statutory bodies. (DP Rec 1)

As we pointed out in the Discussion Paper, the National Competition Policy Agreements do not compel Government to outsource health care functions that have been traditionally performed by public statutory bodies or to adopt any particular organisational form as the preferred vehicle for health service delivery. National Competition Policy does not require homogeneity of organisational structure or business approach between organisations competing in the marketplace. In an environment of public sector involvement in the marketplace, National Competition Policy simply requires competitive neutrality between public and private sector competitors, where the benefits of implementing competitive neutrality are judged to outweigh the costs.

In our view, there is no need under National Competition Policy to alter the statutory provisions dealing with the structure and governance of public statutory bodies unless a decision is made to move to an alternative model of health service provision.

In the Discussion Paper, we argued it would be desirable for regulatory standards to be as consistent as possible both among and between public and private sector providers of health services to obviate arguments that different arrangements create an unlevel playing field. In this context, we recommended that regulatory standards affecting the quality of patient care should, as a general principle, be common standards. We recommended that the Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 should be reviewed for relevance and reformulated to apply also to public hospitals (see section 7.5 of the Discussion Paper).

In contrast, we stressed that the provisions in the Health Services Act with respect to the governance and control of public statutory bodies, such as metropolitan hospital networks and public hospitals, are important tools to ensure these public organisations are accountable to the community and that Government policy objectives in relation to health care can be implemented effectively. The Government of the day is accountable to the people of Victoria for the effective and efficient delivery of publicly funded health services and for ensuring that community expectations are met. It must therefore be capable of

exercising some control in the public interest over bodies such as public hospitals which have been established under legislation to perform the task of delivering public health services to the community.

In our view, leaving aside the issue of regulations pertaining to standards of patient care, the different legislative controls which apply to public and private bodies delivering health services simply reflect the reality that public and private sector organisations are constituted differently, reflecting their distinct ownership, objects and accountabilities. We do not regard the existence of current mechanisms in the Health Services Act for the governance and control of public bodies as imposing an unfair competitive disadvantage which infringes the principles of National Competition Policy.

The retention of existing controls is supported in twenty submissions. The Health Services Commissioner, for example, argues that the current powers in the Act, together with legislation such as the *Financial Management Act 1994*, contain sufficient tools to ensure that Government can hold public bodies to account. In her view, the importance of ensuring accountability outweighs any arguments regarding removing these controls to level the playing field. The public expects Government to have the capacity to exert influence over public statutory bodies in the public interest.

However, some public providers argue that the existence of divergent approaches to the governance and control of public and private agencies delivering health services is a competition issue which should be addressed. The VHA, Inner and Eastern Health Care Network and Barwon Health suggest that the controls imposed by the Act, such as provisions which limit the ability of public hospital boards to secure their assets to raise capital or borrow substantial funds without the approval of the Minister or the Treasurer, disadvantage public bodies and prevent fair competition with the private sector and therefore should be removed. Some comment that a true level playing field will only exist if boards of public statutory bodies can operate without Government intervention, as is the case for private sector organisations.

In our view, the removal of controls over public statutory bodies would result in so-called public organisations which are effectively unaccountable for their actions. They would be able to incur State debt, subject only to the controls imposed by the marketplace, and to raise equity from the private sector, thereby transforming themselves into organisations that are partly privately owned, with no regard to the views of the Government of the day. Victorian taxpayers would ultimately bear the risks associated with such activities. We consider such a situation would be untenable, and that reliance solely on a power of last resort to remove board members would not be sufficient to

ensure the very substantial risks associated with such activities could be effectively managed.

The North Western Health Care Network (North Western Health) queries why public hospitals should not be corporatised in such a way as to allow them to raise equity. We consider that existing corporatisation models such as those provided by the *State Owned Enterprises Act 1992* are not appropriate for public hospitals, as the *raison d'etre* of public hospitals is non-commercial and Government is the primary source of their funds. The Network points out that private not-for-profit bodies have a non-commercial purpose and that Government is the primary source of funds for privately operated hospitals. However, the critical difference in our view is that Victorian citizens do not bear the financial risks associated with equity raising by such organisations because they are not publicly owned.

Further, the State Owned Enterprises Act was clearly designed to be applied to government trading enterprises which have a profit making motive and can charge customers for their services. It is aimed at bodies where community service obligations only amount to a small proportion of the overall activities of what is fundamentally a profit making enterprise. Under the current paradigm of health service provision, most if not all of the core activities of public hospitals could be regarded as community service obligations. In these circumstances, we believe the more traditional public statutory authority is the most appropriate organisational model for public bodies providing health services.

The Inner and Eastern Health Care Network considers the powers that may be exercised over registered funded agencies (such as the power to appoint an administrator or close an agency where there is incompetent management or ineffective services) are anti-competitive. It contends that these powers are far broader than those that apply to private hospitals which are not funded by Government, as registration of these bodies can only be revoked after a 28 day notice period.

In our view, this argument misinterprets the different purposes of the two types of registration available under the Health Services Act. The purpose of registration as a registered funded agency under Division 2 of Part 3 of the Act is to ensure not-for-profit organisations receiving substantial amounts of recurrent Government money are subject to statutory controls designed to ensure their accountability, and that Government has the ultimate capacity to organise the provision of publicly funded services to ensure contemporary health service needs are met.

In contrast, registration of private hospitals and day procedure centres under Part 4 of the Act is designed to ensure that private organisations providing health services and which generally do not receive any

Government funds adhere to minimum standards of safety, quality and probity. Privately operated hospitals contracted by the State to provide public health services are subject to contractual obligations and the regime of controls in Part 3A of the Act as well as the registration requirements under Part 4.

The requirement for notice before action is taken to deregister private hospitals and day procedure centres ensures natural justice is accorded to bodies that are privately owned before taking away their legal right to carry on business. Removal of registration under Part 4 can only occur if there has been a breach of the Health Services Act or Regulations or any of the conditions imposed on registration, or if the proprietor has ceased to be a fit and proper person to carry on the establishment.

However, the statutory provisions with respect to closure or amalgamation of public bodies and other registered funded agencies, whose very existence is dependent on Government funds, are designed to ensure that public resources can be allocated in such a way as to ensure that the community's needs can be met most effectively and efficiently. The Act requires seven days notice to be given to the agency concerned of any proposal to appoint an administrator, and affords the agency the opportunity to make submissions in relation to this proposal (see section 61). We consider it is important that the Government retain the capacity to act quickly if there are concerns about the management of public funds and we do not support any changes which would lengthen the prior notice period.

Further, we do not regard any differences between the closure and amalgamation provisions of the Act and those governing the deregistration of a private hospital or day procedure centre impose any meaningful restriction on competition.

A number of submissions commenting on governance and control mechanisms make suggestions relating to remuneration and immunity for members of boards.

The Peninsula Health Care Network, for example, expressly supports the continuation of remuneration for directors of metropolitan hospital networks, while the submissions from the Ministerial Rural Health Advisory Group and the City of Whittlesea seek a recommendation this be extended for board members of rural public hospitals. The VHA acknowledges there is growing support for remuneration of all board members, but states it is open to debate whether remuneration has improved performance and accountability.

Currently, directors of the metropolitan hospital networks receive remuneration as do the board members of four large provincial public hospitals. This remuneration ranges from $9,000 to $12,000 for board

members of provincial hospitals and $16,000 to $21,000 for directors of metropolitan hospital networks. The chairpersons of provincial public hospitals receive remuneration of $15,000 to $25,000 while chairpersons of metropolitan hospital networks receive between $21,000 and $45,000.

The Act provides in section 34 that board members of public hospitals may be remunerated 'as ... specified in the instrument of appointment'. There is therefore nothing to prevent the extension of remuneration throughout the public hospital system if Government wishes.

The Act also provides that a director of a metropolitan hospital or board member of a public hospital or multi purpose service is 'not liable to an action or other proceedings for damages for or in relation to an act done or omitted to be done in good faith in the performance or purported performance of any function or the exercise or purported exercise of any power conferred on the board'. (It should be noted that this immunity only relates to actions or proceedings for damages, not to actions for injunctive or declaratory relief or other remedies which do not involve damages.) Sections 39, 40J and 115K confer this immunity on public hospitals, metropolitan hospital networks and multi purpose services respectively. This immunity does not extend to community health centres.

The retention of immunity from liability for board members of public hospitals in relation to actions performed in good faith as a board member is supported by the Peninsula Health Care Network, North Western Health, VHA and the City of Whittlesea.

The VHA, for example, supports retention of statutory immunity, even if all board members are remunerated, on the basis that the boards of public statutory bodies are unable to freely make decisions on a commercial basis but must operate within the Act and the Department's financial and policy framework. The VHA also suggests immunity be extended to apply to the members of community health centre boards. North Western Health states:

> . . . as long as public sector providers operate in a more heavily regulated environment than the private sector, in particular in ways that constrain governance, it is not reasonable to ask board members of public statutory bodies to accept the same risks (eg personal liability) as board members of private companies. Increasing risks without increasing the capacity to act independently will not increase either the performance or accountability of public statutory bodies.

There is clearly a strongly held view among the public hospital sector that this statutory immunity affords important legal protection for public hospital board members for actions carried out in good faith.

We do not regard the existence of the immunity as a significant competition issue, as we do not believe that it encourages board members of public bodies to take more risks or exercise less skill or care in the performance of their functions than would be expected of private sector boards. However, we note that the traditional justification for granting this immunity was that board members were acting in an honorary capacity, volunteering their time and expertise to perform a community service. As noted earlier, all directors of metropolitan hospital networks are now remunerated as are board members of some public hospitals. The rationale for legislative immunity is weakened where board members receive more than token remuneration. We understand the Department currently arranges more than adequate insurance coverage for all officers and directors of public statutory agencies. We question whether immunity should remain given the level of insurance obtained by the Department.

The role and membership of boards are also issues raised in the submissions. The VHA, for example, considers the role and function of the boards of public statutory bodies should be re-examined. It argues that the Discussion Paper infers the accountability of metropolitan hospital network boards is enhanced through the spelling out of responsibilities in the Act. The VHA suggests other public hospital boards are equally accountable to the Minister, even though the Act does not contain such a detailed statement of their role. It is their view the Act ought to enable flexibility in governance structures so that agencies can respond to changing patterns of service provision and organisation over time.

The Inner and Eastern Health Care Network also points to inconsistency in the Act regarding the composition of boards of public hospitals and those of metropolitan hospital networks. They suggest there is no overriding public benefit in retaining these inconsistencies. We agree these are issues that need to be examined.

The Health Services Commissioner and the Health Issues Centre believe consumer participation is crucial at all levels of health planning, policy, services delivery and evaluation to ensure the quality of services is improved. This includes participation on the boards of public statutory bodies. The Health Issues Centre suggests consumer participation in the health system could be enhanced by the introduction of regional and/or statewide secretariats to provide resourcing and training for consumers interested in more active participation in the health system, such as by being a member of a board or an advisory committee. This submission also suggests the Act could require the appointment of consumer consultants.

The Health Issues Centre notes that although the Act requires metropolitan hospital networks to establish community advisory committees, in its opinion this has not worked satisfactorily. It

considers that this is due to the absence of legislative timeframes for the establishment of committees, guidelines for their terms of reference and membership, and arrangements for monitoring by, and reporting to, Government on the extent to which committee recommendations are accepted by the networks. It suggests the Act should be more explicit as to how collaboration and partnership can be fostered; at the very least it should include a formal commitment to consumer participation at all levels of the health system.

The submission from the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) also refers to the membership of boards and emphasises the need to have employee representation on boards to encourage advocacy for the workforce as a key stakeholder, and to maintain links between the boards and those who deal with clients.

We accept that the health system should be responsive to consumers' views and needs. However, without a genuine commitment to consumer participation in the health system, simply entrenching a mechanism in the Act will not guarantee effective consumer input. The Act does not prevent consumer and employee representation except to the extent that medical practitioners cannot comprise more than one quarter of the number of board members of a public hospital. Many public hospitals in rural areas already have committees which provide advice to the board about health, aged care and, in some cases, the needs of the local community. Also, as pointed out earlier, metropolitan hospital networks are required by the Act to establish community advisory committees, although it is not clear what this legislative requirement has achieved in practice.

It is more important for Government to ensure that, in appointing members of boards, individuals are chosen who can work together and with the chief executive officer to achieve goals set by the board and Government to a standard acceptable to Government. Individuals chosen should have skills in areas relevant to the management of a hospital and a commitment to ensuring that the board, as a whole, is responsive to the many parts of the community which it serves.

Unlike the Corporations Law, the Health Services Act does not clearly set out certain standards with which directors and officers are required to comply, such as a duty to act honestly, to exercise a reasonable degree of care and diligence, and to declare any conflict of interest. The fact that the Act does not articulate the duties of board members or directors does not mean that there are no governance principles which apply to their conduct. However, these principles are contained in the common law and are not articulated in a source readily accessible to directors and members of boards. Although we acknowledge the work of VHA in promoting discussion of governance issues, we believe it would be useful to board members and directors if there were clearer guidance from Government about governance principles as well as

clarification of their duties and functions. The statutory standard of care and diligence set out in the Corporations Law would be a useful starting point. The Department could issue this advice as part of its normal administrative functions or, alternatively, key principles could be inserted into the Health Services Act. Consideration could also be given to the provision of enhanced training for new board members, particularly with respect to the role of the public hospital sector in the context of Government policy.

We are still of the opinion that the controls imposed over public statutory bodies by the Health Services Act are appropriate. We also believe the accountability of boards of all public statutory bodies could be enhanced by legislative direction on governance, including articulation of governance principles. We have changed our original recommendation accordingly.

Final Recommendation 2

Measures should be developed to enhance the capacity and accountability of boards of all public statutory bodies, including articulation of governance principles.

2.3.2 Charities

Charities are not-for-profit agencies controlled by their members. Members may be contributors who pay a nominal sum for the privilege for membership, members of a religious Order or determined in some other way. Agencies in this category may receive payments under agreements with the Department of Human Services, in which case they may be classified as registered funded agencies. Examples currently include not-for-profit incorporated associations and denominational hospitals. Alternatively, they may be funded from other sources, such as patients and private health insurers. Examples include not-for-profit private hospitals such as Epworth and Cabrini as well as the large number of bush nursing hospitals (although the latter may also receive funding from Government in recognition of their special function in rural areas).

The Department has little interest in the governance or internal structure of a not-for-profit agency unless it receives funding. The controls which the Department imposes under Part 4 of the Act are the same for all private agencies, whether for-profit or not-for-profit. These

controls regulate these agencies as private providers of health services via a licensing regime.

However, the Department does have an interest in not-for-profit agencies for which funding is provided, and may choose to require an agency to be a registered funded agency under the Act.

The Act provides for substantial controls over registered funded agencies. As we said in the Discussion Paper, through the Act the Government asserts a significant level of control as the price to be paid for accepting recurrent operating funds. However, although denominational hospitals receive funding on a similar basis to public hospitals, their special independent status is recognised by their inclusion in Schedule 2 to the Act and they are exempted from certain provisions of the Act which apply to public statutory bodies and ordinary registered funded agencies.

Although no denominational hospital took issue with the level of control exerted by the Act, the Inner and Eastern Health Care Network suggests these controls result in a competitive disadvantage for denominational hospitals and should be removed.

We disagree with this view and believe that the Act contains appropriate controls for denominational hospitals given their level of Government funding.

2.3.3 Private for-profit organisations

As the name suggests, private for-profit organisations are agencies established for the purposes of enabling profit to be distributed to their owners. Private for-profit organisations include private hospitals run on a for-profit basis as well as a new type of agency known as a 'privately operated hospital' which is contracted by the Government to provide public patient services. (The latter could also be operated by a charity, although this has not occurred to date.)

Both private hospitals and privately operated hospitals are subject to the licensing regime in the Act which we discussed in chapter 7 of the Discussion Paper.

Privately operated hospitals are subject to additional special controls outlined in Part 3A of the Health Services Act which include the right of Government to step in and intervene in management to protect the health and safety of public patients.

The Health Issues Centre and AMA Victoria emphasise the need for accountability of privately operated hospitals. AMA Victoria makes two suggestions relating to the management and monitoring of contracts to enable public scrutiny. The first is the establishment of a

community advisory committee for each hospital, appointed by the Minister, which would advise the hospital and report to the Minister. The second suggestion is the creation of an independent body to monitor contract compliance across the sector.

In our view it should be possible to ensure the accountability and community responsiveness of a privately operated hospital through tight contractual arrangements, including monitoring by Government of key performance indicators and standards. We recommend in chapter 5 that the operation of the privately operated hospital experiment be thoroughly evaluated and such an evaluation could address these issues.

2.4 The role of the Department of Human Services

In the Discussion Paper we suggested the Department of Human Services has three roles: it is both a regulator and purchaser of services and an 'equity holder' on behalf of the broader community in the assets and business of Government directed agencies, notably public hospitals. We concluded there is no basis for separating the purchaser and regulator functions provided a common approach in regulatory standards is adopted for the Government funded and non funded sectors.

VHA, Peninsula Health Care Network, Cabrini Hospital, Catholic Health Care Providers and others emphasise the need to consider a fourth role of the Department as planner, and also the role of the Commonwealth as a purchaser.

We consider the Department does have a planning role by virtue of the three functions it fulfils, particularly in respect of the funded sector. In relation to the non funded sector, we believe that common regulatory standards should be adopted. This is further discussed in chapters 3 and 5.

2.5 Registration and funding arrangements

In the Discussion Paper we highlighted inconsistencies of approach to registration of funding bodies and to health service agreements. We concluded:

- There is no justification for establishing separate registration mechanisms for agencies funded under the Health Services Act and the Mental Health Act.
- The various practices regarding registration indicate that its significance as a device for statutory control is not well understood by the Department of Human Services.
- There is no reason why mental health community support services should be funded through funding and services agreements made

under the Mental Health Act and other health agencies funded through health service agreements made under the Health Services Act.

We recommended:

> Division 3 of Part 6 of the Mental Health Act should be repealed. All mental health and other health care agencies should be funded under health service agreements made pursuant to section 26 of the Health Services Act. (DP Rec 2)

This recommendation has already been implemented through the introduction of the Mental Health (Amendment) Act.

We also recommended:

> All agencies receiving a requisite level of funding from the Department of Human Services should be issued with a certificate of registration under the Health Services Act. A central registration unit should be re-established by the Department of Human Services. (DP Rec 3)

This recommendation does not relate to the registration of private hospitals and day procedure centres under Part 4 of the Act. Rather, it relates to a separate registration process which can be applied to bodies the Department funds. Contracts with privately operated hospitals are entered into under other specific provisions.

Under the Act at present, metropolitan hospital networks, public hospitals, denominational hospitals and declared community health centres are automatically deemed to be registered. Other funded agencies may be registered in accordance with a process set out in Division 2 of Part 3 of the Act. Essentially, this involves the Department taking into account factors such as the extent and nature of health services provided by the agency, and the nature and amount of funding that it receives from the Department or other Government agencies. If an agency is registered, the Department has at its disposal a range of controls designed to protect the public interest. This gives the Department control over the agency's rules and appointment of chief executive officer, and requires the agency to enter into health service agreements. It also has powers to appoint an administrator if the agency is being incompetently managed, censure the agency and amalgamate the agency with other bodies.

The establishment of a central unit to superintend the registration process is supported by nine submissions, including those of North Western Health, AMA Victoria, ADA Victoria, St John of God Health Service and the Health Issues Centre. One reason advanced is that

centralisation of this technical administrative function should ensure consistent regulation.

The VHA opposes the establishment of a central registration unit, however, on the basis it should be possible for regional offices or those staff that are involved in health service agreement negotiations to register funded agencies.

The Inner and Eastern Health Care Network supports the need to have registration, but suggests it is overly prescriptive to require the function to be carried out by the Department. Implicit in this submission is the possibility that registration decisions could be incorporated into an alternative model in which the purchasing function is not carried out by Government, but by Health Improvement Agencies which are funded by Government on a weighted capitation basis to purchase health services for their members. We discuss this further in chapter 4.

Careful consideration of the issues raised in the submissions has not led us to change our view regarding the need for all agencies receiving a requisite level of funding from the Department of Human Services to be registered under the Health Services Act and for a central registration unit to be formed.

We also note that a central registration unit would facilitate the operation of the Fundraising Appeals Act by the establishment of one point of contact to ascertain whether an agency is exempt from the requirements of Part 3 of that Act.

We are therefore retaining our initial recommendation.

Final Recommendation 3

All agencies receiving a requisite level of funding from the Department of Human Services should be issued with a certificate of registration under the Health Services Act. A central registration unit should be re-established by the Department of Human Services.

3. THE PRIVATE PATIENT MARKET

3.1 Features of the market

As outlined earlier, we see the health care market as being made up of a private patient market, a public patient market and a PHACS market. In this chapter we discuss the private patient market; the public patient and PHACS markets are discussed in later chapters. Although we discuss these three as if they are separate and distinct markets, we are mindful that changes in one may impact upon the others.

When analysing the private patient market, it is important to remember that private patients can be admitted to private hospitals (for-profit or not-for-profit) and public hospitals. Indeed, approximately 18% of all private patient bed days are in public hospitals.

There are a number of anti-competitive elements in this market. First, the fees charged by public hospitals for private patients are often significantly less than the fees charged by private hospitals for private patients. There could thus be an implicit subsidy from the public sector to private patients in public hospitals. Public hospitals also have significant tax advantages over private hospitals (although under the Commonwealth Government's tax reform package this will be curtailed). Not-for-profit private hospitals have similar tax advantages.

Set against this, for-profit private hospitals are able to raise capital through equity allocations rather than borrowing, although the extent of this advantage is difficult to quantify.

Another anti-competitive feature is the different regulation of public and private hospitals, with the latter regulated by the Health Services (Private Hospitals and Day Procedure Centres) Regulations while the former are not.

A distinct sub-market of the private patient market relates to the provision of day procedure services, which may occur in public or private hospitals (either through specifically designed areas or as part of the ordinary patient flow) or in dedicated day procedure centres. The regulations specifying which procedures must be performed in day procedure centres or hospitals and which can be performed in doctors' rooms are somewhat anomalous. The requirement for a procedure to be undertaken in a day procedure centre adds additional cost to that procedure because of the additional overheads involved.

Chapter 7 of the Discussion Paper dealt with the market for patients receiving services as private patients at public and private hospitals and day procedure centres. For the purposes of analysing market forces, we considered four aspects of this market:

- competition between for-profit private hospitals;
- competition between for-profit and not-for-profit private hospitals;
- competition between public hospitals and private hospitals; and
- competition for the same-day patient.

We made 11 recommendations designed to ensure fair competition between private providers (both for-profit and not-for-profit) and public hospitals in relation to the treatment of private patients (DP Recs 4 to 14). Some of our recommendations were contentious, others were generally accepted. While there is general support for trying to identify anti-competitive practices, some query the underlying objective of a competition review in the health care market and whether a level playing field is desirable. Others comment on the need to identify the role of not-for-profit private hospitals and the dividends they generate for the community. Another concern expressed is that implementation of only some of our recommendations could in fact lead to an imbalance between those proposals assisting the public sector to compete and those assisting the private sector to compete, thus leading to further anti-competitive practices.

We agree that a number of our recommendations are interrelated and that care should be taken with selective implementation so as not to advantage or disadvantage any sector. We also agree it is important to identify the social dividends which not-for-profit private hospitals return to the community.

We also recognise that creating a level playing field in all sectors may not be a desirable outcome, but the first step is to analyse unfair competitive advantages and quantify the resultant benefits to provide a comprehensive view of how the market operates. This is what we have attempted to do. Our comments on the four aspects of the private patient market follow.

3.2 Competition between for-profit private hospitals

3.2.1 How the sub-market is currently regulated

Victoria has one of the largest private hospital sectors in Australia, accounting for 30% of all occupied bed days in 1997-98. Private for-profit hospitals comprise the most rapidly growing part of the Victorian private hospital market.

For-profit entities compete with each other on a level regulatory and financing playing field (outlined in chapter 7 of the Discussion Paper). The Health Services Act is directed toward regulating patient safety and orderly planning. Currently, orderly planning is regulated solely through the licensing mechanism, while patient safety is regulated both through licensing and the setting of standards in Regulations. While we accept the State has a legitimate interest in these areas, we concluded in the Discussion Paper that orderly planning is best achieved in this sub-market through the interplay of market forces, and patient safety best achieved through more targeted regulation. This is discussed further below.

3.2.2 Planning controls and the bed cap

The number of private hospital (and day procedure) beds in Victoria is currently 'capped' at the existing level. This is usually known as the 'cap on private hospital licences' or 'bed cap'. In effect, this means new entrants into the market, or private hospitals wishing to expand their bed numbers, have to acquire (purchase) the right to operate additional beds from other proprietors who then relinquish their right to operate those beds. This ensures that the overall number of beds does not increase. The requirement to source beds from the existing pool is encapsulated in the Department's *Guidelines for the Development of Acute Hospital Beds* (the Guidelines). The Department plays no role in influencing the conditions of transfer but simply requires confirmation that the right to operate beds has been transferred and adjusts the certificates of registration accordingly.

Section 83 (1)(b) of the Act relates to distribution controls. It requires the Secretary of the Department, when deciding whether to register a private hospital, to consider whether the carrying on of the proposed hospital may result in 'more than adequate' health services of any kind becoming available. This requirement is expanded on in the Guidelines which set a maximum ratio of 4.1 acute hospital beds (both public and private) per 1,000 population in the relevant area. The Act provides no further guidance on what criteria should be applied for the purposes of section 83(1)(b). The Department has effectively treated the Guidelines which impose the bed cap and beds to population ratio as the criteria to be considered in determining whether registration of a private hospital would result in more than adequate health services of any kind becoming available in an area for the purposes of section 83(1)(b).

We concluded in the Discussion Paper that the requirement for new proprietors (or those wishing to expand) to purchase bed licences is a barrier to entry, the effect of which is to limit the number of private hospital beds in the State.

We recommended:

> Section 83(1)(b) of the Health Services Act should be repealed. The Secretary of the Department of Human Services should no longer be able to take into account adequacy of health services in an area when considering applications for registration of new private hospital developments. The Department should remove the bed cap by withdrawing the existing Guidelines for the Development of Acute Hospital Beds. (DP Rec 4)

This recommendation is supported in fifteen submissions and opposed in seven. Other submissions comment on aspects of the recommendation without specifically indicating support or opposition.

Reasons given in support of our recommendation include:

- The bed cap is anti-competitive, restricts supply and is applied solely to the private sector. (Inner and Eastern Health Care Network)
- The current uncertainty is restricting the ability of hospital operators to proceed with needed developments. Considerable time and expense is involved in sourcing and purchasing beds. (Murray Valley Private Hospital)
- The bed cap is not an appropriate tool for limiting supply and encouraging cost control in private hospitals. The supply and level of health insurance subsidy for private patient beds should generally be negotiated between providers and private health insurers.

Reasons given for opposing the repeal of section 83(1)(b) and removal of the bed cap include:

- The costs of removing the bed cap outweigh the benefits. One of these costs arises because publicly listed companies have the value of the bed licences in their balance sheets. This will be affected by the removal of the bed cap and should be taken into account. (AHC)
- The bed cap has not had a negative impact on the structure of the industry and has not prevented changes such as the entry of new providers or the exit of existing providers. (AHC)
- The studies upon which we based our conclusions were flawed, as the earlier studies only examined the theoretical effect of government regulation on the bed supply and did not do any modelling to assess the actual effect. (PHAV; CCPHA; St John of God Health Care)
- It is a fallacy to think that orderly planning can be accomplished by the interplay of market forces. The suggestion that the role of

private health insurers through provider agreements would be capable of contributing to or enhancing a technically efficient allocation of resources is not substantiated. (PHAV; AHC; Cabrini Hospital)

Many submissions, whether for or against our recommendation, comment on the State's role in planning rather than the market in bed licences created by the bed cap. Most equate the requirement that the Department assess adequacy of services when allowing a new entrant into the private hospital market (together with the bed cap) with a planning function.

The submission from VHA encapsulates the views of many. In their view, effective statewide planning is important and involves more than a purchasing role. If services are poorly planned and distributed, purchasing will occur within a sub-optimal system. Service planning is an appropriate and essential role for the Department. Given the high proportion of public expenditure allocated to both public and private hospital services, there is a strong public interest in favour of this function. The role of the Commonwealth as a purchaser also needs to be acknowledged.

Other issues raised by the submissions include:

- The Department has sufficient control over planning in its role as funder and purchaser. (North Western Health)
- Government has a vital role in planning for the private sector, in particular limiting the establishment of new private hospitals in over-supplied areas. (VCHC)
- The repeal of planning controls may lead to more elective procedures being provided. Commercial pressure may lead hospitals to advertise aggressively and provide services to patients that they do not really want. (Health Services Commissioner; HBC)
- If the bed cap is removed, supplier induced demand may arise. In a deregulated private hospital market providers may compete with each other to deliver capital intensive services. This may encourage over-utilisation with little regard to best practice. (VCHC)
- If the Government does not limit the number of hospital beds, the health insurance industry will be forced to limit the number it pays for. This may be preferable as, despite the existence of Government controls, the number of private hospital beds has nearly doubled in the last fifteen years while the privately insured population has halved. The requirement for private health insurers to pay a default benefit to all hospitals should be removed. (HBC)
- It is in the public interest that Government review and retain legislation that ensures orderly and logical development of the private sector coordinated with the public sector. There should be a

demonstrated community need before additional services or facilities are approved. The duplication of unnecessary services is costly, has the potential to increase utilisation, and will lower quality. (Cabrini Hospital)

- Non-regulated entry into the private hospital market could lead to a reduction in the quality of services provided, as expertise is scattered through a greater number of hospitals. Research indicates hospitals that perform a higher number of particular procedures are likely to have lower rates of morbidity and mortality associated with those procedures. (PHAV; Associate Professor Davis, Head of Cardiothoracic Services, The Alfred)
- Allowing open entry into the private hospital market may create a potential for large operators and private health insurers to drive out smaller operators. This may lead to an anti-competitive situation where large operators monopolise the system. (AMA Victoria; RACP)

It is important to stress that the existing bed cap approach to planning in the health sector is a very limited approach. Firstly, since the Guidelines were introduced 20 years ago there has been no attempt to redress the problems of the past by requiring bed closures in 'over-bedded' areas (such as East Melbourne). Secondly, the Guidelines and bed cap are extremely crude: there is only a limited number (11) of types of care regulated and so hospitals can change their patient mix from specialties or procedures which are in short supply to those which might evidence excess provision without any requirement for planning approval. Thirdly, because medical technology is changing rapidly, if planning is to be undertaken properly 'adequate provision' should be reviewed on a regular basis and bed planning norms adjusted accordingly. This has not been the case to date.

In summary, the planning controls do not appear to be working effectively and now simply function as an anti-competitive price barrier to new entrants into the private hospital market and those who wish to expand. As we argued in the Discussion Paper, we believe there is little benefit to consumers in maintaining these controls. Despite the concerns expressed about removing statutory controls perceived to perform a planning function, section 83(1)(b) has not been used as a tool for determining which specific health services should lawfully be capable of being provided by particular private hospitals.

In relation to private hospitals which do not receive substantial State funds, the fundamental question is what role Government should have in attempting to determine where private hospitals should be permitted to locate, or the preferred size of such facilities, in circumstances where decisions about size and location are not directly related to safety or quality issues. Two different views have emerged from the submissions. Some consider the Department's role should

encompass assertive service planning for both the public and private hospital sectors. Others consider the Department can influence planning in other ways. We agree with the view expressed by North Western Health, that is, that the Department has sufficient influence over health service planning in its role as funder and purchaser of public health services.

An implicit assumption in some submissions supporting retention of the bed cap is that the Department is better placed to judge community need or demand for private hospital facilities in particular areas than private sector operators who are prepared to risk their capital in establishing a private hospital. We consider that any prudent operator seeking to enter the private hospital market or to expand their existing operations would have undertaken substantial market research and detailed business planning in an attempt to ensure that the venture will be viable and that there will be a genuine market for the services proposed to be provided.

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

Even among submissions which support the removal of the bed cap, we detected some unease about our proposal to repeal section 83(1)(b) as this provision is perceived to be a potentially useful planning tool. However, as we have indicated, section 83(1)(b) has not been used in this way. If a policy decision were made to assertively apply section 83(1)(b) as a planning tool independently of the guidelines establishing the bed cap and beds to population ratio, detailed criteria would need to be developed to determine what constitutes more than adequate health services of any type in a designated area. The Department would need to apply the criteria consistently and transparently in making registration decisions across the sector in order to ensure its decisions could withstand legal challenge. The likely outcome would be prescriptive controls over the types of services able to be provided in registered facilities which would restrict the private hospital sector's capacity for innovation and responsiveness. We consider that the costs of implementing such a policy would outweigh the benefits.

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

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

As we said in the Discussion Paper, if the bed cap was ever effective as a cost control device, it is no longer so in the current market. The total private hospital market has stabilised as the trend toward ambulatory care increases and length of stay reduces. A significant recent development is that the private health insurers can now determine whether they will enter into provider agreements with particular private hospitals. Patients attending those without an agreement will receive the default payment only. We consider this will be a powerful tool in ensuring technical efficiency and cost containment in health care by enhancing the transformation of private health insurers from passive third party payers to active managers of health outcomes.

The *Trade Practices Act 1974* is also a powerful tool which can be invoked to curb any abuses of market power in negotiations between private hospitals and private health insurers and to prevent consolidation of the private hospital industry where this would be

contrary to the public interest. We believe that such matters are best regulated directly by the ACCC instead of indirectly by capping the number of private hospital beds.

Some submissions express concern that removing the bed cap could lead to a reduction in the quality of services provided as expertise may be scattered through a greater number of hospitals. We acknowledge that research indicates that hospitals and practitioners that perform a higher number of procedures tend to have better patient outcomes. However, the existence of the bed cap does not ensure that all private hospitals are currently performing a clinically optimum number of procedures. We consider that implementation of our recommendations on risk-adjusted clinical performance indicators (see chapter 7) would ensure information is publicly available about the type and volume of procedures performed at each hospital. This would assist consumers to make informed choices and contribute to system wide quality improvement.

We believe the bed cap is an ineffective way of addressing the concerns raised in submissions opposed to our recommendation. The National Competition Principles require us to assess whether these legitimate public interest concerns can only be achieved by restricting competition. We do not think this is the case. For example, other more direct mechanisms can be invoked to tackle issues of supplier induced demand, and both the Department of Human Services and private health insurers will have continuing roles in oversight of quality. In particular, private health insurers should ensure that contracts with participants in the private market include provisions to enable insurers to market or promote quality.

Although we note in particular the opposition from some parts of the private sector to our recommendation for the opening of the private hospital market by removing the bed cap on the number of private hospital beds in the State, we stand by our original recommendation on the ground that the bed cap poses a substantial barrier to new entrants.

We also note the concerns raised about the removal of distribution controls which many have equated with a planning function. Section 83(1)(b) has not been used in this manner, and it is our view that the distribution of private hospitals should be governed by market forces.

For these reasons we do not propose to change the intention of our original recommendation, however we have made an amendment to refer to the approval in principle process. As we indicated in the Discussion Paper, removal of the bed cap has been widely anticipated in the private hospital sector and the average cost of beds in the marketplace has declined substantially. We therefore see no merit in delaying the implementation of this recommendation.

Final Recommendation 4

Sections 83(1)(b) and 71(1)(a)(iii) of the Health Services Act should be repealed. The Secretary of the Department of Human Services should no longer be able to take into account adequacy of health services in an area when considering applications for approval in principle or registration of new private hospital developments. The Department should remove the bed cap by withdrawing the existing Guidelines for the Development of Acute Hospital Beds.

3.2.3 Safety Controls

Licensing of private hospitals involves a two-stage process comprising the obtaining of an approval in principle and final registration. The factors the Secretary to the Department is required to consider are:

- fitness of principals;
- financial viability of principals;
- suitability of building and fitout; and
- suitability of operating arrangements.

The direct cost to applicants in the form of fees is not significant.

We concluded in the Discussion Paper that a number of the factors considered by the Secretary do not advance patient safety and could be dealt with by other means. We considered that an expedited licensing process would help to create a more competitive environment.

We concluded that of the four licensing criteria, only the fitness and propriety of principals should be retained on the ground that the integrity of the principal can affect the outputs of a business. By fitness and propriety we mean taking into account whether an applicant is suitable to be concerned in the management of a private hospital. This includes considering whether the applicant is of good repute, having regard to character, honesty and integrity. It also includes consideration of the applicant's past conduct as a provider of a health (or related) service and compliance with any regulatory standards. This criterion should be considered by the Secretary at each stage of the licensing process, including renewal under section 89.

We did not consider the financial viability of principals should be of interest to the State. The principal of a private hospital would either scale down or abandon the proposal or fail if the venture was not financially viable, in which case any market opportunity would be taken up by a competitor. Patients would not be at risk because of the continued existence of controls ensuring quality of care (in the set of minimum regulatory standards), and because of the presence of a number of competitors in the market place. That is, if a private hospital closes, prospective patients could generally be referred to another appropriate hospital at short notice.

We agreed that unsafe premises or equipment have the potential to impact on patient care, however we considered this could be addressed by including all necessary building standards for hospitals in the Victorian Building Regulations. This would mean the Department would no longer be required to review and approve plans.

We considered matters related to the suitability of operating arrangements could be more appropriately managed through the operation of market forces and minimum regulatory standards. By this we meant the criteria currently found in sub-sections 83(1)(h)(i) and (j), namely appropriate staffing arrangements, quality control and provision for monitoring and improving quality, should be in Regulations applying equally to the public and private sectors (discussed further in section 3.4.5 of this Report).

We further noted that section 147 of the Act gives the Department the power of inspection of private hospital premises. We concluded the inspectorial process imposes a slight regulatory burden on proprietors of private hospitals but it is in the public interest for patient safety that this power be retained.

We therefore recommended:

> Building standards for hospitals should be incorporated into the Victorian Building Regulations. Once this occurs, the Department of Human Services should no longer approve the design and construction of private hospital premises. The sole criterion for registration under what is now section 83 of the Health Services Act should be whether the applicant is a fit and proper person to operate, or be a director of a private hospital. The Secretary of the Department of Human Services should retain the power to set conditions under section 85. Criteria for renewal under section 89 should be fitness and propriety of the principal, conformity with the law and compliance with conditions of registration. The Department should retain the power to inspect premises pursuant to section 147 of the Act to

determine compliance with the Act and Regulations.
(DP Rec 5)

The retention of the fit and proper criterion is accepted in the submissions addressing this issue. There is also some support for the incorporation of building standards into the Victorian Building Regulations and the removal of the requirement that the Department approve the suitability of building and fitout.

The submission from Mr M Croxford of the Building Control Commission points out that technical building requirements relating to construction are contained in the Building Code of Australia (BCA), which is picked up by the Victorian Building Regulations. The BCA is a performance based document and any requirements must be able to be expressed in a performance fashion. Performance requirements may be supported by deemed-to-satisfy provisions which provide acceptable prescriptive solutions. As the BCA applies across Australia, the Australian Building Codes Board in each jurisdiction will have to agree to the changes to incorporate other hospital design features into the Code. However, in the short term there is discretion to include State based variations if they are for the purposes of achieving consolidation.

Concern is expressed by the private hospital sector, however, that a consolidation may not fully encapsulate all the technical specifications and requirements of private hospital building and design. The ability of bodies other than the Department to adequately enforce these requirements is questioned.

We are of the view that appropriate hospital-specific standards are capable of distillation into the building control framework and that those responsible for granting approval will have expertise in applying such standards.

Our proposal that the criterion of financial viability be removed was questioned in a number of submissions on the ground that, if finances are tight, operators may seek to cut corners in an effort to cut costs and so compromise patient care. However, the assessment by the Department of a private operator's financial viability has not prevented private operators from failing in the past. We are not proposing any reduction in regulation of quality or safety measures which is the lynchpin for ensuring patient safety. We believe that regulation, together with an assessment of whether the operator or proposed operator is a fit and proper person, are far more effective safeguards than financial viability.

Removing suitability of operating arrangements as a criterion raised some concerns on the ground that market forces may not be sufficient to maintain quality. Both the Health Services Commissioner and the

Health Issues Centre emphasise the need for operators to listen to consumers and to take complaints more seriously. The Commonwealth Department of Health and Aged Care and AMA Victoria suggest regulations in relation to safety should be bolstered, and compliance with quality related regulations looked at, when renewing registration of private hospitals.

We agree that regulation of safety and compliance with quality requirements is important, and we suggest later in this chapter that regulatory standards should be developed which are common to both the public and private hospital sectors (see section 3.4). In this process, requirements for operators of all hospitals could be strengthened, not only for quality and safety, but also for the manner in which consumer complaints are handled.

Our proposal that the Department retain power to impose conditions on registration and inspect premises was explicitly or implicitly supported in most submissions.

After consideration of the issues raised in the submissions, we have decided to retain our original recommendation regarding the criteria to be considered in the registration and approval process for private hospitals.

It is important to note we are not recommending change to the registration or renewal processes. Rather, we are recommending a change to the criteria that should be considered. The only criterion which must be considered if our recommendation is accepted is whether the applicant is, or remains, a fit and proper person to be concerned in the management of a private hospital. In terms of renewal, this includes compliance with regulatory standards including staffing and quality requirements.

The fit and proper criterion has many limbs. It goes to the honesty of the operators or proposed operators, their character and integrity. For example, it encompasses whether they have satisfied their obligations under State and Commonwealth laws and their past conduct as providers of a health or related service.

We believe there is merit in giving some legislative guidance as to the criteria to be used when determining whether an applicant is suitable (ie fit and proper) to operate a private hospital. A good example of how this can be accomplished can be found in the Commonwealth *Aged Care Act 1997* and the Approved Provider Principles 1997.

It was not clear in the Discussion Paper whether we considered the approval in principle process should remain. This process enables persons proposing to establish a private hospital to know in advance of

registration whether they are likely to become registered provided their circumstances do not change.

The approval in principle process is important as it provides substantial certainty to those who are seeking to invest in the private hospital sector in this State. It allows operators to first establish that they will be able to operate a facility, prior to investing significant amounts of capital in a new project. Consequently, we believe the approval in principle process should remain but that the only criterion which should be considered is the broad one of whether the applicant is a fit and proper person.

We have made minor changes to our recommendation to clarify this.

Final Recommendation 5

Building standards for hospitals should be incorporated into the Victorian Building Regulations. Once this occurs, the Department of Human Services should no longer approve the design and construction of private hospital premises.

The sole criterion for approval in principle and registration under sections 71 and 83 of the Health Services Act should be whether the applicant is a fit and proper person to operate, or be a director of, a private hospital.

The Secretary of the Department of Human Services should retain the power to set conditions under section 85.

Criteria for renewal under section 89 should be fitness and propriety of the principal, conformity with the law and compliance with conditions of registration.

The Department should retain the power to inspect premises pursuant to section 147 to determine compliance with the Act and Regulations.

3.3 Competition between for-profit and not-for-profit private hospitals for private patients

3.3.1 Competitive inequities

Not-for-profit private hospitals have significant market share in Victoria. They fall into two distinct categories: not-for-profit hospitals owned by religious Orders and other charitable organisations; and small not-for-profits, often operating in rural areas, many of which were formerly bush nursing hospitals.

We found in the Discussion Paper that the not-for-profit sector has significant competitive advantages over the for-profit sector in the private patient market. This is because the not-for-profit sector is exempt from income tax, sales tax, fringe benefits tax, payroll tax, land tax, payment of local rates and charges, stamp duty, FID and BAD. In addition, not-for-profits are able to attract tax deductibility for donations. We also pointed out that, unlike public hospitals, not-for-profit private hospitals are not required to comply with competitive neutrality principles.

Because of the inequities and distortions which arise as a result of the ability of not-for-profits to obtain input tax exemptions, we recommended this advantage be removed. We argued, however, that not-for-profit health providers should be able to retain their income tax exempt status. We believe introducing tax for not-for-profit bodies would be contrary to the philosophy underpinning the income tax system that individuals are the only entities which can consume or exercise economic powers. Also, the net income of charitable organisations is difficult to measure. We also proposed that donations of $2 or more should continue to be tax deductible to provide an incentive for members of the community to make donations. Our specific recommendation was:

> Exemptions from input taxes represent an unfair advantage which not for profit private hospitals have over their for profit counterparts. That advantage should be removed. (DP Rec 6)

This recommendation was controversial. Of the 24 submissions addressing this issue, 18 are opposed or raise concerns.

In support of the removal of exemptions, the Inner and Eastern Health Care Network argues that input taxes are a component of the cost of providing a service and should be reflected in the price paid for the service. Elimination of the exemptions would enable the true cost to be established, providing for fairer competition between the for-profit and not-for-profit sectors.

Australian Hospital Care Ltd (AHC) also supports the removal of exemptions on the grounds that they are inequitable, create distortions (eg they make it more difficult for the for-profit hospitals to attract staff), and limit the federal, state and local government revenue base.

The Commonwealth Department of Health and Aged Care notes that under the recently proposed taxation reforms, wholesale sales tax and many state taxes will be abolished. This means exemptions for most input taxes for not-for-profit hospitals will be removed. It is proposed that the fringe benefits tax exemptions be capped at a specified level per employee (at the time of writing the proposed cap was $17,000, however this figure is subject to debate).

Opposition to the recommendation is based on the potential detrimental impact upon the not-for-profit sector and on the services the sector provides. For example, a number of submissions comment that the Discussion Paper does not provide a satisfactory description of the particular role and nature of the charitable sector in relation to the provision of health care. They believe this leads to an inadequate assessment of the advantages which the community derives as a result of the favourable input tax treatment given to these providers.

The Health Issues Centre states the differential taxation regime is:

> ... an issue in an environment with multiple service providers. Like all historical artefacts it does need to be reviewed to test its continuing benefit to the community. However, it cannot be seen in isolation from the role of not for profit groups and their motivations in providing community services. Whilst some of the larger not for profit hospitals may demonstrate little difference in raison d'etre to for profit hospitals, many not for profit agencies, including bush nursing hospitals, have provided services where the market has failed and government is absent.

3.3.2 The potential impact of removing input tax exemptions

The submission from Victorian Catholic Health Care (VCHC) best illustrates the reasons underpinning opposition to our recommendation. (Victorian Catholic Health Care is a group comprising the Sisters of Charity Health Service, Melbourne Region; Bethlehem Hospital; St Frances Xavier Cabrini Hospital; St John of God Health Care; and Mercy Health and Aged Care.) They point out that in Victoria the mix of public and not-for-profit and for-profit private providers gives individuals a wider choice of hospitals, each with distinctive attributes. The ways in which not-for-profits serve the community is consistent with their mission and values. For instance, some people may attend a facility to obtain emotional or spiritual care as well as physical care. To arbitrarily tip the balance in favour of the

for-profit providers would reduce this choice of access to a different kind of product in their view.

The VCHC submission also refers to the Industry Commission report on charitable organisations which noted that the existence of the charitable sector ensures no government has a monopoly on the way it deals with its citizens, especially the vulnerable. The sector enhances society by ensuring pluralism and free choice and by enabling citizens to participate in, and take responsibility for, their community.

VCHC suggest there are a number of ways in which the not-for-profit sector provides benefits to the community which are not generally available from for-profit private operators. For example:

- Any surplus derived from services provided is not retained as profit to be used for private purposes but rather is used for altruistic purposes such as subsidising existing services or providing services not provided by others. These services are provided to the marginalised and vulnerable, such as the elderly, the poor, the homeless, the mentally ill, the dying and those in minority ethnic groups. Surpluses have been used, for example, to provide funds for Ozanam House; the Good Samaritan Fund; services to the disadvantaged in Victoria, outback Australia and third world countries; Mercy Hospice in Sunshine (land, buildings and equipment); health care to uninsured patients in private settings and health education.
- The not-for-profit sector is able to provide unprofitable services which the private for-profit sector will not deliver. Examples given include palliative care in both the public and private sector, neurological inpatient services, area mental health services, mother/baby units, research, professional education and development and pastoral care services. In VCHC's view, the unwillingness of the private sector to provide such services has been illustrated when they have been put to tender.
- In the areas which receive Government funding, services are provided at a cheaper price because of the contribution made by the not-for-profits from their own resources. Examples include the Mercy Hospice, Mercy Hospital for Women, St Vincent's Hospital, Bethlehem Hospital, Caritas Christi Hospice, treatment of public patients at the plastic surgery unit at the Mercy Private Hospital and discounted public coronary angiography at the Mount Alvernia Mercy Hospital. This contribution includes rent forgone.
- The nature and public profile of the not-for-profit sector means it can attract donations which are used to help people in need. The sector acts as a facilitator of direct community input. This relieves Government from the need to provide additional revenue. A lack of recognition of the role of not-for-profits could discourage the community from donating.

VCHC also suggests the Discussion Paper does not conduct an assessment in accordance with the National Competition Policy guiding legislative principle. That principle would permit the retention of the exemptions if a sufficient community benefit could be demonstrated. They suggest it is premature to propose removal of the exemptions without first assessing the extent of the community benefit derived from them. They comment the Discussion Paper does not conduct such an analysis, but rather presumes there is none. In their view, such a study would have to assess the benefits that flow from the operation of the charitable sector, and then consider the extent to which those services are funded through the exemptions from input taxes.

VCHC suggest this failure is not academic and that we did not propose a contingency plan to ensure the continuation of services currently provided through the surplus gained by the exemptions.

In their submission, VCHC states that:

> By granting not for profit institutions tax exemptions, society has trusted them to use their resources in the best interests of the community. There has been no requirement for organisations to explicitly identify and quantify these activities that they have been trusted to provide. We are seeking to develop a greater accountability to the community for these benefits.

VCHC estimate the removal of the exemptions will result in additional costs of between 4% and 6% of total revenue. For many services this represents the difference between viability and closure, or the loss of capacity to improve capital. They are particularly concerned about the potential effect removal of exemptions would have on those aged care services with marginal surpluses which are essential for capital re-investment to improve the quality of facilities.

The VCHC submission provides information on the value the Sisters of Charity estimate they provide to the community in the form of direct services to the poor from private hospital surpluses and rent forgone for land made available without charge to Government for public hospital services. Although these represent only some aspects of the community benefit provided, the Sisters of Charity Health Service estimate their value at 8% of total turnover. VCHC suggest this exceeds the value of input tax advantages. VCHC consider this assessment represents a strong case for concluding the advantages to the community of the exemptions from input taxes outweigh the costs, and that retention of the exemptions can be justified under the guiding principle of National Competition Policy. Further study is required to confirm this and to look at the rest of the sector.

VCHC also believe the Discussion Paper does not adequately take into account the advantages that for-profit operators have over not-for-profits. They believe these include tax advantages, the ability to raise capital, employment incentives and an unfair advantage in tendering.

VCHC point out the not-for-profit sector has to rely on borrowing money from the traditional debt market as it cannot raise equity funds through the stock market. The advantage in relation to capital raising by the for-profit sector is significant in VCHC's view. They believe that in tendering for infrastructure investment projects for the provision of public patient services this can be the difference between winning and losing a tender.

They also point out that many employment incentives are not available within the charitable sector, such as employee share schemes and indexed superannuation. Fringe benefit tax salary packaging is the main way in which not-for-profits can compensate for this to attract good staff by providing market level remuneration.

In VCHC's opinion, when bids for infrastructure investment projects for public patient services are assessed a level playing field does not exist. The State neutralises the payroll tax advantage of the not-for-profit bidders by adding the amount of tax that would be paid by a for-profit bidder to the payments which would be made to that bidder if it was successful. Such a for-profit bidder is effectively reimbursed for payroll tax payments. If payroll tax is abolished, the for-profit operator will make a windfall gain. Conversely, if payroll tax is imposed on the not-for-profit body at any stage during the contract period, Government will receive both the discounted contract price and the tax.

3.3.3 Quantifying the benefits of retaining input tax exemptions

The VCHC submission concludes that the net effect of these advantages and disadvantages should be considered. In their view, the advantage derived from the input tax exemption does not seem to have unfairly benefited the not-for-profit operators in the wider market; market growth has primarily been in the for-profit sector.

In our view, there is no denying the differential tax regimes grant competitive advantages to public and not-for-profit hospitals. In a competition review, the key issue then becomes whether the differential tax regimes result in a net public benefit to the community as a whole when compared with the public benefits which may result from fostering competition.

The relief of sickness, pain and suffering by organisations whose core purpose is to provide such services on a not-for-profit basis, either to all people regardless of their ability to pay or social status, or to those with a recognised need for particular services who could not otherwise

access them, has traditionally been recognised by Australian Governments as a charitable function which merits community financial support via the taxation system. Not-for-profit health services clearly perform charitable activities and have therefore been recognised as public benevolent institutions meriting taxation exemptions or concessions.

Also, despite the assumption of responsibility by Governments for many services which were traditionally provided principally by charitable organisations before the expansion of the welfare state, there remains considerable unmet need in the community for services to the disadvantaged such as those mentioned in the VCHC submission. We accept that, by providing services to the needy or disadvantaged, the charitable sector performs a very valuable and valued role in society and that such activities merit Government and community support.

Having accepted that there should be Government support for charitable activity, the key policy issue is then whether the best means of supporting such activities is indirectly via taxation exemptions or concessions instead of via direct transfers from Government and the community.

In designing a taxation system, the purist approach would be to ensure that taxation does not distort the market by encouraging or discouraging any particular form of business activity or favouring not-for-profit organisations over for-profit organisations when they are in competition. However, we note that the taxation system is used to provide support for various activities deemed socially useful by Governments, such as rebates to assist families meet childcare expenses and to encourage lower to middle income earners to take out private health insurance. Such measures are designed to foster equity or to meet other policy objectives, even if this may occur at the expense of competing objectives of a sound taxation system; namely, efficiency and simplicity.

Since our recommendation was made, the Commonwealth Government has indicated that it proposes to maintain concessional taxation arrangements for the charitable sector in relation to fringe benefits tax. In relation to GST, all health services are proposed to be tax exempt. We do not believe that this decision was motivated principally by a desire to facilitate competition between the public and private health sectors. The principal reasons for exempting health services from GST were probably to ensure Parliamentary support for the GST package in the Senate, to maximise simplicity in the design of the GST thereby containing administration costs, and to contain the inflationary effects of GST on the health budget overall. Nevertheless, on one view, the Parliament may be seen as sending mixed signals in its treatment of the for-profit and not-for-profit sectors in its deliberations on taxation

issues. In this context, there is an argument for suggesting differential input tax regimes be maintained.

We believe a better option, however, would be to establish a working party to quantify the benefits that accrue to the public as a result of the tax exemptions which charitable organisations (including all not-for-profit agencies such as bush nursing hospitals) receive. Consideration could then be given to making these benefits explicit in a 'Community Charitable Return' (or some similar term to be determined by the working party) for the charitable organisations, representing the social dividend they provide to the community. The 'Community Charitable Return' should be not less than the tax revenue forgone. We particularly welcome the comment in the VCHC submission indicating that they are willing to identify and quantify the benefits flowing to the community from their charitable activities. This approach would remove distortions which impede competition, while recognising and supporting charitable activities. We note that such a review would need to occur cooperatively at both Commonwealth and State levels.

We have revised our original recommendation regarding input tax exemptions to reflect this.

Final Recommendation 6

Exemption from input taxes represents a competitive advantage which not-for-profit private hospitals have over their for-profit counterparts in the private patient market. Government should establish a working party to quantify the benefits of the tax exemption to the public. These benefits could then be made explicit in a 'Community Charitable Return' for not-for-profit hospitals. The Community Charitable Return should not be less than the tax revenue forgone.

The issue of input tax exemptions should be re-visited in the light of the working party's conclusions.

3.4 Competition between public and private hospitals for private patients

3.4.1 The barriers to competition

In the Discussion Paper we analysed the barriers preventing competition between public and private hospitals (both for-profit and not-for-profit) for private patients. We pointed to the following issues:

- the tax advantages that public hospitals and not-for-profit private hospitals have over private for-profit hospitals;
- restrictions on the charging practices of public hospitals in respect of private patients;
- the disadvantage to public hospitals of receiving lower default benefits for privately insured patients than non-contracted private hospitals;
- the preclusion of public hospitals from keeping private patient fee income;
- the inability of public hospitals to access the Pharmaceutical Benefits Scheme (PBS) for private patients;
- the disadvantage public hospitals have in delivering pathology services because they are unable to obtain a patient episode initiation fee from the Health Insurance Commission; and
- the lack of access public hospitals have to the capital or debt markets to raise funds to refurbish their facilities.

Our preferred option was to remove the maximum fee requirement imposed under Commonwealth/State financing arrangements, to encourage public hospitals to obtain full cost recovery for private patient services and to allow them to retain any private patient fee income. (At that time we considered this strategy would require a change in Commonwealth funding policy.) We considered public hospitals should abide by competitive neutrality principles when assessing their costs of providing private patient services and then set fees in accordance with normal commercial practices. The State should then cease to make any WIES payment to public hospitals in connection with private patient services.

To ensure that this would not create an incentive to treat more private patients at the expense of public patients, we suggested the Department of Human Services should set clear targets for public patient activity.

In addition, in the interests of patient care we recommended the State continue its negotiations with the Commonwealth so that private

inpatients of public hospitals are not disadvantaged in accessing pharmaceuticals.

In exchange for public hospitals having an enhanced right to compete with private hospitals for the private patient market, we recommended their competitive tax advantage in relation to input taxes be removed. The rationale for this recommendation was thoroughly explored in chapter 7 (section 7.3) of the Discussion Paper. We noted that removal of these benefits would inevitably also necessitate a review of the adequacy of WIES funding. We took the view that the claw back of taxation by the State and Federal Governments as a result of the removal of exemptions would need to be fed back to the public hospitals in the form of enhanced WIES payments.

We made three recommendations regarding competition between public and private hospitals for private patients. These recommendations related to:

- private patient fee income for public hospitals;
- pharmaceuticals benefits and health insurance; and
- tax advantages.

We also made a recommendation (DP Rec 10) about common regulatory standards.

3.4.2 Private patient fee income for public hospitals

Recommendation 7 of the Discussion Paper stated:

> The State should negotiate with the Commonwealth to ensure that the maximum fee requirement imposed on public hospital charging practices for private patient services is removed. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income received by public hospitals should be retained by them and the State should cease to make WIES payments in connection with those services. (DP Rec 7)

The response to this recommendation was divided, with 13 submissions supporting it and 14 rejecting it.

Reasons given for agreement with the recommendation include support for the notion that public funds will then more clearly be used for public patients, and agreement in principle that there ought to be fair competition for private patients between public and private hospitals.

Opposition to the recommendation centres around two main concerns: possible adverse impacts on the private sector and possible adverse impacts on the fundamental activities of public hospitals.

With regard to the private sector, concern is expressed that the consequence of lifting the ceiling on private patient fees in public hospitals will be an increase in private health insurance fees. This, in turn, may lead to a reduction in the number of people privately insured. Also, if public hospitals actively seek more private patients there could be a fall in the occupancy of private hospitals.

With regard to the impact on the activities of public hospitals, there is concern that public hospitals may chase private patients for extra revenue, either by filling under-utilised beds or treating more private patients at the expense of public patients. There is also concern that if public hospitals seek contracts with private health insurers, those insurers may require guaranteed preferential access for their members as well as separate facilities. Any decline in private health insurance could also place greater pressure on the public system and may increase waiting lists. It is argued that pressures such as these may compromise not only the treatment of public patients but also the expensive activities of teaching and research.

A number of submissions raise issues which they believe will require resolution or acknowledgment if our proposal is adopted. For example:

- Flow on issues such as patient election practices and emergency admission will need to be addressed. (Medibank Private)
- Public hospitals will have to negotiate with purchasers in setting their fees in accordance with normal commercial practices. (Medibank Private)
- A code of practice regarding the fixing of fees in accordance with 'normal commercial practice' and revised accounting standards will be required. (HVPH)
- Public hospitals may charge at marginal cost rate, which will mean that private patient treatment will still be subsidised. (HVPH)
- Adjustment of the Australian Health Care Agreement will be needed to take into account transfer of costs from the State to the Commonwealth and private health insurers. (HVPH)
- Full cost recovery may not always be possible, as public hospitals treat some private patients with complex conditions who cannot be treated in a private hospital. The maximum private insurance rebates may not adequately cover the full cost of treating such patients. (VHA)
- If public hospitals are subject to disputed claims by private health insurers, the required level of cost recovery to offset reductions in

WIES payments may not be achieved. Given their safety net function, public hospitals will not be able to refuse to treat in such cases. Consideration should be given to the State agreeing to reimburse public hospitals for disputed private claims until private health insurer practice is gauged. (VHA)

- The Victorian Government will need to ensure that net funding to public hospitals is maintained. (Southern Health Care Network)
- Full fee charging may encourage private health insurers to direct patients away from public hospitals. (VHA)
- If private patient fees in public hospitals increase to average private hospital levels, total costs to a private health insurer could be up to 8–10% more (costs may be less where services are not of a similar standard). (Medibank Private)
- There will need to be adequate product differentiation for private patients. (Medibank Private)

Further, although the VHA does not support *requiring* public hospitals to set fees in accordance with normal commercial practice (if this implies that they must recover their full costs of treating private patients from fees), it does support the principle of *allowing* equivalent charging by those hospitals which wish to do so.

AMA Victoria, while it opposes our recommendation, suggests there is an anomaly in the charging of private patients by public hospitals that could be rectified. It states that at present when overall throughput targets have been met, a hospital does not receive any additional WIES payment if it treats additional private patients, however the Department still recoups the fees paid by the patient. This means the hospital receives no revenue for the treatment. AMA Victoria suggests hospitals should be able to retain this income to encourage better use of facilities without disadvantaging public access.

In considering these submissions, we note that in 1997-98 Victorian public hospitals were funded for 716,190 WIES. The WIES for private patients was 88,052. (Both volumes were for patients other than those funded by the Department of Veterans' Affairs.)

The inpatient payment system essentially provides for the following levels of funding:

- The 651,737 WIES in Target A were funded with a full fixed and variable payment ranging from $2,094 for public WIES ($1,703 private WIES) in a major metropolitan teaching hospital to $2,262 for public WIES ($1,871 private WIES) in a rural group D or E hospital.
- The 13,956 WIES in Margin A were funded at a very low variable rate of $936.60 for public WIES and $662.90 for private WIES.

- The 50,497 WIES which were offered to hospitals (Option WIES) or for which hospitals tendered (Tender WIES) are essentially funded as follows:
  - The Option WIES were funded at the Department's variable payment level of $1,388 for public WIES and $947 for private WIES.
  - The Tender WIES were funded according to the price nominated by the bidding hospital or network.

An implicit assumption of the current funding system is that the Tender and Option WIES are marginal to the core activity of the hospital (hence the lower payment rate). An alternative way of viewing patient activity is to see the private patients as marginal and hence attracting a lower payment rate. (This is a system-wide perspective, as it is acknowledged that different public hospitals have different balances of private versus Tender and Option activity.)

In terms of funding and costs for private patients (excluding Department of Veterans' Affairs patients), in 1997-98:

- public hospitals received $64m from patients and/or private health insurers for accommodation charges;
- the estimated cost of treating the private patients who generated that revenue was $121.6m (on a variable cost basis) or $156m (on a full cost basis); and
- the Department made WIES payments to hospitals of approximately $83m (on a variable cost basis) or $143m (on a full cost basis) for these patients. (The Department also made other payments such as Training and Development Grants, which may explain the difference between the full costs of $156m and the payments of $143m.)

Clearly, private patients are significantly subsidised even if they are seen as marginal patients to the core activity and hence the hospital only looks to cover its variable costs.

Our proposal is to deregulate fees for private patients so that individual public hospitals (or networks) are required to make independent decisions about their charging practices and negotiations with private health insurers.

This process should be cost neutral to the system as a whole. On the basis of an analysis conducted on 1997-98 data, total WIES payments should effectively be increased by $79m (the current WIES payments of $143m less the $64m of revenue to the State forgone). Hospitals should also be allowed to retain any private patient revenue they receive.

Implementation of this policy requires consideration of the extent to which the $79m is allocated as extra public WIES rather than increased payment per public WIES. Similarly, the differential impact on individual hospitals will also need to be addressed. The policy might therefore need to be implemented on a hospital by hospital basis. We note this may be administratively difficult.

It is important to stress this recommendation does not propose that Government increase fees for private patients in public hospitals. Rather, the recommendation is about creating a level playing field: just as private hospitals have to negotiate fees with private health insurers (and patients) so too should public hospitals. Private health insurers can make independent judgements about the benefits to them and their contributors of paying increased (or reduced) fees. Health insurance premiums would only rise if private health insurers felt the additional outlays on public hospitals were beneficial.

We note that the Department's funding formula has been adjusted for 1999–2000 to change the nature of revenue targets for private patients. This moves in the direction we are proposing.

Similarly, the recent Australian Health Care Agreement gives increased autonomy to States on fees. According to the Commonwealth Department of Health and Aged Care, the requirement to limit private patient fees to an amount agreed to by the State and the Commonwealth no longer applies. The current Australian Health Care Agreement differs from its predecessors, and provides in clause 57 that private patient fees can be set by the State alone. Further, the Agreement sets activity targets for Victoria in terms of public patients alone. Private patient activity in public hospitals is not included in targets set under the Agreement.

In the light of the change in Commonwealth regulation of fees, we have amended Recommendation 7 to read:

Final Recommendation 7

The State Government should no longer prescribe fees for private patients in public hospitals and should not set targets for private patient activity. Targets for public patient activity should be retained. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income received by public hospitals should be retained by them and the State should cease to make WIES payments in connection with those services.

3.4.3 Pharmaceutical benefits and health insurance

We suggested in the Discussion Paper that private inpatients in public hospitals can in practice be disadvantaged when compared with inpatients in private hospitals. Some high cost drugs such as those required in cancer treatment are more readily available in a private hospital as they are subsidised under the PBS. As a public hospital does not have access to the PBS, if it is to provide the drugs it must do so out of its own budget, which may not always be possible.

We also noted in the Discussion Paper that one significant disadvantage experienced by public hospitals when competing with private hospitals for the treatment of private patients relates to health insurance. The structure of default benefits introduced by the Commonwealth does not treat the two categories of hospital equivalently.

Default benefits are the minimum amounts that private health insurers must pay for members who are treated as private patients. The minimum set for treatment in a public hospital which has not entered into a Hospital Purchaser Provider Agreement (HPPA) with an private health insurer is set at the lowest 'first tier'. (An HPPA would enable higher benefits to be paid.) In contrast, patients at private hospitals which have not entered into HPPAs with private health insurers are entitled to be paid the higher 'second tier' default benefit, which is set at 85% of the average benefit paid to hospitals which have entered into an HPPA.

This mechanism reduces the pressure on private hospitals to enter into HPPAs. It also discriminates against public hospitals which receive much lower default benefits than non-contracted private hospitals.

To enable public hospitals to compete with the private sector for private patients on more equal terms, we recommended:

> The State should negotiate with the Commonwealth to ensure that:
>
> - private inpatients of public hospitals are not disadvantaged in comparison to private hospital patients in accessing subsidised pharmaceuticals; and
> - public and private hospitals are treated equivalently for health insurance purposes. (DP Rec 8)

Fifteen submissions support the proposal to permit private inpatients of public hospitals to access subsidised pharmaceuticals; nine submissions express opposition. Predictably, support comes more from the public sector and opposition more from the private sector. This is true also of the second limb of our recommendation, where it is supported in thirteen submissions and opposed in seven.

With regard to our first point, the submission from the Commonwealth Department of Health and Aged Care suggests our recommendation does not recognise the effect of clause 35 of the Australian Health Care Agreement, which enables reform of the funding of pharmaceuticals. Under the Commonwealth reform proposals, pharmaceuticals provided to all non-admitted patients, and public and private admitted patients on discharge, will be available under the PBS. Public hospitals will be 'approved hospitals' under section 94 of the *National Health Act 1953* for this purpose. Chemotherapy drugs provided to public and private same day patients will be subsidised under the Highly Specialised Drugs Program. The only restriction under clauses 35, 56 and 58 of the Australian Health Care Agreement relates to admitted private and public patients (other than for day-only chemotherapy drugs). This requires that pharmaceuticals be provided free by a public hospital to both categories of inpatient.

The Department of Health and Aged Care argues this means private patients in public hospitals are not disadvantaged in comparison with private patients in private hospitals. It states the reasons for not giving private inpatients in public hospitals access to the PBS are that:

- there is a policy of avoiding inequitable treatment of public and private patients in the same public hospital; and
- opening access to private patients as a distinct group raises logistical difficulties in terms of auditing admission status.

We agree that the Australian Health Care Agreement has provided the framework for substantial reform in the funding of pharmaceuticals, however the Agreement explicitly provides that inpatient pharmaceuticals are not to be charged against the PBS. We recognise there are difficulties in achieving equivalence between the public and private sectors, however the existence of this differential inevitably means there is not a level playing field between the two sectors in relation to access to the PBS for private inpatients. We therefore do not intend changing this aspect of our recommendation.

In relation to our proposal that public and private hospitals be treated equivalently for health insurance purposes, the Commonwealth Department of Health and Aged Care advises that the default table for the payment of benefits is under review, and the outcome of this process may be that all hospitals may have to meet the same quality criteria to be eligible for default benefits. It is hoped that the Commonwealth will develop criteria which do not specifically relate to the type of registration of a hospital.

The Department of Health and Aged Care also suggests there is nothing to stop public hospitals entering into HPPAs to attract higher benefits. (However it acknowledges there should not be any undue increases in insurance premiums if these agreements are made between private health insurers and the public sector.)

Although not opposing the recommendation, Medibank Private notes the corollary of the proposal is that there needs to be equivalence in the quality of services provided to private patients by both sectors.

Concerns raised in opposition to the recommendation include:

- It is not possible to have fair competition, as the public sector receives an unfair advantage through the receipt of Government funding which subsidises the treatment of private patients. To remove the factors which currently advantage the private sector will only exacerbate the existing unfair advantage held by the public sector. (AHC)
- Insurance premiums will increase if the same level of benefits is to be paid. (Epworth Hospital)
- It will encourage the treatment of private patients by public hospitals, and in conjunction with the other recommendations which are geared towards enabling competition for private patients, will eventually prevent those who do not have private health insurance from receiving adequate health care. (VAC/GMHC; NCWV)

VHA and North Western Health suggest that the policy underlying this recommendation – treating the public and private sectors

equivalently for the purposes of health insurance – should be extended beyond the hospital setting to primary health providers. They believe patients with private health insurance who receive treatment in a community health centre are currently disadvantaged. This is because they cannot be reimbursed from private health insurers because their allied health practitioner cannot obtain the necessary provider number from the Commonwealth.

North Yarra Community Health, on the other hand, comments that community health centres exist to provide services for those who cannot afford to attend private providers. It will be counterproductive in their view if such people, especially those with health cards, have more difficulty in gaining access to these services because staff are busy treating people who have private insurance and who could attend a private practitioner instead.

The submissions raise valid concerns and we suggest that the Department examine these issues. We consider our original recommendation is still appropriate, however, and retain it unchanged.

Final Recommendation 8

The State should negotiate with the Commonwealth to ensure that:

- **private inpatients of public hospitals are not disadvantaged in comparison to private hospital inpatients in accessing subsidised pharmaceuticals; and**
- **public and private hospitals are treated equivalently for health insurance purposes.**

3.4.4 Tax advantages

Recommendation 9 of the Discussion Paper stated:

> Public hospitals should cease to receive exemptions on input taxes. The resultant financial impact of this measure should be reviewed and, in principle, any costs should be fed back into the system in the form of enhanced WIES payments. (DP Rec 9)

This recommendation is supported in nine submissions and opposed in fifteen.

The reasons given in support are similar to those in support of removing the exemption for private not-for-profit hospitals, and include comments to the effect that the current exemptions are inequitable, create distortions (for example the private health insurers provide the same level of reimbursement regardless of tax status), and limit the Government's revenue base.

A number of submissions which support, or do not specifically oppose, the recommendation raise additional matters for consideration:

- A competition principles code should be developed and audited by an independent body to encourage and monitor change. (HVPH)
- Any costs imposed as a result of the removal of the input tax exemption should be fed back into the system. As well as changes to WIES levels, changes will need to be made to the Victorian Ambulatory Classification Funding System (VACS) and specific program grants to compensate for this. (Inner and Eastern Health Care Network; DHSV, Sisters of Charity Health Service; VCHC; City of Whittlesea; NCWV)
- State funding arrangements will need to address concerns of hospitals about the impact of the removal on their budgets. (Commonwealth Department of Health and Aged Care)
- This proposal may, when considered in conjunction with other policies designed to enhance competition within the private patient market, result in public hospitals seeking private patient revenue at the expense of carrying out their core functions. (Health Services Commissioner)

In many instances, the reasons for opposing the removal of the exemptions are the same as those which are given for opposing the removal of the exemptions for the private not-for-profit sector and we have not repeated them here. Additional reasons raised in various submissions include:

- It is illogical to tax Government funded activities. (St John of God Health Care; CCPHA)
- There could be a consequential increase in the cost of health care to the State (on the assumption that the bulk of the funds saved from the exemptions relate to Commonwealth taxes). (MRHAG)
- It could place at risk the effective management of complex cases. (AMA Victoria)
- Tax exemptions encourage full time doctors to stay in academic medicine. The removal of exemptions could elevate fairness above the principle of ensuring quality through research and training. A great amount of clinical research is undertaken in public hospitals which leads to discoveries and advances which benefit Victorians.

By contrast, little teaching or research is undertaken in the private hospital sector. (Professor John Zalcberg of the Peter MacCallum Cancer Institute)

- Rural communities may be adversely affected. Tax advantages provide rural public health services with a competitive edge that enables them to provide high quality services (including attracting qualified staff) to rural communities. (Robinvale District Health Service)

Although the VHA opposes our recommendation, it proposes an alternative. VHA suggests it would be preferable to impute the amount that would be payable in tax, as the net effect would be the same but with the advantage of avoiding compliance costs.

We note the comments relating to the core business of public hospitals, namely the treatment of public patients, and acknowledge the importance of clinical education and research. In Recommendation 6 we propose the concept of a Community Charitable Return. This is not relevant for public hospitals as their main activity is, in effect, such a benefit. However, the 'private' activities of public hospitals are not of this character and input tax exemptions for these impede a level playing field. We acknowledge the points made by VHA about compliance costs, points which are especially valid if the tax is levied on only a component of the activity of the hospital. We have therefore revised our recommendation as follows.

Final Recommendation 9

Input taxes create an unlevel playing field between public and for-profit hospitals in the private patient market. Given that we have recommended that public hospitals set fees for private patients in accordance with normal commercial practices it is appropriate that this difference be eliminated. However, there are complex interactions involved in implementation and as a first step a levy equivalent to payroll tax should be imputed to reflect private patient and other commercial activity of public hospitals.

3.4.5 Common regulatory standards

In the Discussion Paper we pointed out that public and private hospitals are currently regulated in an entirely different manner. If public hospitals are to compete with private hospitals, whether for public or private patient services, serious consideration should be given to applying common standards to both. We therefore recommended:

> The Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 should be reviewed for relevance and reformulated to apply also to public hospitals. Regulatory standards affecting quality of patient care should, as a general principle, be common standards which apply to public and private hospitals. (DP Rec 10)

There is widespread support for uniformity in standards across the public and private sectors; all 25 submissions commenting on this issue endorse this approach.

In addition, some submissions suggest areas where standards could be uniform, aside from the matters currently covered under the Health Services (Private Hospitals and Day Procedure Centres) Regulations. For example:

- ADA Victoria considers oral health care provided in hospitals, especially for medium and long term patients, should be equivalent to that required by the Commonwealth for accredited residential care facilities.
- The Mental Health Legal Centre suggests there should be an investigation regarding the extent to which private providers are aware of their obligations under the Mental Health Act and that all providers should be required to implement the principles of treatment and care provided in section 6A of the Mental Health Act.

We agree with these comments and refer them to the Department for consideration and action.

In light of the widespread support for this recommendation, we do not propose to change it.

Final Recommendation 10

The Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991 should be reviewed for relevance and reformulated to also apply to public hospitals. Regulatory standards affecting quality of patient care should, as a general principle, be common standards which apply to public and private hospitals.

3.5 Competition for the same day patient

3.5.1 The issues

We raised the following issues related to the same day patient in the Discussion Paper:

- the definition of day procedure centres and whether they should be registered;
- whether the bed cap should apply to day procedure centres;
- whether the proximity requirements should remain; and
- whether the registration process for day procedure centres should be the same as for private hospitals.

3.5.2 Definition and registration of day procedure centres

A day procedure centre is defined by the Health Services Act as premises where:

- a major activity carried on is the provision of health services of a prescribed kind or kinds and for which a charge is made; and
- persons to whom treatment of that kind or those kinds is provided are reasonably expected to be admitted and discharged on the same date;

but does not include a public hospital, denominational hospital or private hospital.

As we said in the Discussion Paper, the reference to 'major activity' has created difficulties in deciding whether particular premises should be registered. 'Major' clearly means 'majority'. It relates to volume. We pointed out this reference to volume produces a nonsensical result. A general effect of the current definition is that where they constitute a

major activity, the prescribed procedures which are carried out on a same day basis for a charge cannot be performed at a private doctor's rooms but must only be performed at premises which are registered as a day procedure centre or in a hospital.

The Health Services (Private Hospitals and Day Procedure Centres) Regulations set out in Regulation 206(b) and Schedule 9 the prescribed health services which may be carried out in day procedure centres. The activities listed in Schedule 9 (with the exception of medical services) are invasive procedures and require anaesthesia or sedation. We put forward the view in the Discussion Paper that it is in the public interest for premises where invasive procedures are undertaken to be regulated in the interest of quality and safety of patients, irrespective of whether one procedure is performed or twenty. We suggested the definition of day procedure centre should therefore be amended by deleting any reference to 'major activity'.

It was also our view that the Department should consult with the relevant learned Colleges in order to determine the best way of regulating procedures which must only be undertaken in either a day procedure centre or hospital. One way would be to list a schedule of procedures which could be easily updated in line with the rapid development of medical techniques. The other method of regulating the procedures performed could be by reference to whether an anaesthetic, major nerve block or sedation is administered.

This list could be in the Regulations or alternatively in guidelines issued under section 12 of the Act. However, we noted that section 12 would require amendment to enable guidelines to be developed for prescribed activities in day procedure centres.

We recommended:

> Day procedure centres should continue to be registered by the Department of Human Services but the current definition of a day procedure centre should be amended to delete any reference to the volume of activity. Consultation should take place as to the most appropriate manner of determining what procedures should be prescribed. (DP Rec 11)

There are no submissions opposing the continued registration by the Department of day procedure centres, and there is wide support for our recommendation that consultation take place to determine what procedures should be prescribed.

For instance, the Medical Practitioners Board of Victoria strongly supports the retention of tight regulation of day procedure centres. It comments that it has received complaints regarding inadequate infection control at unregistered centres. The Private Hospitals

Association (PHAV) and St John of God Health Care also emphasise the importance of ensuring quality standards are maintained in day procedure centres, not only with respect to infection control and sterilisation, but also for general patient safety.

PHAV, St John of God Health Care and the Church and Charitable Private Hospitals Association (CCPHA) suggest that where it is unclear whether a premises must be registered, private health insurers seek to capitalise on this by entering into agreements for services to be provided in doctors' rooms instead of day procedure centres. In their view, clarity in the scope of the definition of day procedure centre is desirable.

There is considerable discussion in the submissions regarding the kinds of procedures which should be prescribed. Issues raised include:

- whether expanding the list of procedures may have the effect of removing a patient's choice to have some procedures performed by a general practitioner (VAC/GMHC);
- the need to extend the list to include dental procedures such as surgery performed by a registered dental practitioner (ADA Victoria; DHSV; Dr John Curtin); and
- the importance of ensuring public funding is not misused by allowing simple procedures (such as removal of wisdom teeth) or non-therapeutic cosmetic surgery to be claimed under Medicare (DHSV).

We specifically note the comments from the Health Services Commissioner regarding the need to expand the list of procedures which are prescribed to include laser eye treatment, cosmetic surgery and liposuction, as there are a number of complaints in this area. Her comments and those of others who made submissions on this recommendation reinforce our view that there needs to be further consultation on the most appropriate manner of determining what procedures need to be prescribed.

The Commonwealth Department of Health and Aged Care believes our proposal to remove any reference to volume of activity in the definition of day procedure centres is likely to be cost effective and improve patient outcomes. This is because it has the potential to increase the number of registered day procedure facilities and therefore increase the proportion of procedures performed in such premises rather than in hospitals or doctors' rooms.

A number of submissions, including those from PHAV, St John of God Health Care, Epworth Hospital, AHC and CCPHA do not support removal of 'volume of activity' from the definition, however. They suggest that day procedure centres generally perform a greater volume

of a given procedure than doctors' rooms, and therefore are likely to comply with higher quality standards. This is one of the reasons for continuing to distinguish the two types of premises in the definition.

Both AMA Victoria and the Royal Australasian College of Surgeons (RACS) take the view that some minor surgery can be performed safely in doctors' rooms, and that registration as a day procedure centre ought not to be required. The College suggests that in such cases the carrying out of the procedure in the doctor's rooms is more convenient for both patients and surgeon, and is also cheaper. It advocates a set of standards which could be used by voluntary accreditation bodies to certify doctors' rooms for such a purpose, and suggests there should be further consultation regarding the scope of the definition of day procedure centre. AMA Victoria believes quality can be ensured by practitioners voluntarily complying with accreditation standards. It also suggests that certification by the learned Colleges and the application of minimum standards determined by the Medical Practitioners Board are appropriate.

This is a complex area which attracted a number of comments and considerable number of submissions. In the light of those comments, we do not propose to alter our recommendation, particularly as we have recommended there be further consultation to determine what procedures should be prescribed.

Final Recommendation 11

Day procedure centres should continue to be registered by the Department of Human Services but the current definition of a day procedure centre should be amended to delete any reference to the volume of activity. Consultation should take place as to the most appropriate manner of determining what procedures should be prescribed.

3.5.3 Application of the bed cap to day procedure centres

A day procedure can be carried out in a freestanding day procedure centre, in a private hospital with a discrete day procedure area or in a public hospital as a same day patient. Under the Health Services Act, the approval process for a freestanding day procedure centre is the same as that for a private hospital.

Until July 1997, the planning guideline of a ratio of 4.1 acute beds per 1,000 population applied to all day procedure beds. This meant that

operators of day procedure centres (or private hospitals with day procedure areas) had to purchase 'bed licences'. In other words, there was no distinction between a private hospital bed and a day procedure bed, both were subject to the same bed cap. (For a more expanded discussion of the bed cap see section 3.2.2 earlier in this chapter.)

However, a few proprietors became frustrated at the barrier to entry imposed by the bed cap and proceeded to establish and operate day procedure centres without obtaining registration as required under the Health Services Act. This placed the Department in a dilemma. Most of these facilities otherwise complied with the criteria for registration under the Health Service Act and were providing an effective health service. The Department did not wish to prosecute them or close them down as the only barrier to registration was the understandable reluctance of proprietors to pay high market prices to facilitate the transfer of beds. It therefore took steps to bring these facilities within the regulatory framework. The Governor in Council subsequently provided a temporary exemption from the distribution controls in the Act for day procedure centres and private hospitals with day procedure beds (known as a 'moratorium' on the need to acquire beds from the pool). This moratorium was due to expire on 20 July 1999 but has been extended to July 2000.

We believe that these events demonstrate that the bed cap has ceased to perform a useful role and should be removed. In relation to day procedure centres, the moratorium has effectively resulted in the deregulation of the market for day procedure beds. It would be difficult to reimpose the bed cap for day procedure centres now, and this could realistically only be done prospectively in relation to new applicants for registration or applications to increase the number of beds in a facility. Earlier in this chapter, we outline our reasons for recommending the removal of the private hospital bed cap (see section 3.2.2). We believe the same issues arise in relation to day procedure centres, and that the bed cap applicable to day procedure centres should be removed permanently prior to the expiration of the moratorium.

In the Discussion Paper we recommended:

> The bed cap should not apply to day procedure centres. The necessary steps should be taken to remove the bed cap, pending the repeal of section 83(1)(b) of the Health Services Act (refer to Recommendation 4). (DP Rec 12)

Our reasons for recommending the removal of the bed cap for day procedure centres were the same as those for private hospitals.

This recommendation is supported in 14 submissions and opposed in nine.

Many of the concerns raised or reasons given for opposing the recommendation are the same as those discussed in relation to Recommendation 4, which proposed the removal of the bed cap and the criteria relating to adequacy of services with regard to registration of private hospitals. We have therefore not repeated them here.

Some submissions comment on aspects of this recommendation which relate only to deregulation of day procedure centres, however. For example, a day procedure proprietor comments that the moratorium is unfair on those proprietors who purchased beds prior to July 1997. The bed cap should be reapplied to ensure fair competition in their view. Alternatively, Government should reimburse operators who paid for beds.

The PHAV and a number of private operators comment that the lack of demarcation about what can be carried out in doctors' rooms rather than day procedure centres has enabled many day procedure centres to remain unregistered. They consider removal of the bed cap will exacerbate this inconsistent regulation of the sector.

Our view is that, by definition, the planning criteria included in the Health Services Act for day procedure centres (and private hospitals) provide barriers to entry for new operators. The existence of barriers to entry benefit the existing operators and it is not surprising that there is substantial support from them for their retention.

Day procedure centres only came into existence in the 1980s, so it is not possible to ascertain what effect planning criteria have had on their distribution. However, in our view any improved distribution of private hospitals in the late 1990s compared with the 1960s (prior to the planning criteria) was the result as much of market pressure as any planning criteria – where there are low levels of health insurance, there are a small number of private hospitals. We do not propose that day procedure centres be exempt from any form of quality regulation, and there seems to be little public benefit in maintaining these barriers to entry. Accordingly, we do not propose to change the thrust of our recommendation, although we have made a minor amendment to make it clear that applications for approval in principle should also not be subject to the bed cap.

Final Recommendation 12

The bed cap should not apply to day procedure centres. The necessary steps should be taken to remove the bed cap, pending the repeal of sections 71(1)(a)(iii) and 83(1)(b) of the Health Services Act.

3.5.4 Proximity requirements

The Department applies as a condition of registration a requirement that a freestanding day procedure centre be located within 15 minutes driving time of a public or private hospital and that arrangements, satisfactory to the Secretary, are made between the day procedure centre and the hospital to ensure emergency support and the referral of patients.

In the Discussion Paper we recommended:

> The Department of Human Services should review the proximity requirement in the context of any available data on the number of patients who require emergency transfer from a day procedure centre to a proximate hospital. (DP Rec 13)

Although our proposal for a review is supported by the submissions commenting on it, a number emphasise the importance of retaining the proximity requirement.

The Medical Practitioners Board of Victoria notes the proximity requirement may be less important if emergency staff and equipment are available at a day procedure centre, but that this is only likely in large, busy centres. Their view is the requirement must be retained in relation to all other centres and these centres must also be assessed generally in terms of safety.

A number of submissions suggest the proximity requirement should be retained given the increased complexity of procedures performed at day procedure centres. One submission points to the potential complications that can arise from laparoscopic surgery in particular.

The Health Issues Centre comments on the lack of information about the safety of procedures performed at day procedure centres and suggests any review consider broader issues than just the number of emergency transfers. At the very least, it should consider the adequacy

of after care arrangements, given that an emergency may arise after a consumer has left the centre.

We agree that these issues are important and they should be addressed as part of the process of consultation to determine what procedures should be prescribed as needing to take place in a day procedure centre (see Final Recommendation 11).

We obtained data from the VIMD (Victorian Inpatient Minimum Dataset) for the three years from 1996 to 1999 to investigate how the proximity requirement works in practice. In 1996-97 there were seven emergency transfers from a day procedure centre to a public hospital and five elective transfers. Of these, four emergency and one elective transfer were to a proximate public hospital. The remaining patients were transferred to public hospitals quite some distance from the day procedure centre.

The patterns were similar in 1997-98 and 1998-99. In 1997-98 there were one emergency and twenty-six elective transfers. None of these were to nearby hospitals. In 1998-99 the figures were nine emergency and eighteen elective transfers. One emergency and two elective emergency patients were transferred to a nearby public hospital. The remainder went to public hospitals which were further away than 15 minutes driving time.

This data suggests there have been a trivial number of transfers from day procedure centres to hospitals over the last three years. Also, most transfers were not to hospitals within 15 minutes driving time. The figures suggest the hospital of destination more likely reflects referral patterns or patient choice than the need for immediate emergency treatment. We therefore have retained our original recommendation but re-worded it slightly.

Final Recommendation 13

The Department of Human Services should review the proximity requirement for day procedure centres in the context of any available data on the number of patients who require emergency transfer from a day procedure centre to a proximate hospital.

3.5.5 The registration process

As we said in relation to registration of private hospitals, only one licensing criterion is relevant: fitness and propriety of the principals. The other factors – financial viability, suitability of building and fitout, and suitability of operating arrangements – should not be taken into consideration.

We recommended:

> The registration process for day procedure centres should be the same as the process described in Recommendation 5 for private hospitals. (DP Rec 14)

Our reasons for recommending changes to the registration process are the same as those for private hospitals set out in section 3.2.3. Reasons given in support or opposition to this recommendation are also the same as those discussed in that section. For the reasons we outlined in our earlier discussion, we do not propose to change our recommendation.

Final Recommendation 14

The registration process for day procedure centres should be the same as the process described in Recommendation 5 for private hospitals.

The effect of this recommendation in relation to day procedure centres is that:

- Building standards will be incorporated into the Victorian Building Regulations. The Department of Human Services will then no longer approve the design and construction of premises.
- The sole criterion for approval in principle and registration will be whether the applicant is a fit and proper person to operate, or be a director of, a centre. Criteria relating to financial viability of the establishment and the suitability of operating arrangements (eg quality of services and staffing arrangements) will be removed. However, quality of services and staffing arrangements will be contained in a set of minimum regulatory standards.
- The Secretary of the Department of Human Services will retain the power to set conditions.

- Criteria for renewal of registration will be fitness and propriety of the principal, conformity with the law, and compliance with conditions of registration.
- The Department will retain the power to inspect premises pursuant to section 147 of the Act to determine compliance with the Act and Regulations.

4. THE PUBLIC PATIENT MARKET – COMPETITION AMONGST PURCHASERS

4.1 Our original comparison of the competitive options

The role of a purchaser in the health care system is to ensure the required services in the right volume are delivered at the right quality and at the right price. The purchaser thus makes informed judgments as to the mix of services to be purchased and can choose between different providers in terms of efficiency and quality. They can also make decisions as to appropriate location of service.

In chapter 8 of the Discussion Paper we evaluated different models for enhancing competition in the public patient market through introducing competition in the purchasing function. We considered two broad models:

- multiple area-based purchasers; and
- multiple competitive purchasers – multiple purchasers that are not area-based.

We compared the strengths and weaknesses of these models, and those of the current single statewide purchaser model, by looking at:

- technical efficiency
- allocative efficiency
- dynamic efficiency
- quality
- consumer choice
- equity

We concluded that some of the advantages of the multiple purchaser models are in part about the extent to which purchasers might pursue different purchasing strategies from those currently pursued by the single purchaser. This led us to question whether existing structures for purchasing in Victoria were working as efficiently as possible. We discussed the introduction of casemix based purchasing/funding strategies. We also considered whether establishing a separate hospital purchasing authority would strengthen the Department's purchasing function. We concluded this would weaken intra-Departmental coordination. It was our view the benefits of establishing such an authority do not at present outweigh the costs.

We noted the current division of Commonwealth/State responsibilities and how this limits the scope of purchasers to State funded services as

the MBS and PBS are excluded. We considered that a multiple purchaser scheme which covered only secondary services (hospitals) would face inherent difficulties. We decided the costs and difficulties involved in establishing multiple purchasers were unlikely to be worth the benefits, although this would change if the State and the Commonwealth took joint action to broaden the scope of services covered by a purchaser.

We concluded that moving from a single statewide purchaser to either of the multiple purchaser strategies (area-based or non area-based) would be a high risk strategy. We therefore recommended:

> The Department of Human Services should not pursue development of models that involve competitive purchasers at this stage, but should revisit this issue if the scope of services encompassed by a purchaser is expanded to include key primary care services such as MBS and PBS. (DP Rec 15)

4.2 Support for retention of the single purchaser model at present

Our recommendation is supported in 18 submissions from a wide range of bodies, either because of an explicit preference for the single purchaser model, or opposition to the development of competitive purchasing models or of particular models.

Reasons for preferring the single purchaser model include:

- A statewide purchaser has a greater capacity to engage in rational service development and planning. (Health Issues Centre)
- Neither the multiple area-based purchaser model nor the non area-based multiple purchaser model is clearly superior to the single purchaser model. Moving from a single purchaser model to either is a high risk strategy. It requires a new legislative framework, and considerable effort to obtain consumer support. (DHSV)

While not explicitly supporting or opposing the single purchaser model, one submission points out that the relative advantages of competitive purchasing over the current arrangements for provision of primary care and community medical services remain unclear. The major findings from the coordinated care trials should be available in the next year or so, and the Commonwealth is intending to establish further trials to provide more evidence upon which to make an assessment.

Reasons given for opposing the development of competitive purchasing models, or of particular types of models, include:

- The experiences of multiple purchaser models in other jurisdictions to date have not been positive. Area-based models have been

abolished in New Zealand and substantially reformed in the United Kingdom. The United Kingdom 1997 White Paper found that the introduction of an internal market in the National Health Service (NHS) led to a waste of resources as a result of hospitals competing with each other, fragmented decision making, a loss of the importance of patient care, a desire to gain a competitive advantage which in turn led to failure to share information about best practice, and a lack of openness. The White Paper emphasised the need to ensure integration through cooperation, and found that decisions as to how to utilise resources are best made by those who treat patients. (VAC/GMHC)

- If the Commonwealth agreed to include MBS and PBS in a competitive purchasing reform, patient care would be altered in a way that would be severely detrimental to those with chronic and complex conditions. It would be better to consider ways to adopt the United Kingdom approach of integrating care based on an equitable sharing of health costs. (VAC/GMHC; AMA Victoria)
- There is insufficient population mass to justify multiple purchasing authorities. (Barwon Health)
- The introduction of multiple purchasers, area-based or not, is likely to lead to variations in the quality of service provision. There is no evidence that gains in efficiency would be achieved and it is preferable to develop a system that takes into account Australia's unique features. (Health Services Commissioner)

A concern is raised about the continuation of a single purchaser which also has planning functions. The development of a separate independent planning authority to address equity in allocation of resources and services was suggested. The purchasing authority would be required to act on the advice of the planning authority.

4.3 An alternative model

Three submissions oppose our recommendation that competitive purchasing models not be pursued and support the immediate consideration of competitive purchasing models.

In particular, the Inner and Eastern Health Care Network proposes a comprehensive alternative to our recommendations. The Network proposes a major restructure of the system which it claims would lead to significantly increased competition. Because this presents the most comprehensive alternative to that proposed by the Review, it is discussed in some detail here.

Essentially, the Inner and Eastern Health Care Network proposal involves the establishment of new organisations known as Health Improvement Agencies (HIAs). These agencies would:

- have a role in planning and purchasing health services; and
- be funded on a weighted capitation basis, with consumers being required to sign up with one HIA (with an ability to transfer between HIAs annually).

The Network claims competition would be enhanced under this model because consumers would have free choice of HIA and there would be no barriers to entry.

Although not explicit, the Network's proposal essentially assumes HIAs would be private agencies. It also suggests that networks may purchase from independent health services or directly managed units, although the processes for how HIAs would acquire directly managed units is not specified.

4.4 Our analysis of the alternatives

HIAs introduce a new tier into the health system, namely, competitive purchasers. Such an approach would automatically bring with it additional administrative costs, the question being whether the new HIAs would be able to extract sufficient efficiency dividends through improved purchasing arrangements to offset the additional costs of competing purchasers and of management of this new organisational level. No evidence is adduced by the Network on this issue.

It is important to note that given the current structure of the health system, HIAs would only purchase for State funded services, principally hospitals and State funded primary health and community support services. In our view, the scope for sophisticated purchasing and investment strategies would then be limited as, for example, primary medical care and specialist services in the community would still be funded by the Commonwealth on a fee for service basis. This disjunction would reduce the ability of HIAs to achieve efficiency benefits from substitution strategies, further reducing the overall likely benefits of the model.

The Network's proposal for HIAs states there would be no barriers to entry. However, the main revenue for HIAs would be from Government. Government would therefore need to assure itself of such issues as the probity and competence of the HIAs and hence there would need to be some restrictions on entrants. United States experience suggests that the regulatory environment for HIAs would be likely to elaborate relatively quickly to limit certain purchasing practices (for example, US managed care organisations are regulated to require minimum hospital stays for maternity services). The risk of the collapse of an HIA would only in part fall on the equity holders in the agency. Government would presumably have to act as a purchaser of last resort in the event of a collapse of an HIA, lest the consumers of the HIA essentially be left without access to health care as unsecured

creditors of a failed or bankrupt organisation. The HIAs will thus not involve a complete transfer of purchasing risk.

Although the Network's proposal suggests the HIAs could be direct providers of services, obviously this could only evolve over time (as there could be no transfer of public assets to the agencies without some competitive process). Importantly, the larger the sale of public assets to the HIAs, the greater the capitalisation requirement of the new agencies and hence the greater the barriers to entry for new HIAs. This would thus vitiate some of the claimed benefits of competition in this model.

The Network's model suggests the creation of the new tier of independent purchasers will mean that Government avoids any operational risk of hospital services. The Government's operational risk at present is limited, as it specifies in advance funding under the casemix funding formula and hospitals are required to live within the funding envelope. Although there is a residual risk in terms of the operational risk for the Government as owner, this has been shown to be relatively small. The only way Government can avoid having this residual operating risk is to have a complete privatisation of the hospital system. (Obviously, in the context of universal government-financed access to hospital services, some risks, especially political and purchasing risks, cannot be shifted).

Complete privatisation appears to be assumed as a long term outcome in the Network's proposal, although this is not explicit. This Review has not recommended extensive privatisation of the hospital system, rather, in Final Recommendation 17 we have proposed that further privatisation should await an evaluation of the existing arrangements. An evaluation is appropriate in our view, as the Department of Human Services is still developing its skills with respect to privatisation. This is also an issue in other States (see the Productivity Commission's recent review of privatisation of hospital services in New South Wales). The measurement of the product of hospital services is well advanced in the case of inpatient services but is still developing in the case of training and development and non-inpatient services.

If a model based on decentralised purchasing implicit in the Network's proposal were developed, the Government would need to determine, very specifically, the minimum range of services to be purchased. This may need to include new specifications such as maximum waiting times for surgery, maximum travel times for access by consumers and the scope of purchasing. (For example: is the scope the same as covered by the MBS and the PBS? Public hospitals at present are not limited by those arrangements.)

The Network accepts that purchasing would be for the 'full range' of health services. HIAs would need to be regulated to ensure

comprehensive purchasing because of Victoria's obligations under the Australian Health Care Agreement to provide universal access to services. A number of countries have attempted to specify minimum or core services but this has not been successful. The boundaries for the specification of the range of services that should be provided needs to be done comprehensively because the HIA would have an incentive to shift costs outside its required area of provision.

The Network proposal assumes HIAs would be funded on a weighted capitation basis. There are significant technical difficulties in doing this as, at best, demographic and other variables only predict about 20% of future utilisation, which means there are considerable opportunities for gaming and cream skimming. The Network's model does not address the critical issue of how differential rates of private health insurance would be incorporated into the model.

One of the significant weaknesses of the creation of an HIA model is the reduction in accountability of the system that it entails. The HIAs, as private agencies, would have a confused accountability relationship to Government. Government would need to regulate their existence, because they would be essentially entirely funded from Government revenue. On the other hand, as private agencies they will be (and be seen to be) relatively autonomous. Thus, accountability for ensuring service requirements are met would be in part based on the right for consumers to transfer on an annual basis to another HIA, and in part through the Government regulation process.

Evidence from the United States suggests a considerable amount of 'churning' (transfers between managed care organisations) on an annual basis. The simplest arrangement for funding is on an annual revenue basis (based on the number of weighted members in any one year, for example). This would lead to a short term focus by the HIAs, which would de-emphasise long term structural changes and the long term prevention investments which are necessary in the health system.

HIAs could thus lead to significant efficiency losses in our opinion. Unless complex arrangements for transfer of liabilities between HIAs are developed there is likely to be little incentive on HIAs to invest in prevention. For example, if one HIA invests considerable resources in prevention to reduce long term demand and others do not, and consumers transfer from the prevention-oriented agency to a treatment-oriented agency, who should accrue the benefits of the prior prevention investments? Should some payment be made to the prevention-oriented agency? Similarly, if an HIA provides poor access arrangements in one functional area (such as rehabilitation) and a consumer who has a large need for rehabilitation transfers to another HIA, should there be some payment from the first HIA for a number of years after the transfer takes place? (That is, is the revenue stream

purely on an annual basis or is the agency going to have some long term responsibility?)

There may be other areas of divergence between commercial criteria to be followed by an HIA and social or public criteria. For example, an HIA may place a reduced emphasis on long term health promotion, on a network of geographically accessible hospitals, and on teaching and research functions. This problem is not likely to be able to be overcome by specifying the objectives which HIAs should pursue, partly because of the difficulty of measuring the less commercially relevant functions.

There are a number of other aspects of the Network proposal (including one for joint ventures with general practitioners) which presumably themselves would be anti-competitive if State purchasing for general practice services, intimated in the proposal as a desirable development, were to eventuate.

Although superficially attractive, the HIA proposal is not implementable given current management technology. It is also undesirable in the long term because of the reduction in accountability and the increase in inefficiency caused by the increased level of management within the system. It is therefore not supported by this Review.

Overall, our recommendation not to pursue development of competitive purchasing options at this stage was widely supported in the submissions. There were few criticisms to the general approach other than the proposal of the Inner and Eastern Health Care Network already discussed. In the light of this, and our earlier critique in the Discussion Paper, we do not propose to alter our original recommendation.

Final Recommendation 15

The Department of Human Services should not pursue development of models that involve competitive purchasers at this stage, but should revisit this issue if the scope of services encompassed by a purchaser is expanded to include key primary care services such as MBS and PBS.

4.5 Separation of the purchaser/provider functions

In the Discussion Paper we also recommended:

> If competitive purchasing models are introduced, consideration should be given to whether purchasers would also be disallowed from engaging in direct service provision. (DP Rec 16)

Disallowing purchasers from engaging in direct service provision was supported by the Health Services Commissioner, Health Issues Centre, AMA Victoria and Dental Health Services Victoria (DHSV). Allowing purchasers to engage in direct service provision was supported in seven submissions including those of four metropolitan hospital networks (Inner and Eastern, Peninsula, Southern and North Western) and Ramsay Health Care.

The submissions which support enabling purchasers to also be direct providers of services tend to draw upon their experience of purchasing within the existing framework. For example, North Western Health comments that its experience has demonstrated it is possible to achieve appropriate purchaser/provider separation without requiring organisations with a purchasing role to cease engaging in direct service provision. Our recommendation was made in the context of a discussion of models for major structural reform of Victoria's health system, however. These models might enable purchasers to benefit from vigorous competition for contracts among providers. If implemented, the models we explored would result in a fundamentally different health system. We therefore consider that experience under current arrangements is not necessarily a useful guide to behaviour under a system of competitive purchasing.

Southern Health Care Network believes that not requiring separation would enable coordinated care to be provided and purchased by a primary care provider. Inner and Eastern Health Care Network comments that allowing a purchaser to also be a service provider enables purchasing by bodies which are knowledgeable about service provision and permits vertical integration between purchasers and providers through the grouping of primary, secondary and tertiary providers within each purchasing body. Ramsay Health Care suggests it is anti-competitive to require a separation of these functions.

In our view, mixing purchaser and provider roles may be appropriate in some circumstances, such as where the 'product' to be purchased is poorly specified. However, if mixing of roles is necessary to achieve coordinated care or integration, then any separation of roles should be avoided.

We believe that purchasers would be inclined to favour their own directly managed units and this would create (or at the very least, appear to create) a conflict between purchasers and other providers. Accordingly, we do not propose to change the substance of this recommendation. However, we have made a minor change to more clearly link it with Final Recommendation 15 which proposes that competitive purchasing models not be introduced at this stage.

Final Recommendation 16

We have recommended that competitive purchasing models not be introduced at this stage. However, if they are introduced, consideration should be given to whether purchasers should also be disallowed from engaging in direct service provision.

5. THE PUBLIC PATIENT MARKET – COMPETITION BETWEEN PROVIDERS

5.1 The competitive options

In the Discussion Paper we looked at ways in which competition between providers of public patient services could be enhanced. We compared four options:

- competition within providers (status quo);
- competition at the margin between providers;
- core business competition between providers; and
- competition for management of an existing entity ('management competition').

We compared these models on the basis of six criteria:

- technical efficiency
- allocative efficiency
- dynamic efficiency
- quality
- consumer choice
- equity

We concluded that the status quo option provides for a significant amount of competition at a sub-contractor level. In our view, that competition has driven the most significant technical efficiencies in the metropolitan health care sector since the introduction of casemix funding.

A significant change to the provision of public patient services has recently commenced with a privately operated hospital operational in the Latrobe Valley and two other projects underway. We concluded that the lessons from this program should be understood and evaluated before any further major changes to the structure of the sector are undertaken.

We recommended:

> The status quo provides for a significant level of competition in public patient services between the for profit and not for profit sectors. Further efficiencies may be achieved by allowing the two sectors to compete for the right to operate existing public hospitals or constellations of services. However, it would be desirable to await evaluation of outcomes at privately

operated hospitals before proceeding with further implementation of this model. (DP Rec 17)

The submissions addressing each of the four options as well as our comparisons are discussed further below.

When considering the four competition models in the Discussion Paper, we noted that a good case could be made for making Training and Development Grants available to the private sector on the basis that they are directed at the entire health workforce irrespective of whether the training occurs in the public or private sector. We also discuss our recommendation regarding these Grants and the response later in this chapter.

5.2 Comments on specific options

5.2.1 The status quo

In the Discussion Paper we found the application of competitive neutrality principles has meant public hospitals have increasingly market tested major clinical and non-clinical services. As a result, public hospitals, especially metropolitan hospital networks, are more efficient than in the past. In this sense, competition in health is alive and well within the current legislative framework.

A number of submissions challenge the assumption that the application of competitive neutrality principles has led to greater efficiencies, however. One concern expressed is that public hospitals do not necessarily have the resources to develop the skills and bureaucracy required to contract manage private providers to ensure service standards are acceptable. VAC/GMHC and the Health Services Commissioner refer, for example, to problems that have been experienced with outsourced catering, where in some instances the specific dietary needs of patients have not been adequately catered for or patients have complained about the quality of food. The Health Services Commissioner also comments that complaints have been received from consumers about the dirty appearance of some public hospitals following the outsourcing of cleaning services.

The Health Issues Centre suggests there are problems with defining and measuring efficiency. It argues it is not clear whether changes to services actually represent a benefit to the community. The difficulties experienced by new mothers who are returned home without adequate community support services is given as an illustration.

VCHC also question whether competitive tendering has improved the efficiency of public hospitals, and suggest that it is more likely to be due to casemix and the funding reductions in previous years.

The Mental Health Legal Centre points out that there is a lack of competition amongst providers of mental health services as the users of publicly funded mental health services must attend the service in their area. Also, centres of excellence which are accessible to people from any geographical location do not exist for a number of conditions. They believe this barrier to consumer choice should be reviewed.

The submissions provide some evidence that, in the short term, the application of competitive neutrality principles has not produced an optimum result in every instance. Considerable further empirical analysis is necessary to determine whether the application of competitive neutrality has produced a net public benefit overall. This is beyond the scope of the present Review.

5.2.2 Competition at the margin between providers

In the Discussion Paper we found that further competition between providers could be introduced by opening tender WIES to competition from the private for-profit sector. This could be achieved with modest amendments to the Health Services Act. However, it was our view this model would be difficult to implement and of doubtful benefit.

The two submissions which comment specifically on competition at the margin support our view. Barwon Health suggests there is no need for further competition unless public agencies are unable to achieve the required efficiencies. In their view, attempts should be made to protect public infrastructure from under-utilisation to keep average costs down. VAC/GMHC is concerned about the detrimental effect competition at the margin could have on public hospitals.

5.2.3 Core business competition between providers

In the Discussion Paper we found that further competition between providers could be introduced by allowing the private sector to compete at five yearly intervals to operate existing hospitals or existing constellations of services. This model could be implemented with appropriate changes to the Health Services Act, however there may be significant associated transaction costs.

The Australian Dental Association Victorian Branch (ADA Victoria) comments specifically on this option, and notes that the Discussion Paper does not address the efficiencies which could be achieved by tendering for services in remote or disadvantaged areas, where there is no point in duplicating expensive infrastructure across the public and private sectors.

We believe that only the public or not-for-profit sectors are likely to be willing to provide services in remote or disadvantaged areas, as services in these areas are unlikely to be commercially viable.

5.2.4 Management competition

In the Discussion Paper we found that further competition between providers could be introduced by allowing the private sector to compete at five yearly intervals for the right to manage public hospitals. Amendments would need to be made to the Health Services Act to implement this model.

Two consumer organisations comment on this option. VAC/GMHC suggests that cost cutting associated with management competition would have an impact on patient care, and the use of 'commercial in confidence' as a ground for not disclosing details about the contracts with bodies who will provide the management services could prevent necessary public scrutiny. The Health Services Commissioner notes that whenever management structures are changed, much time and energy must be spent to 'bed down' the changes. The introduction of the management model could also lead to a loss of public sector management skills and capacities. We agree with these observations.

5.3 The need for further evaluation

There is considerable support for our recommendation that any further development await evaluation of the new privately operated hospital sector. The reason commonly given is that placing public hospitals under the control or management of a private operator could have unintended consequences. Caution is recommended by most. For instance, the Health Issues Centre refers to the National Competition Policy report as confirming the view that there may be '...longer run costs to the economy of transferring ownership of businesses which have not been properly re-structured to the private sector, where there are fewer constraints on profit maximising behaviour'.

A number of submissions address the nature of the process to evaluate the operation of privately operated hospitals. Several note that a proper evaluation requires the setting of clear objectives and outcome criteria, together with an adequate time frame. It also requires a satisfactory disclosure of information/contracts about existing projects without resort to the 'commercial in confidence' protections which do not apply to the public sector. In their view, the contract terms and prices in the tendering process should be transparent and publicly available. The VAC/GMHC refers to the experience in NSW in relation to the Port Macquarie Base Hospital, which indicates scrutiny is especially important as tendering may not lead to cheaper services.

Other issues raised include:

- It important to assess whether private operators will provide a satisfactory level of care. Purchasing frameworks must also take into account the most disadvantaged, such as those with chronic illness. (Maternity Coalition Alliance; HBC; VCHC)

- Consideration should be given to the effects of the private operator holding a monopoly, given that the contract with the Department could restrict Government funding of other health services in the vicinity of the privately operated hospital. It is necessary to consider whether this restriction would be detrimental to the general health of the community. (VAC/GMHC)
- Compliance with the kind of principles outlined in section 1.3 of the Discussion Paper is important. (North Yarra Community Health)
- Quality teaching is important and it is questionable whether a private operator will have this commitment. (Jensen et al.)
- The loss of corporate knowledge associated with tendering may diminish the ability to train staff, conduct innovative research and treatment, and provide care. (Health Issues Centre)
- A cost benefit analysis is needed to reveal whether any improved efficiencies derived from competition would outweigh the significant transaction costs associated with tendering the right to operate public hospitals. (North Western Health)
- It is questionable whether privately operated services will be able to draw on community goodwill in the way that public hospitals have traditionally done to enhance their resources (eg through donations and volunteer work). (Health Issues Centre)
- Current projects, which involve extensive new capital developments, may not be the best cases to use in determining whether efficiencies can be gained from tendering *existing* services. (VCHC)

A number of submissions also query the need for the development of competition for core business now or in the future.

VHA argues there is another factor that must be addressed before existing services could be subject to tender. Tendering for the right to operate public hospitals for a five year period would be hindered by the current health service agreement process used in relation to public hospitals. VHA suggests private sector operators would not be willing to provide services if the agreement was not signed until halfway through the year and the hospital did not have a budget. It argues that the dispute resolution process is inequitable, as health service agreements are not legally enforceable because the reserve powers in the Health Services Act are relied upon rather than commercial dispute resolution procedures. Accordingly, the VHA favours the application of the following rules to both sectors:

- the completion of budgets and contracts prior to the commencement of the financial year;
- clearly specified tender processes;

- clearly specified tender evaluation processes; and
- performance agreements containing targets, with annual performance review and a focus on outcomes rather than compliance with rules, policies and guidelines.

We agree that tendering for existing constellations of services would require arms' length contractual dealings between the Department and the successful tenderers, including commercial dispute resolution mechanisms. As we pointed out in the Discussion Paper, the transaction costs associated with this model would be significant, and a thorough assessment would need to be made as to whether the overall benefits of implementing the model would outweigh the costs.

However, the costs of moving to commercial contractual arrangements and commercial arbitration or litigation to resolve budget and health service agreement disputes between the Department and public statutory bodies would far outweigh the benefits in our view. We therefore do not recommend pursuing this approach.

In the Discussion Paper we suggested that if tendering of the operation of existing public hospitals proceeds, the Government may need to regain control of hospital land which would be leased to the successful bidder. One way of achieving this which we canvassed would be for the Department to compulsorily acquire property owned by public hospitals. While supporting Recommendation 17, the VHA and Southern Health Care Network voice concern about this, suggesting it would undermine the role of boards of management of public hospitals and antagonise local communities. Southern Health Care Network suggests there are 'other commercial solutions' to the problem of obtaining hospital land.

Some submissions support evaluation of existing projects, but argue it is possible to introduce more competition at the same time. The Inner and Eastern Health Care Network and Ramsay Health Care argue, for example, that:

- To delay ongoing development will risk loss of interest by the private sector and place further improvements in jeopardy. Introduction of more competition now will capitalise on the current momentum.
- Current projects can inform new projects and refine the process.
- Delay would be unfair as it amounts to restricting the entry of private providers into the public market, while the Discussion Paper advocates opening up the private market to the public sector.

The Inner and Eastern Health Care Network, for example, expresses the following views:

> Contrary to the Discussion Paper's assertion that the status quo does not require immediate change, our current health system, good as it is, requires urgent redevelopment to meet our current and future needs. Similarly, in contrast to the Discussion Paper's contention which underpins their aforementioned assertion, Australians are not satisfied with their health care system. The future cannot be the past. To let it be is to risk the 'crisis' so often wished upon us by the media. The solution is the introduction of market forces and fair competition. As Steven Schwartz from the Murdoch University said: 'We have tried government controls and they have failed; it is time to make the market save the health system'.

We believe, however, that it is important that current projects be openly and critically evaluated, both in terms of cost and benefit to the community, before allowing the public and private sector to compete further for the right to operate existing public hospitals or constellations of services. Evaluation will not impede momentum; it will offer the opportunity to better inform both sectors, the Department and the public.

In light of this, and the considerable support for our recommendation to await evaluation of outcomes at privately operated hospitals before proceeding with the introduction of further competition, we have retained our original recommendation. We have made a minor change, however, to emphasise that the Health Services Act as it currently stands provides the capacity for competition between the two sectors to provide public patient services.

Final Recommendation 17

The status quo provides the capacity for a significant level of competition in public patient services between the public and private sectors. Further efficiencies may be achieved by allowing the two sectors to compete for the right to operate existing public hospitals or constellations of services, however these efficiencies need to be demonstrated. Evaluation of outcomes at privately operated hospitals should therefore occur before proceeding with further implementation of this model.

5.4 Training and Development Grants

In the Discussion Paper we noted that Training and Development Grants are designed to train the hospital workforce, both public and private. We concluded there was no reason why these Grants should not be made available to operators in the private sector. We recommended:

> Training and Development Grants should be available to the private sector. (DP Rec 18)

Our recommendation is supported in 15 submissions from a wide range of organisations, including consumer groups, public and private providers and professional bodies.

A number of those making submissions believe that making Training and Development Grants available to the private sector could lead to broader education, research and training programs, and the widespread deployment of medical personnel (eg interns, RMOs, allied health personnel) in private settings. They argue that this would help fund junior doctor positions, as working within an accredited training program is necessary to obtain Medicare reimbursement.

Ten submissions (including a number who support the recommendation) have reservations. The issues they raise include:

- Training and Development Grants should be the subject of stringent qualifications criteria before being offered to the private sector. It must be clear what the Grants are intended to cover and quantifiable outcomes and comparative costing mechanisms must be developed. There must also be a focus on issues such as level of sub-specialisation and the capacity of the body to carry out postgraduate teaching. (VHA; Jensen et al.)
- What is to be funded as training must be identified precisely. This process should address the problems of the current system, where such Grants are sometimes used to offset inequalities in the casemix payment for inpatient services. (VHA; North Western Health)
- Elective surgery presents an opportunity to develop training arrangements with the private sector but a coordinated approach rather than a competitive one is likely to optimise the range of experiences provided to postgraduates. (North Western Health)
- Funds available to the private sector should be additional to those funds allocated to the public sector, rather than spreading the existing grants more thinly. (North Western Health; AMA Victoria; VCHC)
- The outcomes of the activities of private operators must be shared with the public sector. (City of Whittlesea)

- Competition between the two sectors must be transparent. (AMA Victoria)
- Much of the teaching of medical staff at public hospitals is performed without payment, due to the longstanding traditions of training graduates and undergraduates. This is unlikely to occur in the private sector. (VAC/GMHC)
- The nature and extent of the efficiencies and community benefits to be achieved with public funding to the private sector is questionable. (Health Services Commissioner)

Although our recommendation is widely supported, we have noted some of these reservations regarding the capacity of the private sector to carry out postgraduate teaching and to provide the level of sub-specialisation which is required.

We have therefore revised the recommendation to address these concerns.

Final Recommendation 18

Subject to developing robust measures of quality of training and research (which should be pilot tested in the public sector), Training and Development Grants should be available to the private sector.

6. PRIMARY HEALTH AND COMMUNITY SUPPORT SERVICES

6.1 The competitive options

Primary health and community support services (PHACS) account for Departmental expenditure of around $350 million each year. The key PHACS activities funded by or through Government include:

- community health services
- home and community care activities
- dental services
- community nursing services

As the Health Services Commissioner comments, these services are important to ensure the health needs of the vulnerable are met. They also allow people who would otherwise be institutionalised to live in the community.

In chapter 10 of the Discussion Paper we examined the potential for applying competition principles to the PHACS sector. We noted the Department was proposing a restructuring of PHACS intended to focus purchasing and accountability on population health needs and outcomes for particular catchment areas.

The PHACS reforms have medium term implications for integration with other health and community services and for increased budget holding for institutional and acute services by the PHACS system.

We looked at four options for competitive structures in the PHACS arrangements:

- the status quo;
- open competition for the core services for particular catchments;
- open competition for service elements within a particular catchment; and
- marginal competition either on a global or service element basis.

We compared these options on:

- product definition
- market development and provider sophistication
- transaction costs

We concluded the most appropriate approach for the development of PHACS was to continue to develop a model that facilitates progressive service integration with a focus on population and client outcomes.

This would involve a two-stage process, the first being an integrated accountability system for all PHACS activity in a given catchment. The second stage would involve the Department instituting a common purchasing approach across PHACS elements.

We recommended:

> The outcomes of the PHACS redevelopment process should be evaluated before further competitive elements are implemented in this area. Progress towards the application of contestability principles to PHACS should also be reviewed when the current PHACS redevelopment has been completed. (DP Rec 19)

At the time of writing this Report, the Government announced that the PHACS redevelopment which we analysed from a competition perspective in the Discussion Paper would be subject to a fresh review. Readers should note that the discussion which follows relates to the PHACS reform process that was being pursued at the time our Discussion Paper was released, and that policy directions for PHACS may be subject to change.

6.2 Issues raised

Of the 19 submissions which comment on our recommendation, all but one are in support, either because they agree there should be evaluation of the PHACS redevelopment process before further competitive elements are introduced, or they have reservations about introducing contestability principles into PHACS.

The Inner and Eastern Health Care Network submission is the only one which argues that the introduction of contestability principles should not be delayed pending the implementation of the PHACS redevelopment proposal. They state:

> The PHACS redevelopment process favours geographically based, non-competitive lead agencies to reduce the number of stand-alone service providers in the primary and community sector. The PHACS reform will result in structural change within the health system that is not necessarily consistent with competitive principles. There is no identified benefit to waiting for evaluation of PHACS before opening the market for primary and community services.

On the other hand, reasons for supporting a delay before introducing further competitive elements include:

- Introduction of contestability principles to PHACS prior to evaluation of the outcomes of the redevelopment could hinder that

process, as it could undermine cooperation within the sector. (VHA; City of Moreland)

- It is necessary to improve market development, and the funding and purchasing of PHACS, before considering putting them to tender. (Health Issues Centre)
- Issues will arise out of the redevelopment process requiring resolution. For example, hospital discharge planning will need to change. (NCWV)
- An integrated accountability system will need to be introduced for all PHACS activity in a given catchment area, which should apply to all participating providers. (DHSV)
- Further consideration needs to be given to the use of consumer budget fundholding. The frail and disadvantaged will often need someone to advocate for them and manage their complex needs. There is a question as to who will case manage in these circumstances. There is also an issue of conflict of interest between the role of advocating and purchasing services for an individual, and managing limited resources to meet the needs of a broad range of consumers. (Health Issues Centre; City of Yarra)

A number of submissions voice reservations about the prospect of introducing contestability principles into PHACS. For example:

- The National Council of Women of Victoria (NCWV) comments that competitive tendering, privatisation and the amalgamation of services can restrict choices of care, especially for those in rural areas, the socio-economically disadvantaged, and those with chronic illnesses.
- The City of Whittlesea notes that a number of primary care services have already been exposed to the market through tendering, and the private market is largely unresponsive. They say:

  > It is likely that this is due to the very limited ability to make profit from these services, especially as volunteers have consistently withdrawn their labour when for profit businesses win community services tenders. This 'free labour' effort has been estimated by the sector at being worth around 20% of the total cost of services. Therefore without it, providers will need to find this 20% plus to still make profits, in an area where fees are regulated, and the ability of clients to pay is severely limited.

  In many areas of tendering by local government, the decision was made to maintain in-house services because no tenders were received.

- The Health Issues Centre and North Yarra Community Health suggest that competitive tendering has inhibited communication and support between services.
- North Yarra Community Health considers one reason why there is no clear product definition in PHACS is because the strengths of these services, when they are operating effectively, are that they are integrated and coordinated, focus on illness prevention and health promotion, offer flexible programs and service delivery systems for special needs, and involve community development. These characteristics, and the interrelationships between them, are difficult to describe in output or outcome terms.
- The City of Moreland, Health Issues Centre and North Yarra Community Health comment that consumers rely on integrated services, but integrated services tend to be anti-competitive. The City of Moreland states, for example:

  > It is difficult to envisage how greater integration of the service system — a central aim of the PHACS redevelopment process will be achieved and sustained under a model requiring active competition for discrete service elements.

- The Health Issues Centre also states:

  > Fragmented services can be a real burden with many different providers who do not necessarily work together for the consumer's interests, and where this is exacerbated by contracting out, there is a real need for better consumer consultation structures and complaints handling mechanisms.

- The Health Issues Centre suggests integrated services may be more cost-effective because of lower overheads. They may also provide better continuity of services to vulnerable and disadvantaged people (such as the aged, the homeless, new immigrants and refugees). Recent research indicates that although such groups may be badly in need of assistance, they will only seek services if they trust the worker and the agency and feel they have some control over the service through that relationship. The Health Issues Centre points out that paid and volunteer staff generally work in the community sector because they are sympathetic to the needs of the disadvantaged. This kind of commitment may be lost if competition is introduced.

The City of Yarra suggests that its experience of compulsory competitive tendering is salutary, not only for PHACS but also for other areas of the health system. It advises that it tendered all HACC services (meals, home care and home maintenance) and these were won

by private for-profit operators. It provides the following thoughts on the impact of tendering:

- The greatest reduction in unit costs was realised in the first round of tendering. The second round resulted in an increase in costs greater than CPI. As a purchaser, the smaller size of the contract did not give councils the monopsony power to hold down costs.
- Part of the reason for the increase in costs was the increased size, and reduced number, of providers tendering. For example, the production of food for meals on wheels is now dominated by four or five providers compared with the previous 78 councils. This means that a degree of 'market capture' has already occurred with a few dominant providers, and there has been a reduction in the power of councils as purchasers. The City of Yarra suggests that as providers become larger, purchasers need to be of an equal or greater size to drive public policy. The increased concentration of providers has led to very little difference in the unit costs for operators and minimal consumer choice as there is not great product differentiation.
- Service integration cannot be guaranteed through inter-agency protocols alone. The capacity of the service system to integrate, coordinate and shift resources horizontally diminishes in direct proportion to the distance from the point of individual service purchase. This means that capacity and resources must be shifted to the 'front end' of the system.
- The assessment function was not tendered, to ensure there was no cream skimming by providers at the individual client level. This allowed the council to retain public control of resource allocation and to maintain accountability with its constituents. Government cannot transfer public risk management responsibility (duty of care) no matter how deregulated the health sector becomes. Devolving the purchaser function does not necessarily transfer risk to the purchaser.

These, and the other issues raised in the submissions, can be further examined as part of the announced review of PHACS.

We have slightly altered our original recommendation to include a reference to the announced review.

Final Recommendation 19

The outcomes of the PHACS redevelopment and review processes should be evaluated before any competitive elements are implemented in this area.

6.3 Data integration systems

In the Discussion Paper we also looked at the question of data integration in the context of the PHACS proposal. We concluded it would be desirable to introduce a common data system within each PHACS catchment to facilitate coordination of care to individual clients and accountability of the PHACS agencies in terms of the number of clients receiving services. We recommended:

> Consideration should be given to legislation to allow PHACS agencies serving a single catchment to establish data integration mechanisms. (DP Rec 20)

This recommendation is supported in thirteen submissions from a wide range of providers and opposed by four.

One issue of concern raised by submissions both supporting and opposing our proposal is the need to preserve patient confidentiality.

The NCWV and AMA Victoria note that the integrity and security of the system for sharing records must be guaranteed so people do not refuse to receive services out of fear about their details being recorded in a central database or because they believe the system is not secure. The NCWV also stresses that legislative mechanisms to ensure confidentiality should be in place prior to the commencement of any data sharing, and that no patient should be denied care because they do not consent to information being recorded in the database.

The Mental Health Legal Centre is concerned that information obtained by one agency should not automatically be available to other services, but only be passed on if the consumer attends another service and agrees to the transfer. In their opinion, if information is to be transferred, only information which is necessary should be provided. For example, it may be sufficient to advise on a person's support needs without giving clinical information such as specific diagnoses. Also, only certain classes of workers, who are appropriately qualified and need the information, should have access to it. They point out that one of the greatest fears of the users of mental health services is the

disclosure of confidential information. Consumers should be advised when they first make contact about how information is to be shared.

In VHA's opinion, integration of data for PHACS raises legal, operational and funding issues which are outside the scope of this Review. They believe a separate process is needed to consider issues such as the suitability of a central repository or a decentralised model and to establish legal guarantees of privacy.

The Inner and Eastern Health Care Network does not support our recommendation for a different reason. Although it agrees that data integration is important, it suggests that restricting it to identified segments of the market, such as PHACS, may further fragment the system and enshrine a structure that is not optimal.

The Ministerial Rural Health Advisory Group also suggests the proposal should be broadened. They suggest enabling all agencies serving a catchment to establish data integration mechanisms, regardless of whether they are a PHACS agency.

Although our recommendation is widely supported, we accept the suggestions that our proposals regarding data integration should extend beyond PHACS agencies and that confidentiality issues should be addressed. Accordingly, we have amended our recommendation to reflect these concerns. The announced review of PHACS may provide an opportunity to explore these issues in more detail.

Final Recommendation 20

Consideration should be given to enabling designated agencies funded for provision of public services (including public hospitals, PHACS agencies and other relevant agencies) to establish data integration mechanisms. Such mechanisms should ensure appropriate protection of consumers' rights to privacy and access to services.

7. PROMOTING CONSUMER CHOICE AND CONFIDENCE

7.1 The need to address information asymmetry

The market for health services is distorted because of information asymmetry between providers and consumers. This asymmetry handicaps consumers in making informed choices about the services available to them in the market. The importance of consumers having access to information is recognised in the objectives in section 9 of the Health Services Act.

Although some information about the nature, quality and extent of health services eventually makes its way to consumers, that information is not always readily accessible or disseminated in a targeted manner. One of the reasons for government involvement in the health care market is to redress the information and power advantages of the provider over the patient.

In our view, increasing the ability of consumers to make informed choices about treatment options and providers is one of the most effective ways of enhancing competition in the health care market. As we have already said, we consider consumer empowerment is the foundation stone of competition. Transparent competition should lead to quality improvement which, in turn, enhances consumer satisfaction.

In the Discussion Paper we made a number of recommendations to address this issue. These recommendations related to:

- the establishment of a call centre staffed by trained professionals to enhance consumers' ability to navigate through the health care system;
- the development of a statewide waiting list for surgical procedures;
- the publication and dissemination of information about individual medical practitioners (qualifications, specialty, achievements and any disciplinary proceedings);
- the publication of meaningful and comparative performance indicators for hospitals and day procedure centres on a generalised basis; and
- the enactment of a statutory right of patients to access their medical records, subject to certain limitations.

We also examined different types of patient charters and questioned whether the statutory immunity mechanisms for quality assurance committees established by the Health Services Act have facilitated peer review and thus improved quality of care.

These recommendations drew a vigorous response, not only in the submissions but also in the press and on radio and television. In fact, the recommendations in this chapter were the ones most debated, and seemed to hit a chord with many in the community who believe that information will go a long way toward redressing their power imbalance. Each of these recommendations is discussed in some detail in chapter 11 of the Discussion Paper. We have not repeated that detailed discussion in this Final Report.

There was widespread support from both consumers and providers for the notion of enhancing consumer information and consumer choice. It was the subject of explicit endorsement in 32 submissions.

Rather than focusing on the enhancement of competition, the reason most commonly given in support of addressing information asymmetry is to assist consumers to receive the most appropriate treatment, taking into account their individual medical needs, values and life plans. There are differences of opinion, however, as to how information asymmetry is best addressed. These opinions are summarised in the following discussion. We have altered a number of our original recommendations in light of the submissions.

7.2 Call Centres

7.2.1 Our original recommendations

The need for credible, timely and around the clock medical advice is well recognised. In the Discussion Paper we discussed the experience of call centres reported in a Western Australian study and with NHS Direct in the United Kingdom (see section 11.2.1 of the Discussion Paper). NHS Direct has since expanded the number of nurse-staffed call centres to 16, covering 19 million people (40% of the English population).

An assessment of the first six months of operation of the three pilot NHS Direct sites has shown that the volume of calls is greatest on weekends and after 6pm. Based on these preliminary results, it is estimated that NHS Direct should expect to reach call levels of 20% of the population covered per year. The study also found that of those callers triaged by NHS Direct nurses:

- over 80% of callers were advised to act differently to their pre-call intention;
- 40% of callers were advised to seek less resource-intensive care than they intended;
- between 30% and 35% of callers were advised to seek more resource-intensive care than they intended;
- 460 callers were transferred to the ambulance service; and

- 30% of callers were advised how to look after themselves at home.

Another development since the release of our Discussion Paper is that the Department of Human Services has approved the establishment of 18 PHACS Demonstration Projects and given eight other projects 'approval in principle'. Each proposal was required to demonstrate 'the capacity to link with a statewide 24 hour health information, support and referral telephone service'. These projects were scheduled to commence in November 1999.

We made three related recommendations regarding call centres:

> Consideration should be given to establishing a 24 hour call centre in Victoria on a pilot basis to assist consumers to be better informed about health care, health care providers and health choices. (DP Rec 21)
>
> The pilot call centre should receive information from each public hospital waiting list and advise patients of waiting times at alternative locations. The centre should also maintain and release data on accreditation status of public and private hospitals, the health insurers with whom the hospitals have contracts, and the relative performance of public and private hospitals on the indicators developed pursuant to Recommendation 24. (DP Rec 22) [Discussion Paper Recommendation 24 proposed the development of risk-adjusted clinical performance indicators.]
>
> The pilot scheme should be subject to evaluation. If the pilot is successful, and the call centre established on a non-pilot basis, section 141 of the Health Services Act should be amended to impose a statutory obligation of confidentiality on staff of call centres. (DP Rec 23)

Establishment of a pilot call centre is supported in 14 submissions and opposed in 17. A number of submissions also comment on the functions a call centre should undertake if one is established and the type of information it should make available to consumers. Several other issues and concerns are also raised in the submissions. The discussion that follows attempts to summarise the main points made with respect to all three recommendations.

7.2.2 Views on the establishment of a pilot call centre

A number of submissions question the desirability of establishing a call centre. In general, these concerns relate to the supposed high infrastructure costs and duplication with the proposed PHACS call centres and Carelink. Some suggest that a call centre might not be effective and it might be more efficient to increase the flow of information from providers. Access by people with hearing loss, people

from a non-English speaking background and people with intellectual disabilities is also raised as a concern. Finally, the Inner and Eastern Health Care Network comments that our proposal is anti-competitive as the public benefit has not been demonstrated to outweigh the detrimental effects of a statewide model over one in which competition in the market is fostered.

A number of other comments are made regarding the establishment of call centres:

- The proposal will need to be backed up by adequate funding.
- Information provided to consumers will need to be accurate and of a high quality, and presented in an appropriate format.
- Their function must be integrated with other developments.
- The standard algorithms will need to be updated regularly.
- Appropriate guidelines for operation of the call centre will need to be in place prior to the commencement of the pilot.
- Clarification will be needed on whether the call centre is to have a healthcare advice function in addition to providing general information, as different staffing and infrastructure will be required.
- Appropriately qualified and trained staff must be employed. (One submission suggests they must be either division 1 registered nurses or medical practitioners; another proposes they could also be other health personnel such as psychologists and social workers.)
- Providers must have the opportunity to review and confirm the service directory to ensure it is accurate.
- The centre must not become a substitute for emergency care or primary care.
- Account will need to be taken of how the callers will use the information provided, and of how health status and personal history will guide the advice given.
- Regional call centres could be developed with input from consumers.
- Cooperative call centres are operating in parts of Europe. The Danish system shows how centres can be to the advantage of both consumers and practitioners, as consumers have access to after hours care from general practitioners and hospitals, and general practitioners are not constantly on call.

The Commonwealth Department of Health and Aged Care notes that its HealthInsite project should offer opportunities for linkages with call centres. The Commonwealth will be introducing regional call centres to provide information and referral services regarding community care. There will be a single 1800 telephone number to Carelink, which will put calls through to the relevant regional centre. These centres will be

established in consultation with the States and Territories to ensure integration with other initiatives. In addition, through the Consumer Focus Collaboration, a stocktake is to be conducted of the approaches to informing consumers, including call centres. This will help inform the development of a call centre in Victoria. Other States, such as Western Australia, are developing call centres which also offer models and experiences upon which Victoria could build.

7.2.3 Suggested functions of a call centre

The Discussion Paper envisaged three broad sets of functions for a pilot call centre: the provision of general information to consumers about institutional providers, the provision of information regarding practitioners, and the answering of questions regarding specific health problems.

The first of these, the provision of general information to consumers about institutional providers, includes information about waiting times at public hospitals, the accreditation status of public and private hospitals, and the relative performance of public and private hospitals as measured against proposed clinical indicators.

The second function is the provision of information regarding practitioners. This would include details about specialties, length of registration, location and opening times of premises, languages spoken, fees charged, and admitting rights to hospitals.

The third function is the answering of questions regarding specific health problems that a consumer may have. This involves the use of standardised algorithms incorporating the latest evidence on treatment paths and guidelines of best practice. This also involves a referral function in appropriate cases, with consumers advised about applicable pathways into the health care system (eg by visiting a general practitioner, calling an ambulance or attending another kind of provider).

There is general agreement from those supporting the establishment of a call centre that some practitioner details should be made readily available to the public. However, there is less agreement about what those details should be.

The AMA Victoria, for example, considers information should be available on medical practitioners about specialty, place of graduation, length of registration, location of practice and opening times, languages spoken and hospitals for which they have admitting rights. The Breast Cancer Action Group proposes that a broader range of information be available. They suggest women with breast cancer will be able to make more informed decisions if they can discover the experience and size of practice of treating doctors, as doctors who see more than 30

breast cancer patients per year achieve better patient outcomes than those who see less.

The Melbourne University Medical Students' Society (MUMSS) suggests information should also be available in relation to other kinds of practitioners, such as allied health providers, nurses and alternative health care providers, as there is the same asymmetry of information in relation to these providers.

The Royal Australasian College of Surgeons considers information should be available which includes a practitioner's basic and specialist qualifications, and multi-clinical appointments held by attending doctors. However, the Medical Practitioners Board notes there are difficulties in describing a practitioner's specialty for the purposes of the call centre. There is no single generally accepted system of specialist recognition in Victoria, following the winding up of the National Specialist Recognition Advisory Council. Unlike South Australia and Queensland, there is no system for recognition of specialists in the medical register kept under the Act by the Board. The Board considers that in Victoria the Health Insurance Commission recognition process (which is used for the purposes of permitting higher Medicare rebates to be paid) has become the de facto system. It notes that the Australian Medical Council is currently considering proposals for recognising specialists. The Board states:

> Without the reintroduction of the Specialist register in Victoria, the Medical Practitioners Board would be extremely cautious of establishing an Internet site which allowed all and sundry to self-declare their specialist field.

On the issue of providing information on registration details, the Medical Practitioners Board of Victoria acknowledges that at present the public does not have easy access to the information held in the medical register kept under the *Medical Practice Act 1994*. It intends to publish the register on the Internet. The register includes details about current suspension of registration of a medical practitioner, as well as any current condition, limitation or restriction imposed on registration. The Board notes that extensive debate is required about whether past disciplinary decisions in relation to a practitioner should be readily available to the public. The Royal Australasian College of Surgeons suggests that disciplinary proceedings should not be available, as this kind of information can be misconstrued if the full details of the particular case are not known.

Views also differ in relation to the provision of information about fees. For instance, two consumers point out that surgeons' and anaesthetists' fees can be much higher than the standard Medicare scheduled fee, and that this can be a trap for consumers whose medical

bills may be much higher than they anticipate. They believe information about fees charged should be available. On the other hand, the Royal Australasian College of Surgeons suggests information about fees should be confined to a description of the relevant Medicare and/or AMA scheduled fee. In their view, details about the fees charged by individual practitioners should not be provided as fees for specific procedures must always be discussed with the individual patient and may vary. Similarly, AMA Victoria argues that general practitioners can advise patients directly about their own and specialists' fees.

Although there is general agreement that hospital waiting list and waiting times information should be available to the public, there is less consensus about whether a call centre is the most appropriate way to provide that information. The following issues were raised in relation to the release of waiting list information:

- Information provided to consumers and practitioners must be accurate, up to date and contain reliable indicators of waiting times. Hospitals should not be 'sold' on the basis of waiting times alone, as other factors, such as continuity of treatment, are important.
- The Elective Surgical Information System has the potential to be the database used by the call centre. However, a review in 1998 showed the system was not working efficiently and was unable to provide a realistic indication of the waiting time for specific procedures in categories 2 and 3. (RACS)
- Information about waiting times must be carefully coordinated and have provider input to ensure that patients are not confronted by conflicting information. (North Western Health)
- Waiting list information will assist clinicians, but it is questionable whether it will be of much benefit to consumers, given the limited nature of admitting rights. Unless the consumer is willing to change practitioner, it may be difficult to gain access to a hospital with a shorter waiting time. (Breast Cancer Action Group)
- The need to have data about waiting times in the public domain warrants immediate action, rather than waiting for the establishment of a call centre which has more complex functions. The Waiting List Bureau established recently in Western Australia is given as a useful example of how this information could be provided sooner. (Health Issues Centre)

Providing information about the accreditation status of public and private hospitals was not a contentious issue, although some submissions commented that a call centre may not be the appropriate body to disseminate this information.

We suggested that a call centre might be able to provide information about the private health insurers with which hospitals have agreements. This suggestion is supported by the Health Issues Centre, Health Services Commissioner, consumer groups and public and private providers. It is opposed by a small number of private hospitals on the grounds that it might confuse consumers about access to those hospitals which do not have agreements with insurers.

Our recommendation that the call centre have a health advice and referral function was contentious. Concerns expressed by some of the professional bodies include:

- Physical examination of a patient by a medical practitioner is essential for effective diagnosis. It is problematic for a medical practitioner to diagnose over the telephone; it would be even more perilous for staff who are not medical practitioners to attempt to do so. The use of computer generated algorithms is difficult.
- There is potential for conflicting advice to be given by a general practitioner and the call centre.
- There is a question regarding the legal liability of the call centre if triaging is incorrect and a person suffers some form of harm.
- Staff should not be able to direct people to specific doctors or clinics, but could refer a person to an emergency department or back to their own general practitioner.

In the Discussion Paper we recommended that the Commonwealth and the States collaborate to develop a set of risk-adjusted clinical performance indicators which are comprehensive, consumer focused and current. We also proposed the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres (DP Rec 24). We suggested the call centre could be a source of this information. A number of submissions question whether such information should be publicly available, however. We discuss these issues further in section 7.3.3 of this Report.

Some submissions made suggestions about additional types of information a call centre could provide, such as:

- waiting times for nursing home beds and community health centre services;
- the range of services offered by hospitals;
- recorded complaints;
- drug and poison information. The Society of Hospital Pharmacists of Australia points out in their submission that Victoria presently has no central drug information service as the Victorian Drug

Information Centre closed last year. This information is necessary 24 hours a day;

- general information about specific diseases;
- advice about self care (like the United Kingdom system);
- oral health information;
- complaints mechanisms;
- patients' charters; and
- an explanation of the nature of public patient treatment (ie the right of election and the inability to choose one's doctor) and private patient treatment.

The centre could also provide a link to other existing information services.

DHSV notes there may be considerable difficulties in integrating dental advice in a technology based response centre, however it is willing to provide data and support for the development of a call centre. (For example it could explain to software developers the various rules for eligibility to access public oral health and dental services.)

7.2.4 Issues regarding confidentiality

A number of submissions comment on the need to keep any information about consumers who deal with the call centre confidential. Consent should be obtained from any consumer about whom information may be passed on.

7.2.5 Our conclusions

Many submissions agree the establishment of a call centre will be of benefit to consumers if it provides high quality, accurate information and advice. Of course, the proposed call centre will be only one possible repository of such information. Individual practitioners will continue to provide their patients with much of this information. Some of the information which we recommend be available from the call centre (waiting lists, practitioner details) should also be available from other sources such as the Department and the Internet. We also anticipate that a call centre will inform callers of other sources of information such as the Anti-Cancer Council, Breast Cancer Action Group and the Maternity Coalition. The call centre could also have a web site providing links to these sources.

We note the opposition from professional groups to our recommendation that clinical advice be available from call centres. We agree that providing clinical advice over the telephone is not the most effective way of diagnosing a person's condition. We are not suggesting that the call centre take the place of a doctor. Rather, and the English

experience confirms this, the purpose of the call centre in this regard is to direct consumers with health problems to where they will get appropriate treatment and to provide appropriate advice on self-care.

We agree with the many submissions which cite the need for coordination with other call centres which may be established and for confidentiality of information identifying consumers. We also agree that information capable of identifying a consumer must be released only with that person's consent. If the call centre pilot is auspiced by a 'relevant health service' then section 141 of the Act would require that such information not be disclosed. (A relevant health service includes a public, denominational or private hospital, multi purpose service, day procedure centre or community health centre.) If the pilot is run by a body which is not covered by section 141, then adherence to the Department's Privacy Principles is required. In these circumstances employees should be required, as a condition of their employment, not to disclose information which may identify a consumer.

We also note that any pilot must be for a sufficient length of time, say five years, to enable thorough evaluation and have altered Recommendation 21 accordingly. Recommendations 22 and 23 remain unchanged apart from a minor re-wording for clarification.

Final Recommendation 21

A 24 hour call centre should be established in Victoria on a pilot basis for a 5 year period to assist consumers to be better informed about health care, health care providers and health choices. Measures should be taken to ensure confidentiality of information identifying any consumer.

Final Recommendation 22

The pilot call centre should receive information from each public hospital waiting list and advise patients of waiting times at alternative locations. The centre should also maintain and release data on accreditation status of public and private hospitals, the private health insurers with whom the hospitals have contracts, and the relative performance of public and private hospitals on the indicators developed pursuant to Final Recommendation 24.

Final Recommendation 23

The pilot call centre scheme should be subject to evaluation. If the pilot is successful, and the call centre established on a non-pilot basis, section 141 of the Health Services Act should be amended to impose a statutory obligation of confidentiality on staff of call centres.

7.3 Risk-adjusted clinical performance indicators

7.3.1 Our original recommendations

Neither consumers nor providers have access to information about the quality of care at a particular health facility. Consumers generally rely on their general practitioner to make the choice by referral to an appropriate practitioner or facility. If the referral is to a specialist and hospital based treatment is required, consumers generally have to rely on the specialist's choice. Information on the clinical performance of a facility is relevant to a consumer's decision about where to seek treatment, however. We took the view in the Discussion Paper that access to information on the clinical performance of public and private

hospitals and day procedure centres would empower consumers and lead to competition and improved quality.

We made three recommendations regarding risk-adjusted clinical performance indicators. These were:

> The Commonwealth and the States should collaborate to develop by 1 July 2000 a set of risk-adjusted clinical performance indicators which are comprehensive, consumer focused and current. From that date, the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres. In the absence of an agreed national set of indicators, Victoria should develop and publish its own set for use by that date. (DP Rec 24)
>
> The Secretary to the Department of Human Services, public and private hospitals, and day procedure centres should be empowered to report to the Medical Practitioners Board or to the relevant learned College any medical practitioner whose performance against the specified indicators is significantly below the average outcome. (DP Rec 25)
>
> The Health Services Act should be amended to require health providers regulated under the Act to provide information to enable the Department of Human Services to measure performance against the specified indicators. (DP Rec 26)

The following discussion summarises the responses to these recommendations.

7.3.2 Views on developing the indicators

Our recommendation that valid and reliable risk-adjusted performance indicators be developed is supported in principle in 27 submissions from a wide range of bodies and individuals.

For example, Dr Steve Bolsin, the anaesthetist whistle blower in the Royal Bristol Infirmary case, made a submission to the Review on the desirability of developing risk-adjusted clinical indicators and the importance of data collection and performance monitoring. He commented that the Bristol Audit Group was able to predict a successful outcome from a small database of cardiac surgical patients with a level of accuracy which was 'near certain prediction'. He states:

> Near certain prediction is probably what all health care planners would like for most health processes. More importantly, this level of prediction is more achievable

> than many health care professionals believe. If this level of accuracy of prediction can be achieved for the common outcomes from complex interventions such as cardiac surgery then the goal must be to achieve this level of predicability for all medical and paramedical interventions. Knowing the predicted level of success in the performance of any medical intervention informs both the service provider and the patient about the realistically achievable goals of that intervention in that patient in that setting.

Dr Bolsin also stresses the importance of performance monitoring for all trainee specialists such as that trialed in anaesthetic training in the United Kingdom and which Dr Bolsin has introduced at Geelong Hospital. In these examples, trainees are obliged to collect data in order to continue in an approved program. The collection, analysis and feedback is supervised by the relevant College or specialist association which monitors the trainee until such time as he or she has reached the requisite level of training. Dr Bolsin envisages that such data collection will continue, with the best performers becoming the trainers of the trainees.

Dr Bolsin comments that the development of clearly defined predictive data sets and outcome measures, together with the parallel development of institutional and individual quality assurance techniques for trainees and specialists, should lead to considerable patient benefit.

However, some submissions comment that the development of valid indicators will not be possible as adjusting for risk is not an exact science. AMA Victoria, for example, is concerned we did not give due weight in the Discussion Paper to the difficulties associated with developing valid performance indicators. The Australian Association of Surgeons and Ramsay Health Care also comment that, given the spectrum of human disease and patient characteristics, it is not currently possible to identify risk factors for many common illnesses, especially when using small samples of individual hospitals and doctors.

The Australian Association of Surgeons and AMA Victoria comment that to construct an indicator may require an excessively lengthy follow up period. For instance, one major aspect of the effectiveness of an open prostatectomy is long term survival, as measured over a ten year period. They point out that any indicator developed to include this may be stale by the time it is published.

AMA Victoria also state that risk adjustment cannot be perfect due to difficulties such as low frequency and factoring in probabilities ('almost all health outcomes are highly probabilistic').

Other submissions point out difficulties in adjusting for factors such as severity of illness, the nature of treatments provided and demographic factors. The Australian Association of Surgeons states:

> ... the most difficult cases tend to be sent to the most competent operators, and because of this the results (*however* measured) of the most competent operators can indeed be far inferior to those of the less competent operators, simply because the most able surgeons and physicians are taking on cases with very low probabilities of success.

The Health Benefits Council and Medicare Private suggest that a flow on issue of liability of purchasers also needs to be addressed. The ranking of providers may have implications for health insurance payments made to hospitals which do not rate very well. Following from the High Court decision of *Chappel v Hart*, and the decision in the United States of *Johnson v Misericordia Community Hospital*, a duty of care may be imposed on private health insurers to deal only with the best, thereby substantially limiting the pool of providers.

A large number of submissions suggest the proposed timeframe for developing the indicators is unrealistic. They point out that development of indicators is a long term project, particularly given that existing definitions and data collection methods do not allow clinical performance indicators to be properly adjusted for illness severity. They suggest it is unlikely that suitable indicators can be developed by July 2000, particularly as an initial period of validation prior to publication is essential. They point out that sophisticated measures are required to ensure that like is being compared with like. Without time to validate the indicators, publication could:

- result in practitioners, including the most highly skilled ones, avoiding high risk patients to reduce published mortality rates;
- lead to consumers being misled about the quality of services of particular providers; and
- jeopardise internal review and quality improvement because of the threat of 'exposure' of practitioners and units/agencies to the broader community.

7.3.3 Views on the publication of comparative data

A number of submissions indicate agreement in principle to comparative data on the performance of hospitals and day procedure centres being publicly available. They suggest the publication of data will enhance the ability of consumers to make informed decisions about treatment options.

On this issue, both the Health Issues Centre and the Commonwealth Department of Health and Aged Care comment that publication of performance data can also ensure evaluation is undertaken as to whether the needs of consumers, as defined by consumers, are being met. This can feed into quality improvement processes. The Breast Cancer Action Group suggests it can also aid accountability. They state: 'unless the process is transparent, consumers will not be assured that their interests, and not those of practitioners, are being considered'.

The advantages from a consumer perspective of publishing data are illustrated in submissions from the Australian College of Midwives and the Maternity Coalition Australia which consider the impact in relation to maternity care. They suggest information should be available about the performance of maternity units at the individual institutional level so women can make informed choices regarding the different models of care. This includes data on satisfaction ratings for each type of care, average length of stay, arrangements for post natal care, intervention rates, and services for those with special needs (eg those from non-English speaking backgrounds, Aboriginal women, and those with religious needs). Comparative information is available in New South Wales, as data must be reported by all hospitals which have more than 200 births annually. They suggest that performance data currently collected in Victoria by the Perinatal Data Unit should be available to the public.

The Mental Health Legal Centre argues that enhancing informed consent is especially required in the case of people with a psychiatric disability, where there can be a stark power imbalance between provider and consumer. They state:

> People with psychiatric disability are often particularly fearful of the potential side effects and risks of treatment, and may avoid treatment as a result. 'Report cards' could provide invaluable information to service users about such matters as average length of stays, frequency of readmissions following discharge, adverse events, availability of psychotherapy and other complementary treatments, and the extent to which people are linked in to support services on discharge.

A number of providers are concerned about how consumers will be informed and whether performance as measured against clinical indicators should be published. Some support publication when the indicators are refined, others strongly oppose any publication.

Some organisations believe the problems associated with performance indicators are so great that comparative data about institutions should not be publicly available, certainly not in the foreseeable future. The

basis for this position is that development of indicators is too difficult and lay people would not have the ability to interpret fine insignificant differences in results. There are also concerns that data can be manipulated. AMA Victoria comments, for example, that although it is appropriate to adjust for risk as much as is possible to enable a productive dialogue with doctors about using outcomes information to motivate quality improvement, the imperfections make it inappropriate to make the information publicly available as it is likely to be misconstrued. The Royal Australasian College of Surgeons and RANZCOG also point to the perils associated with assuming performance indicators are reliable indications of the standard of care, and the risk of misinterpretation by lay people.

It is argued in many submissions which oppose publication that the use of performance indicators should be confined to quality assurance activities and not be publicly available.

For instance, the Royal Australasian College of Surgeons suggests that rather than rely on publication to improve quality, clinical performance should be assessed through the existing system of peer review under the supervision of a quality assurance committee. Such measures are backed up by the College's rectification program, which involves medical education, surgical audits and credentialling by hospitals.

Some submissions express the view that the Discussion Paper creates an artificial dichotomy between discrete episodes of care and continuity of care. For example, one submission points out the coronary artery bypass surgery referred to in appendix 3 of the Discussion Paper is part of a continuum of care, which includes management by a general practitioner, specialist intervention pre and post operation, and the surgical and hospital care associated with the operation. Only the latter is measured in the table, yet the other forms of care will affect the success of the procedure. If a patient travels far from home to attend the hospital/surgeon with the highest ranking for the procedure, he or she may not receive the most effective pre and post surgical care and family support, which are all available within his or her local community. The best chance of success *for that particular patient* may lie with having the surgery carried out at a closer hospital. High success rates at any hospital will be due to the overall care provided to patients located near such hospitals, including pre and post operative care.

Other submissions raise the concern that the data will not help consumers make informed health care decisions. Consumers may mistakenly believe that services are substandard, for example. Public comparisons of one institution over another would be frequently challenged and difficult to defend. This could diminish public confidence in the system and influence consumers to cease certain treatment or not attend the most appropriate place. The reputation of

providers may also be wrongly damaged and policy formulation distorted. Others are concerned patients may be screened prior to admission, and those who are high risk could be denied services so that a practitioner can reduce the chances of his or her results being below average.

Another reason for opposing any publication of comparative performance indicator data is given in the submission from Ramsay Health Care. They state:

> The private sector is primarily a commercial environment, with financial survival or profitability a major concern, albeit overlaid at times by ethical principles. Marketing is a key issue with both the doctors and the patients considered customers to be attracted. Accordingly the private sector will object to processes which will erode their competitive advantage, such as divulging confidential and commercial information to competitors and marginalising medical practitioners.

Some submissions suggest that, if publication is to occur, attention needs to be paid to ensure that:

- information provided to consumers is what they need and want;
- information is readily available to those who want it (eg it must be available in many languages, and it should be free); and
- it is presented with assistance as to how to interpret the data, to reduce the risk of misinterpretation by members of the public.

7.3.4 Our conclusions

In discussing the development of risk-adjusted clinical performance indicators, the Health Issues Centre comments:

> This is not simply a matter of perfecting a market. Consumers entrust their lives and their health to the health system with very little information about the likely outcomes of the services or about the practitioner or provider's capacity to undertake the service offered successfully.

This statement reflects our views and we believe it encapsulates the views of consumers generally.

We do not underestimate the difficulty in developing risk-adjusted clinical performance indicators which are meaningful and contemporary. We realise they will not be perfect and will require ongoing refinement. We still believe, though, that the development of risk-adjusted clinical indicators is worthwhile to address information

asymmetry. We have concluded that the development of these indicators should not be seen in isolation, however, and a set of indicators relating to the organisation and management of care (such as waiting times, discharge planning and accreditation) should also be developed.

The validity of the proposed risk-adjusted clinical indicators can (and should) be assessed on an ongoing basis. It is not our view that reporting of the indicators should be the only strategy designed to improve quality of care and assist consumer choice. Hospitals (and other agencies) already have internal mechanisms, some of which are protected. We are thus proposing a dual strategy to improve quality: an external reporting process and an internal (protected) process. The two systems should complement each other. In our view, testing of new clinical indicators for external reporting might best be done by the operation of section 139 of the Health Services Act. This is discussed further in section 7.6.

With regard to the issue of liability of purchasers, we note it may be Australian law that referring doctors and private health insurers have an obligation to take quality of care into account in making referral recommendations and determining which hospitals have contracts. However, if this is the law we do not think the obligation is to deal only with a single 'best' provider as measured using the proposed risk-adjusted performance indicators, partly because what is 'best' may vary depending on the circumstances of individual patients. In our view, publication of indicators will assist doctors and private health insurers to meet their potential obligations in this area.

Many have been critical of the timeframe proposed in our original recommendation. We accept that the timeframe for development and validation is not long enough. Extra time will also ensure the development of a set of indicators of organisation and management of care against which performance can be measured. We now recommend the target date for development should be extended to 1 July 2001. We also accept that hospitals and day procedure centres will need some time to examine their performance against the indicators, to ensure they are accurate and to take steps to improve performance if necessary. We now believe that 1 July 2002 is a more appropriate target for the publication of comparative indicators. We have altered Recommendation 24 accordingly.

In section 7.6, we discuss revised obligations on committees protected under section 139 of the Health Services Act. These changes should provide an improved mechanism to ensure that variations in the quality of care provided by individual professionals are addressed. Further, as a number of submissions suggest, statistically reliable comparisons of the work of individual professionals may not be able to be developed because of the problems associated with small numbers of

cases. For these reasons we have not proceeded with our original Recommendation 25 (reporting of under-performers to the Medical Practitioners Board or relevant learned College). Rather, we have decided to combine elements of that recommendation with Recommendation 29. Our original Recommendation 26 has therefore been renumbered to Final Recommendation 25.

Final Recommendation 24

The Commonwealth and the States should collaborate to develop by 1 July 2001 a set of indicators of organisation and management of care including risk-adjusted clinical performance indicators which are comprehensive, consumer focused and current. Hospitals and day procedure centres should have one year to validate the indicators and review their performance. From 1 July 2002, the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres. In the absence of an agreed national set of indicators, Victoria should develop and publish its own set.

Final Recommendation 25

The Health Services Act should be amended to require health providers regulated under the Act to provide information to enable the Department of Human Services to measure performance against the specified indicators.

7.4 Patient access to their health record

7.4.1 Our original recommendation

Parliament has provided for a right of access to their medical records for consumers of public sector health services. Patients of public hospitals, privately operated hospitals, multi purpose services and community health centres are able to access their records, subject to certain exceptions, under sections 13 and 33 of the Victorian Freedom of Information Act. However, patients in private hospitals or private day procedure centres, or who consult doctors privately, do not have an enforceable legal right of access to their record.

Consumers of private health services must therefore rely on the cooperation of their provider for access to their medical records. Such cooperation is by no means guaranteed, although the AMA and the Royal Australian College of General Practitioners encourage their members to provide information to consumers.

In the Discussion Paper we reviewed the experience of access to medical records interstate and overseas. We discussed issues of complaints mechanisms and penalties and whether there should be exceptions to the release of records.

We concluded there is no valid reason not to extend the right of access to medical records held by private health providers. We therefore recommended:

> The Health Services Act should be amended to enable consumers of health services to have an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner (medical or otherwise). The scope of the legislation should be similar to the *Health Records (Privacy and Access) Act 1997* (ACT). Appeals should lie to the Victorian Civil and Administrative Appeals Tribunal against a refusal to provide access. (DP Rec 27)

We intended that the definition of health records be wide. Under the ACT Act, health records encompass records from providers who perform activities which are intended to assess, record, improve or maintain the physical, mental or emotional health of a consumer or to diagnose or treat an illness or disability of a consumer. This includes disability, palliative care or aged care services.

Submissions to the Review concentrated on three issues: whether access should be allowed, when access should be refused, and which legislative model would be most appropriate.

7.4.2 Whether access should be allowed

Our recommendation is strongly supported by individual consumers and by public hospitals which are familiar with allowing patients access to their own health records. Other supporters include some local councils, the Health Issues Centre and the Health Services Commissioner.

Essentially, submissions supporting our recommendation comment that conferring an enforceable right of access:

- is consistent with the principle of increased consumer participation and responsibility for health outcomes;
- is a means of enhancing the accountability of health care providers;
- has the potential to improve practice, as it will require greater skill in writing records and careful communication to patients about the contents of the record;
- will provide uniformity across the public and private sectors;
- enables the opportunity to correct errors in records; and
- can allow the whole treatment program to be understood, particularly for consumers with complex care needs who often attend a number of providers.

On the other hand, the majority of submissions from the private sector, including professional associations, practitioners and hospitals, do not support our recommendation. They argue the question of access should be the subject of a separate, more thorough, review. Some of the reasons cited for this position are:

- Some opinions are intended only for a doctor's or hospital's reference. Access may lead to records being written in a defensive manner, because doctors will fear litigation or out of a desire to protect patients. For example, a doctor could be concerned that a consumer will misunderstand the records or be distressed (eg if a record notes that a patient's problem is caused in part by anger, or if it contains musings about possible causes of complications or diseases, such as querying whether a patient may have HIV). Defensive record keeping is not in the best interests of the patient in terms of treatment, especially for those with ongoing illnesses.
- Consultant physicians have a charter which supports full and frank opinion regarding patients to referring doctors. This process will be threatened if they are at risk of legal action in relation to their opinions.
- As notes are the property of the hospital or doctor, and prepared at their expense, information derived from those notes should only be provided with their permission.

- The present situation is working satisfactorily. Patients should have information about their physical and mental health and treatment, but this must be distinguished from a right to access all of the actual paperwork. A patient can obtain a summary on request, and a copy of records can be forwarded to a new treating practitioner.
- The implementation of our recommendation would allow employers and lawyers to obtain information without going through established processes.

We believe that the enactment of legislation to give all consumers a right of access to their own health records is long overdue. In this day and age, consumers rightly expect to be informed about, and to participate in, decisions affecting their health care. Consumers also want the ability to obtain second opinions or change providers when desired, with a minimum of fuss.

The ability to chose one's provider (and to change one's provider) is fundamental to a competitive market. Barriers to effective choice are anti-competitive and should be eliminated. The arguments against enhancing access to records are not sufficient in our view to support retention of the existing anti-competitive system. We therefore consider that consumers need a legal right of access to their own records to facilitate effective choice. Despite the enlightened attitude of many clinicians who are willing to make information available to consumers on request, we note that a very significant proportion of the Health Services Commissioner's work still involves attempting to resolve complaints about refusal of access to records. Informed consent to health care has been recognised at common law in Australia for some years. We regard the right of access to individual health records as an important corollary of informed consent. It is also vital to facilitate competition among health service providers.

We note the comment that this recommendation could lead to defensive record keeping. However, we consider that the prospect that consumers may seek access to their records should lead to improved record keeping, with a greater emphasis on recording verifiable clinical observations about patients instead of unsubstantiated opinions. Those who oppose the recommendation tend to be nervous about the perceived possibility of increased litigation as a consequence of patients having access to their own records. While it is difficult to comment authoritatively in the absence of relevant data, we believe that the advent of freedom of information laws in the public sector has not, of itself, led to increased litigation against public hospitals. On the contrary, for some consumers, ready access to information and a full explanation of the treatment that they have received may alleviate concerns and defuse situations which could otherwise lead to the instigation of legal processes.

7.4.3 When access should be denied

The second issue raised in a number of submissions relates to the circumstances in which access should be refused.

In the Discussion Paper we referred to section 33(4) of the Freedom of Information Act which sets out the circumstances when access can be refused:

> Where a request is made ... for access to a document ... that contains information of a medical or psychiatric nature concerning the person ... and it appears to the principal officer ... that the disclosure of the information ... might be prejudicial to the physical or mental health or well-being of that person, the principal officer ... may direct that access ..., so far as it contains that information, ... be given ... instead to a registered medical practitioner ... nominated by ... [the applicant] and approved by the principal officer.

The ACT *Health Records (Privacy and* Access*) Act 1997* provides that access can be denied if the provision of the information would constitute 'a significant risk to the life or the physical, mental or emotional health' of the consumer or any other person. If such a decision is made, the record keeper may offer to discuss the health record with the consumer or refer the record to a provider nominated by the consumer.

The view that patients (particularly those with a psychiatric disability) may be emotionally harmed by accessing their medical record is frequently cited as a reason for not extending rights of access to health records. A representative of the AMA aptly illustrated the opposition of some doctors. In an interview on the '7.30 Report', he expressed the view that access by a patient to his or her medical record 'may cause a disturbed person to jump off the Westgate Bridge'.

However, of particular note is the submission from the President of the Mental Health Review Board. He points out that under section 26(7) of the Mental Health Act, the Board is obliged to give an involuntary patient access to his or her medical records unless the Board is satisfied that access would 'cause serious harm to the patient's health or the health or safety of another'.

The President comments:

> I am not aware of any significant issues having arisen that could not and were not dealt with satisfactorily by the statutory exceptions to access. Indeed I believe that in many cases a patient's access to records has been of therapeutic benefit. In part I base this on anecdotal evidence from legal representatives of patients who have informed me that patients are often very suspicious and cynical about the contents of their file and it is only after they have seen it that they become more appreciative of the relevance and value of its contents and the positive approach being taken to their treatment.

We regard these comments as very persuasive. We consider that the exemptions to access contained in the Mental Health Act and the ACT legislation are adequate to ensure that access can be refused in circumstances where there are legitimate grounds for concern that granting access as requested would cause harm, either to the patient concerned or to another person.

7.4.4 The most appropriate legislative model

The third issue raised relates to the legislative model proposed and the appeal process. We recommended that the Health Services Act should be amended to create a right of access and that the amending legislation should be modelled on the ACT Health Records (Privacy and Access) Act. We also proposed that the appropriate forum for an appeal from a refusal to grant access should be the Victorian Civil and Administrative Tribunal.

One submission from a public provider suggests a right of access applicable to the private sector could be modelled on the Freedom of Information Act. The Mental Health Legal Centre suggests data protection legislation could be the preferred mechanism, as such legislation would create a broad framework for information management covering a wide range of service providers.

The Health Issues Centre argues that the current ACT legislation is not, by itself, sufficient. The Centre contends that the ACT legislation simply replicates the privacy principles contained in the Commonwealth *Privacy Act 1988*, and that this is insufficient to address consumer interests. It prefers more specific 'Fair Health Information Management' legislation to consolidate all Victorian health information legislation and address the collection, use, dissemination and matching of data, including provisions in other legislation such as the *Health Act 1958* (Vic) which currently regulates the collection of infectious diseases data.

Shortly after the release of our Discussion Paper, a Data Protection Bill was introduced into the Victorian Parliament. That Bill proposed the creation of a general right of access to personal information held by the private sector, but it preserved the operation of freedom of information laws as the regime governing access to information held by public sector agencies. If enacted, the Data Protection Bill would have established a broad statutory regime governing information management. It had the potential to create a right of access for individual consumers to their own health records held by private sector providers, in order to complement access rights available in the public sector under freedom of information laws. That Bill lapsed when Parliament was prorogued prior to the 1999 State election.

There is currently considerable activity at both Federal and State levels in relation to privacy and access to information issues. We understand that the Commonwealth Government is currently developing its own privacy legislation aimed at the private sector. Like the Victorian Data Protection Bill, the proposed Commonwealth legislation would create a general right of access for individuals to their own records held by private sector providers, subject to certain qualifications. We note the State's capacity to legislate comprehensively in the areas of privacy and access will depend on the form of any emerging Commonwealth legislation.

As the submissions indicate, there are a number of different ways of creating a legal right of access to health records. Broadly based data protection legislation, fair health information management legislation as proposed by the Health Issues Centre, and specific access to health records legislation all have the potential to be appropriate vehicles for this purpose. We remain attracted to the ACT model because it attempts to address most issues of concern to consumers relating to access and privacy in a reasonably flexible and creative way, although we consider some improvements could be made to the enforcement process under the ACT Act (see below). However, other legislative approaches could also be used to achieve the desired objective. In our view, the statutory mechanism chosen is less important than the outcome that is actually achieved. Whatever mechanism is chosen must be designed to ensure an accessible, timely and enforceable right of access.

We consider that an accessible forum to deal with appeals against decisions to refuse access must be available if the legal right of access is to be meaningful. The ACT legislation provides various avenues of recourse for consumers who are denied access. The right of access to records is deemed to be a term of the contract between a consumer and a provider of health services and is therefore potentially enforceable at contract law. A person who is refused access may seek a declaration from the Magistrates' Court to the effect that the decision to deny

access was not made in accordance with the law. In addition, the Community and Health Services Complaints Commission has the capacity to investigate complaints in relation to decisions to refuse access, and there are penalties for failing to advise the Commission about action taken under a compliance notice. The Commission can also review certain grounds for refusal and make a determination which can be the subject of a re-hearing in the Magistrates' Court.

We consider that this model may not be the optimum approach to enforcement. Victoria's administrative law system could be used to create a more straightforward means of enforcement, by providing a right of appeal against decisions to refuse access to the Victorian Civil and Administrative Tribunal rather than to the Magistrates' Court. This proposal is similar to appeal rights available under the Freedom of Information Act. It could complement the role of the Health Services Commissioner, who can conciliate complaints if consumers prefer a non adversarial approach. We believe this model of enforcement would create greater certainty for both consumers and providers of health services. Over time, a body of law would develop which would assist consumers and providers to understand the kinds of circumstances in which refusal of access is justifiable.

The President of the Mental Health Review Board suggests that people receiving treatment for a mental illness could have a right of appeal to that Board from a refusal to permit access by a mental health provider. The President cites the expertise of the Board and its ability to act speedily. We consider that this suggestion has some merit given this experience. However, for consistency we recommend that all appeals against decisions to refuse access should lie to the Victorian Civil and Administrative Tribunal.

7.4.5 Our conclusions

For the reasons outlined above, we stand by our recommendation that all consumers of medical services should have access to their health record, whether held at a public or private facility or by a private doctor.

We initially recommended that the Health Services Act should be amended to provide a statutory right of access. However, as indicated earlier, we consider the statutory mechanism for achieving the outcome is less important than the outcome that is actually achieved. We have therefore amended our recommendation accordingly.

Final Recommendation 26

Legislation should be enacted to enable consumers of health services to have an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner (medical or otherwise). The scope of the legislation should be similar to the Health Records (Privacy and Access) Act 1997 (ACT). Appeals should lie to the Victorian Civil and Administrative Appeals Tribunal against a refusal to provide access.

7.5 Patient charters

7.5.1 Our original recommendation

We believe patient charters are another important information source for consumers of health services and that they should be readily available at the point of entry into public and private hospitals, day procedure centres and in doctors' rooms. The charter should include information about a consumer's right to elect to be a public patient, to obtain a second opinion and to access health records, as well as specific information about how to resolve a complaint.

In the Discussion Paper we pointed out that a patient charter could be made a more powerful tool in the hands of consumers if its terms were enforceable by a court on application by a consumer. Most patient charters are expressed in very broad terms, however. After reviewing Australian and overseas examples, we concluded it would be inappropriate to vest in an administrative officer, such as the Health Services Commissioner, a power to enforce a document expressed in such broad terms, as it would enable the Commissioner to exercise powers normally vested in superior courts, if at all.

On the other hand, we considered that if the Parliament were willing to enact a very specific charter, we could see merit in providing consumers with a legal means of enforcement.

We recommended:

The Department of Human Services should not introduce an enforceable Patient Charter. (DP Rec 28)

7.5.2 Views on the introduction of an enforceable patient charter

Our recommendation not to introduce an enforceable patient charter is supported in a large number of submissions, including those from public and private providers and a consumer organisation. Six submissions oppose our recommendation as they consider some means for consumers to enforce rights should be established.

The Health Issues Centre acknowledges that a legislative charter would need to be more specific about the nature of the rights conferred on consumers than is the case in the current non-enforceable charter established under the Australian Health Care Agreement. However, it believes the current limited ability of the Health Services Commissioner to enforce rights is a 'longstanding cause of concern and frustration for consumers'. A charter of rights is in itself insufficient to bring about cultural change within closed groups such as health care providers. External assessment of actions is often necessary, as providers may be unlikely to recognise and challenge their own fundamental beliefs and assumptions. The Centre considers that the New Zealand approach (outlined in section 11.5.1.2 of the Discussion Paper) has merit and should be considered. Support for the New Zealand model also comes from the Mental Health Legal Centre, the NCWV and the Health Services Commissioner.

The Health Services Commissioner advises that the New Zealand Health and Disability Commissioner believes the experience in New Zealand of an enforceable charter has been positive. She points out the Commissioner currently has statutory power to take evidence under oath, issue warrants, and to decide whether a complaint is justified. These existing powers could be used to ensure compliance with a charter and would not amount to 'any infringement on the jurisdiction of the courts'.

The Mental Health Legal Centre suggests the review of the Health Services (Conciliation and Review) Act may provide an opportunity to consider an appropriate model. It notes there is no disciplinary board covering service providers such as therapists and counsellors, and no body with power to make binding determinations in relation to hospitals or health centres.

A submission referred to us by VICCAG suggests consumers expect more from a charter than information. It refers to the particular vulnerability of mental health consumers, who may be subject to the involuntary treatment powers. The submission puts the view that an

enforceable charter of rights is essential within a competitive environment.

7.5.3 Our conclusions

We agree with the Health Issues Centre's comment that a charter of rights is, in itself, insufficient to bring about cultural change on the part of health service providers. However, the critical question is whether an adversarial approach, in which individual consumers seek to enforce 'rights' against health care agencies and health service providers, is the best way of fostering the necessary cultural change. There is a danger that moving to an enforcement or litigation model of dealing with consumer complaints may lead to defensive practices on the part of health care agencies instead of greater openness and accountability to consumers. It may also encourage a shift of public resources toward those individuals who are insistent about enforcing their rights and away from others who may have greater clinical needs.

We note that in Victoria the Health Services Commissioner's role is primarily that of an ombudsman whose function is to investigate and conciliate complaints. The Commissioner also has the capacity to undertake broad inquiries into identified problems with the health system. In enacting the Health Services Conciliation and Review Act, the Parliament clearly expressed a preference for conciliation over more adversarial methods of dispute resolution. We consider this approach has many benefits. A move to a legally enforceable charter would shift the focus to enforceable consumer rights and could therefore transform the Commissioner into a health industry regulator. This could potentially impair the Commissioner's capacity to successfully conciliate complaints, as health service providers may not see the Commissioner as a neutral party in conciliation proceedings.

We agree that consumers of mental health services may be particularly vulnerable and in need of special protection, especially in relation to involuntary treatment. However, the Mental Health Act currently provides mechanisms that are designed to ensure that involuntary treatment only occurs when necessary and that those subject to involuntary treatment orders have speedy and accessible rights of review to an independent tribunal. The Mental Health Act affords far more specific protection for consumers of mental health services than would be possible under a general charter of patient rights.

We note the argument that enforceable charters of consumer rights are essential in a competitive environment. However, we have recommended the evaluation of the privately operated hospital experiment before exposing Victoria's public hospital services to further competition. If implemented, our recommendations for a call centre, clinical indicators and access to health records will strengthen the capacity of consumers to make informed choices between providers.

In these circumstances, we consider that the role of a patient charter should simply be to inform consumers about what they can reasonably expect from health service providers, and we believe that the disadvantages of creating a legally enforceable charter of patient rights would outweigh the benefits.

We acknowledge the importance of patient charters in informing patients about such matters as complaints mechanisms and their right to elect to be a public patient. However, as we have already outlined, we do not recommend the enactment of legislation to provide a legally enforceable charter of consumer rights. We have amended our recommendation to clarify this.

Some submissions suggest ways in which the current non-enforceable public patient charter and other charters could be improved. Suggestions include:

- more publicity, as many consumers don't know that charters exist;
- ensuring they are straightforward, so that they can be used by consumers;
- updating the current public patients' charter;
- including the obligations of patients. To ensure optimal results for the patient and the best use of resources, patients could be advised of the need for full communication between the patient, hospital and practitioner (eg notification of intention not to attend an appointment and changes of medication);
- investigating further how charters can do more than contain 'motherhood statements' so that they do not just 'fill in space on a hospital wall'; and
- treating the private patients' charter in a similar fashion to the public patients' charter; it should also be updated and circulated in appropriate languages.

We believe many of these suggestions have merit and have also amended our recommendation to reflect this.

Final Recommendation 27

Legislation should not be introduced to create a legally enforceable patient charter. The Department should review the existing patient charter to take account of the suggestions raised in submissions to this Review. The proposed call centre should publicise the existence of the patient charter.

7.6 Protected peer review

7.6.1 Review of quality assurance committees

Section 139 of the Health Services Act provides statutory immunity to the activities of, and participants in, approved quality assurance committees of hospitals, registered funded agencies, psychiatric services and professional associations. The production of any document or divulging of any matter to any court, agency or person that identifies patients or providers and that was learned through participation in the committee's processes is prohibited. This confidentiality is intended to encourage full and open discussion of quality assurance issues to improve the quality of health services.

Section 139 was drafted when quality assurance was in its infancy, and one of its aims was to encourage the active participation of doctors in reviewing the performance of their peers. Another aim was to encourage a multidisciplinary approach to the evaluation of quality at all levels in a health service. As we noted in the Discussion Paper, the drive for the protection conferred by section 139 came from doctors who argued that peer review could not take place in the absence of statutory immunity because:

- it exposed the reporting doctor to a possible defamation action; and
- it was frequently disciplinary in nature rather than remedial.

To determine whether meaningful peer review for medical practitioners has been enabled by the immunity provided by section 139 of the Act, we recommended:

> Quality assurance committees established under section 139 of the Health Services Act should be subject to formal review to determine whether the object of peer review on a multidisciplinary basis has been achieved. (DP Rec 29)

Discussion Paper Recommendation 25 proposed that the Secretary of the Department be empowered to report to the Medical Practitioners Board or relevant learned College any doctor whose performance against designated performance indicators was significantly below the average outcome. This recommendation was designed to give the Medical Practitioners Board a firmer basis for tackling sub-standard practice as we are aware the Board currently faces some difficulties in this area. However, because of a number of concerns raised in submissions, and given the infancy of risk-adjusted performance indicators, we have now decided that this particular recommendation should not be implemented at present (see section 7.3.4 earlier).

There is general support in the submissions for a formal review of the effectiveness of quality assurance committees declared under section 139.

The principal reason given for that support is that quality assurance is vital for improving the quality of services and for effective risk management. It is therefore considered important to determine whether peer review is working well, particularly those processes which are confidential and protected from disclosure by section 139.

After considering the submissions on Discussion Paper Recommendations 25 and 29, we conclude there should be a thorough review of the effectiveness of quality assurance committees declared under section 139, and the operations of that section generally. The reviewers should be permitted by legislation to have access to all relevant documents, including those generated by quality assurance committees, to enable them to make an independent judgment about whether the committees have been performing effectively, both in terms of identifying issues and episodes of patient care that should be reviewed and in ensuring that appropriate actions follow from any cases reviewed. Reviews conducted to date have not had access to patient records and documents of quality assurance committees, and have therefore had to rely solely on the perceptions of those involved in or knowledgeable about quality assurance processes. Legislation to enable a review could oblige the reviewers to maintain confidentiality, like the obligations of casemix auditors appointed under section 18B of the Health Services Act.

It is pointed out in the submissions that there is currently a lack of transparency in relation to quality assurance activities. The results of the process, even at a general level, are not made available to the public. We agree that public confidence in the health care system could be enhanced by greater public accountability in relation to quality assurance activities.

After the publication of our Discussion Paper, the Victorian Civil and Administrative Tribunal ruled in the case of *Birnbauer v Inner and Eastern Health Care Network* that aggregate data produced by quality assurance committees which does not identify clinicians or patients may be released under the Freedom of Information (FOI) Act. Prior to this decision, it was understood that FOI did not apply to documents generated by quality assurance committees. The decision has caused some concern among clinicians and hospitals about the scope of the protection conferred by section 139.

In the Birnbauer case, the Tribunal accepted that it is in the public interest for public hospitals to be open to scrutiny and for the public to know about the occurrence of adverse medical events. However, these public interests must be balanced against the public interest in

ensuring information is available for quality assurance purposes. Recognising the importance of quality assurance processes, the Tribunal accepted that it would not be in the public interest for identifying information, documents disclosing deliberations or documents containing material obtained in confidence which could impair the ability to collect this information in the future to be disclosed.

We believe that FOI may not be the ideal means of making information about the activities of quality assurance bodies publicly available, however. FOI does not apply to the private hospital sector. Enforcing rights under FOI is difficult for most consumers. Despite the balanced decision in the Birnbauer case, we believe that clinicians will be concerned that, in the future, a tribunal may not give sufficient weight to the public interest in ensuring that confidentiality is maintained. Although participation in quality assurance activities should ideally be an accepted part of clinical practice, it is possible that the broad application of current FOI laws could hinder rather than enhance the evolution of quality assurance processes at this time.

Nevertheless, we consider that the privilege of statutory immunity should be balanced by a concomitant statutory requirement for agencies with quality assurance committees to publish general information about the activities of those committees and, in particular, about improvements to health care delivery that have resulted from their work. Health care agencies and professional associations could be required to report briefly on the activities of all their quality assurance bodies as a condition of maintaining the privilege of statutory immunity. This could be done without imposing a substantial additional administrative burden; for instance, reporting could simply be incorporated into annual reports. Aggregate non-identifying data collected or analysed by quality assurance committees should also be made available to the Department and be publicly available on request.

We consider that these measures, in particular the publication of information about what is being done to enhance quality and address identified deficiencies in practices and procedures, would greatly enhance public confidence in quality assurance processes. This would also complement our proposals (discussed below) for systemic oversight of quality assurance activities by an overarching quality committee.

7.6.2 Effective clinical governance

Statutory immunity is simply one tool to facilitate quality assurance processes. However, the existence of declared quality assurance committees in health care agencies is not, of itself, sufficient to ensure that system wide quality issues are adequately addressed. We consider

there is a need for improved systems to encourage effective clinical governance in Victoria.

As we write this report, the Royal Commission into paediatric cardiac surgery at the Bristol Royal Infirmary is underway. The information emerging from the Royal Commission provides a salutary reminder about the need to have strong, publicly accountable, systems in place to ensure effective clinical performance.

As a consequence of the events at Bristol, the concept of clinical governance has been introduced in the United Kingdom together with the imposition of a statutory duty of quality on NHS Trusts and Primary Care Trusts. Section 18 of the United Kingdom Health Act 1999 requires a Trust to 'put and keep in place arrangements for the purpose of monitoring and improving the quality of the health care it provides to individuals'. It also establishes a Commission for Health Improvement to monitor quality.

In its 1998 Paper on Clinical Governance in North Thames, the UK Department of Health defined clinical governance as:

> the means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards.

The building blocks which make up clinical governance are:

- clinical audit
- clinical risk management
- quality assurance
- clinical effectiveness
- staff and organisational development

We believe this concept of clinical governance which requires reporting to, and monitoring by, the Commission for Health Improvement has merit. We note that the reports of two major national groups established to recommend ways to improve safety and quality in the Australian health care system – the Taskforce on Safety and Quality in Healthcare (June 1996) and the National Expert Advisory Group on Safety in Australian Health Care (April 1998) – both emphasise that there should be management and policy accountability for safety and quality of health care.

7.6.3 Our conclusions

We consider that boards of management of health facilities declared under section 139 should have a clear duty to oversee the quality of

health care provided. Health care agencies should also be required to report on a regular basis to a new overarching quality committee established by the Department. The role of this new peak committee would be to identify systemic quality issues for action by the boards and chief executive officers of health care agencies, and by the Department. The committee should have the capacity to draw together data from all bodies established to perform quality functions, including declared committees under section 139 and consultative councils under the Health Act. Boards could also be required to report to the committee on units or individuals with demonstrated less than average performance, so that the committee can monitor whether necessary action has been taken by the appropriate bodies. This committee would not duplicate the work of existing bodies but would 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.

Legislation should be enacted to enable the committee to receive and compel the production of data (including identifying information). The legislation should outline the authorised uses of such data and should make appropriate provision for confidentiality.

In this way, the State will be able to obtain an overview of quality in the public and private sectors. The committee should be obliged to publish meaningful aggregate information to inform consumers about activities resulting from quality assurance committees and remedial actions taken. This would assist consumers to become more informed about comparative performance in the health sector and would thus facilitate non-price competition between agencies.

As we argue in section 7.3, risk-adjusted performance indicators should evolve over time. One way of testing new indicators is to require hospitals (or other agencies) to collect and analyse proposed indicators. This process would be evaluated to allow a judgment about whether proposed indicators have appropriate levels of specificity and sensitivity for identification of relative performance in terms of quality of care (standardised for casemix and other legitimate factors). While indicators are being evaluated (and hence while there is uncertainty that differences in the indicators reflect differences in quality), indicators should not be subject to public release. One way of facilitating this evaluation process is to involve the protected quality assurance process under section 139. The Secretary should have power to require committees established under section 139 to consider certain indicators and report on their deliberations.

We therefore believe that the Secretary should have the power to direct specific committees (or like classes of committees) declared under section 139 or under the Health Act, or otherwise established to perform quality functions, to review data supplied by the Secretary or,

at the request of the Secretary, to supply data. This data should not identify individual consumers or professionals. Further, these committees should be required to report to the Secretary on the results of their deliberations and proposed action on any matters referred to them.

We have therefore made the following recommendations.

Final Recommendation 28

There should be a formal review of the operation of quality assurance committees declared under section 139 of the Health Services Act, with the reviewer given authority by legislation to examine relevant documents, including documents generated by those committees.

Final Recommendation 29

Section 139 of the Health Services Act should be amended to require health agencies which have committees declared under that section to report to a new peak quality committee established by the Department. Reporting details should include:

- **actions arising out of the quality assurance process, both agency-wide and on a unit basis; and**
- **information on units or individuals whose performance is below average and the steps taken for improvement.**

Consideration should also be given to imposing a statutory duty of quality improvement on (at least) public sector health care providers.

The Secretary should have the power to direct a specific committee (or specified like classes of committees) to review data or investigate a matter referred by the Secretary and to report to him/her on the outcome of their deliberations or proposed actions. The Secretary should also be empowered to call on a specific committee or committees to supply data to him/her.

8. REGULATION OF SUPPORTED RESIDENTIAL SERVICES

8.1 Background

In chapter 12 of the Discussion Paper we discussed the background to the current provisions relating to supported residential services contained in the Health Services Act. In 1997 there were 263 premises catering for 7,702 residents. It is worthwhile to briefly summarise the background again here.

Prior to 1988, special accommodation houses were regulated under the Health Act. A special accommodation house was defined as a boarding house in which two lodgers were aged 60 years or over or had a physical or mental handicap to the extent that their ability was impaired. The Health Act required the Chief General Manager to approve the suitability and siting of the premises and the suitability of the proprietor and manager. The Health (Special Accommodation Houses) Regulations 1980 imposed standards.

A 1987 review of the operation of the special accommodation house sector found that it dealt with the most marginalised and vulnerable groups in Victoria. The review recommended nursing homes, hostels and special accommodation houses be treated similarly and that legislation be introduced to:

- ensure equitable distribution of the three sectors;
- protect and promote the rights of residents; and
- set and enforce standards.

It further recommended the approval process for these three sectors be the same as that recommended for private hospitals and day procedure centres.

These recommendations were adopted and the term 'supported residential services' used to include these three groups. Initially, the three groups were subject to the same regulations (although hostels and nursing homes were subject to additional Commonwealth control). However, over the last decade the Commonwealth has increased its regulation of nursing homes and hostels and the State has ceased to regulate these facilities. Nursing homes and hostels are currently governed exclusively by the Commonwealth *Aged Care Act 1997*. As a result, the Health Services Act and the Health Services (Residential Care) Regulations now apply only to what are now called supported residential services (SRSs).

A supported residential service is now defined as premises where accommodation and special or personal care are provided or offered for persons (other than members of the family of the proprietor) for fee or reward, but does not include a residential care service or State funded residential care service.

Special or personal care is defined as assistance with bathing, toileting, dressing or meals; physical assistance to people with mobility deficits; assistance with medication; or the provision of substantial emotional support.

Amendments to the Health Services Act in 1997 and 1998 substantially increased penalties for breach of standards and transferred some offences from the Regulations to the Act. For example, failure to ensure the personal hygiene of residents now attracts a maximum penalty of $60,000 or 5 years imprisonment or both.

8.2 The need for a comprehensive review of the residential care market

The residential care market is highly segmented and supported residential services are in competition with a number of different service types. For example, 'up market' supported residential services compete with retirement villages for the well-off elderly and with hostels for the general elderly population. A further market caters for people with intellectual and/or physical disabilities and marginalised individuals. Here, supported residential services compete with community residential units and community care units. Other options available for this group in the private sector marketplace include rooming houses, public housing, the bottom end of the hotel market and caravan parks. Governments now attempt to address the needs of people residing in such facilities for special or personal care by providing services for individuals through the HACC program.

Different regulatory controls apply depending on the classification of the service, with the Aged Care Act applying to hostels and nursing homes, the *Retirement Villages Act 1986* to retirement villages, and the *Residential Tenancies Act 1997* to rooming houses and other situations regarded as tenancies. Community residential units and community care units have a different set of controls.

These different service types evolved along separate paths and at separate times and there is no coherent program framework encompassing all the services. The lack of a coherent program and regulatory framework means people with the same level of needs who are accommodated in different environments receive different levels of protection. Those who provide services to them are also subject to different regulatory regimes, some more onerous than others, with an

unlevel playing field. We concluded in the Discussion Paper that addressing these issues will require a systematic policy and program review covering all the identified service types. Only then can the relevant legislation be reviewed.

We recommended:

> The Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in the supported residential sector. This process should involve some form of public consultation. (DP Rec 30)

The question of whether supported residential services provide housing services or health services is debated in the submissions. Attention is drawn to the different regulatory framework applying to rooming houses and supported residential services, and to the belief that some providers register their premises as supported residential services to avoid the obligations of the Residential Tenancies Act.

The following submissions best illustrate these themes.

The Health Issues Centre comments:

> History may have included these services in the health care arena even though the key issue is housing or its lack. [We] would argue that housing or the other needs of this group are essentially a health care issue still. The externalities of housing and poverty have a major impact on the development of health inequalities. NCP may not be the most suitable management mechanism for this area of health care because the most needy and vulnerable live in circumstances that diminish their capacity to make choices and to advocate for themselves.

The Villamanta Legal Service states:

> ... there are a number of options for people who need support in their daily living. These include private supported residential services, funded mental health supported residential services, rooming houses or hostels. [We] consider there should be uniformity and clarity in the regulation of all these housing options.
>
> In our experience while the support needs of people vary from individual to individual, the profile of groups of residents is fairly uniform across the different housing options. That is most residents who live in these different places have disabilities and require support in daily living. Where a particular individual with support needs lives (or is placed) depends on regional factors

> and simply the availability of beds rather than the type or classification of the accommodation.

Villamanta Legal Service takes the view that, although residents have health problems, the special care required is not necessarily to do with health:

> Characterising supported residential services as "health" services seems to turn the clock back on the de-medicalisation of disability.

The Tenants Union comments:

> [We] believe that there may be a proportion of supported residential services which are actively registering as such to avoid their responsibilities under the Residential Tenancies Act rather than because of any genuine intention to provide care and support to residents. At the same time, anecdotal evidence from residents, and reports prepared by community visitors, indicate that these supported residential services are also failing to fulfil their obligations under the Health Services Act.

The Mental Health Legal Centre points out that many disabled people live in rooming houses and in their view:

> … the [recommended] review should not confine itself to registered supported residential service accommodation, but should aim to establish a regulatory system which
>
> - Applies to any residential services where people are provided with support in relation to disabilities and who may be vulnerable.
> - Gives such people the protection of tenancy rights and the broader rights set out in the Act.
> - Provides access to a dispute handling authority which has power to make binding determinations in relation to both sorts of 'rights'.
>
> The particular piece of legislation which creates such a regime is less significant than what it provides as a matter of substance.

Two proprietors of supported residential services comment on the perceived unfairness of the controls imposed on them as opposed to community care units and community residential units, both of which are funded by Government. They point in particular to the requirement that bedrooms in supported residential services must be $12m^2$, but the same requirement is not imposed on State funded rooms.

The Department advises that the minimum recommended size of 12m^2 for bedrooms in supported residential services is a guideline rather than a mandatory rule. The Office of Housing's Standards Policy Manual governing community residential units states that bedrooms shall approximate but be no less than 11m^2. The Department argues that it is reasonable for its guidelines to make allowance for larger minimum room sizes in supported residential services, as some residents spend much of their time in their rooms. In contrast, programs are provided for residents of community residential units focused on individual requirements which involve interacting with other residents and the community.

The Association of Supportive Care Homes argues that the Department is the biggest competitor of the supported residential services sector. They also contend that supported residential services operate in an anti-competitive environment as the Department is the regulator and its competitor.

We wish to stress that National Competition Policy does not preclude Government from providing supported accommodation directly to individuals who need it. As we indicated previously in relation to public sector health services, in an environment of public sector involvement in the marketplace National Competition Policy requires competitive neutrality between private and public sector competitors where the benefits of its implementation are judged to outweigh the costs. Regulatory standards between public and private sector competitors should be as consistent as possible to obviate arguments that different arrangements create an unlevel playing field. Both providers of supported accommodation and advocates for people who need such accommodation have clearly demonstrated there are differences in the way in which different types of supported accommodation are currently regulated. Whether removing these differences is appropriate requires further consideration.

We note that there is a substantial power imbalance between most users and the providers of supported residential services and other forms of supported accommodation. In these circumstances, we agree with the submissions which argue that market forces may not be sufficient to ensure that users of such services will be treated fairly and reasonably.

However, we can envisage some practical difficulties with certain proposals floated in the submissions. For instance, the suggestion that all such services should be brought within the framework of the existing Residential Tenancies Act may be difficult to implement, as many residents of supported residential services or other forms of supported accommodation may not have the capacity to meet standard obligations under current tenancy laws. In a situation of shared accommodation, the rights of a particular resident may have to be

balanced against the need to protect the amenity of other residents. These are complex and sensitive issues which require careful consideration. We consider that any legislation conferring tenancy rights on residents of supported accommodation services should be tailored to the special circumstances of residents and proprietors.

Overall, there is widespread support for our recommendation for a review of the supported residential sector. Most submissions support a wide-ranging review which looks at regulations/standards affecting all residential services which accommodate vulnerable aged people or people with disabilities (including community care and community residential units). There is support for a review which examines the controls on the various classes of providers as well as the level of protection provided for vulnerable people. We agree that such a review should be undertaken. We have made an alteration to our recommendation to reflect the concerns expressed in the submissions that the review should encompass those in supported accommodation, not just those in supported residential services.

Final Recommendation 30

The Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in supported accommodation. This process should involve some form of public consultation.

8.3 Planning Controls

We also looked at the question of whether the current planning controls contained in the Act should be retained.

As is the case for private hospitals, the Health Services Act requires the Secretary of the Department to consider any existing planning guidelines in determining whether to grant an application for approval in principle and registration as a supported residential service. The Act also requires the Secretary to consider (at both approval in principle and registration stages) whether establishment of a facility would result in more than adequate supported residential services becoming available in the relevant area.

We noted in the Discussion Paper that the Act envisages planning controls to ensure equitable distribution of supported residential services throughout the State but that planning guidelines have never been published. Accordingly, the distribution of supported residential services has been left to the market to determine.

We concluded it is a fundamental misconception to think the State could control the distribution of private facilities, and that ultimately distribution will be determined by the market.

Accordingly, we recommended:

> The Secretary of the Department of Human Services should not be able to take into account the adequacy of services in an area when considering applications for approval of supported residential services. Sections 71(1)(a)(iii), 71(1)(c)(iii) and 83(1)(b) should not apply to supported residential services. (DP Rec 31)

This recommendation is supported in a number of submissions, generally for the reason that there is a problem of undersupply rather than oversupply. Four submissions oppose the recommendation on the ground that affluent areas would obtain beds at the expense of less affluent areas.

We consider the appropriate role for Government in this area is regulation to ensure acceptable standards of accommodation and personal care and that vulnerable people are not abused or exploited. We do not accept, however, that planning controls can be used to ensure equitable distribution, particularly when no direct State funding is provided to supported residential services. Distribution will inevitably be determined by the market. This has been recognised by the Department since the inception of the Health Services Act, as there has been no attempt to control the distribution of supported residential services. We therefore have retained our original recommendation but made a minor amendment to refer to the approval in principle process.

Final Recommendation 31

The Secretary of the Department of Human Services should not be able to take into account the adequacy of services in an area when considering applications for approval in principle and registration of supported residential services. Sections 71(1)(a)(iii), 71(1)(c)(iii) and 83(1)(b) of the Health Services Act should therefore not apply to supported residential services.

8.4 Safety Controls

We also looked at the question of the current safety controls imposed when the Secretary considers whether to approve a supported residential service. We noted that licensing involves a three-stage process (approval in principle, registration and renewal), with the Secretary taking into account four criteria at the registration stage: fitness of principals, financial viability of principals, suitability of building and fitout, and suitability of operating arrangements.

Despite having taken a different approach to private hospitals and day procedure centres, we recommended that all four criteria be retained for supported residential services. We based this on four reasons:

- users are more vulnerable and less able to advocate for their rights;
- their vulnerability is generally lifelong;
- the shortage of accommodation means that a dissatisfied person cannot easily find other accommodation; and
- because they are generally small operators, the integrity of the owner of the service is likely to have a profound effect on the way it is run.

We also examined whether we should make a similar recommendation regarding removing the need for the Department to approve building and fitout and replacing it by the Building Code as we did in relation to private hospitals and day procedure centres. We concluded that the Department's involvement was warranted in the case of supported residential services as the Building Code only deals with structural integrity and safety. There are special features required in these facilities, such as the need for a home-like environment where privacy and dignity can be respected, which are not required in private hospitals or day procedure centres.

We also noted that section 89 requires the Secretary, when deciding whether to renew registration, to consider (in addition to fitness and propriety and financial viability) whether:

- quality has been maintained;
- the Act, regulations and any conditions on registration have been complied with; and
- satisfactory arrangements have been made relating to provision of residential statements.

We did not propose any changes to this process.

We recommended:

> The criteria set out in sections 71(1)(a)(i), (ii) and (iv) and section 83 (1)(c) should be retained in relation to applications for approval of supported residential services but the process should be streamlined. (DP Rec 32)

Our recommendation was widely supported and we have retained it, however we have made a minor change to clarify our intention.

Final Recommendation 32

Residents of supported residential services are particularly vulnerable (unlike patients of a private hospital or day procedure centre). The criteria set out in sections 71and 83, other than those specified in Final Recommendation 31, should therefore be retained in relation to applications for approval in principle and registration of supported residential services. Section 89 should be retained in full for supported residential services.

8.5 Protecting vulnerable residents

As noted earlier, the Health Services Act was amended in 1997 and 1998 to provide heavier penalties for breach of minimum standards. The standards are best described as input controls, whereas the Aged Care Act, which deals with equally vulnerable residents, imposes outcome-based controls.

In our view, input controls have the advantage of certainty but should be supplemented by outcome controls.

We recommended:

> Consideration should be given to developing outcome-based controls to supplement and, where appropriate, replace input controls. (DP Rec 33)

This proposal is generally accepted, although one submission notes that input controls are the 'first line' in maintaining quality. One proprietor notes and welcomes the new qualifications for personal care providers as an important step in improving quality but suggests a more cooperative approach from the Department would be beneficial.

Accordingly, we have not changed our recommendation but have re-worded it slightly to clarify that it relates to supported accommodation.

Final Recommendation 33

Consideration should be given to developing outcome-based controls in relation to the supported accommodation sector to supplement and, where appropriate, replace input controls.

APPENDIX 1: TERMS OF REFERENCE

The Consultant is required to investigate and make recommendations to the Minister for Health on the core elements of an improved statutory framework for the delivery of health services which will drive continuous improvement in the quality, efficiency and accessibility of health services and facilitate greater consumer empowerment by harnessing market forces effectively.

In carrying out this task, the Consultant is required to:

- *Analyse* how State government policy and legislation has affected the operation of the markets for health services within the scope of the Health Services Act, the Health Services (Private Hospitals and Day Procedure Centres) Regulations and the Health Services (Residential Care) Regulations, in particular, the extent to which policy and legislation has created restrictions on competition.
- *Assess* the costs and benefits to the community of the restrictions on competition flowing from State policy and legislation and whether these restrictions have proved to be in the public interest overall, having regard to government objectives of accessibility, quality and efficiency.
- Having regard to constraints imposed by Commonwealth policy and legislation, special features of the market for health services and the specific questions outlined below, *identify and consider possible alternative approaches* which could better meet government policy objectives of access, quality and efficiency and ensure accountability for the use of public funds including -
  - options for increasing competition and enabling market forces to play an optimum role in resource allocation;
  - options for increasing substitutability among providers of health care services where appropriate;
  - options for improving quality and continuity of care; and
  - options for redressing the information asymmetry between consumers and providers of health care services and for increasing consumer sovereignty.
- Assess the likely forseeable costs and benefits of each of the identified options.

Specific consideration should be given to the following questions:

- How could competition be effectively managed to -
  - ensure that government objectives in relation to access, quality and efficiency are met;
  - prevent abuse of market power;
  - minimise government exposure to risk; and
  - ensure that continuity of care is not compromised?
- To what extent would it be desirable in the public interest for national competition policy principles, especially competitive neutrality, to be applied to the not-for-profit sector?
- What regulatory controls and quality mechanisms are necessary to ensure that consumers of health and residential care services are protected and services are of a reasonable standard whether they are provided by the public sector or the private sector?

APPENDIX 2: MEMBERS OF THE STEERING COMMITTEE

Department of Human Services

Mr Warren McCann	Secretary
Dr Chris Brook	Director Acute Health
Mr Alan Clayton	Director Aged, Community and Mental Health
Mr Barry Nicholls	Director Corporate Strategy
Dr John Catford	Director Public Health
Mr Andrejs Zamurs	Director Disability Services
Ms Anne Wearne	Director Portfolio Services
Dr Phyllis Rosendale	Assistant Director, Intergovernmental Relations
Ms Penny Tolhurst	Executive Officer, Portfolio Services
Ms Pauline Ireland	Project Manager, Health Services Policy Review

Department of Premier and Cabinet

Mr Jamie Carstairs	First Assistant Secretary, Economic Development (until February 1999)
Mr David Adams	Assistant Secretary, Social Policy

Department of Treasury and Finance

Dr Chee-Wah Cheah	Assistant Director, Reform Policy
Ms Una Gold	Assistant Director, Reform Policy

APPENDIX 3: A COMPARISON OF THE RECOMMENDATIONS

Discussion Paper	Final Report
-	New recommendation Final Rec 1 The objectives in section 9 of the Health Services Act should be expanded to recognise the differences in delivery of health care in different parts of the State and the critical importance of clinical research and the teaching and training of health professionals. We suggest the following words be added: [The objectives of this Act are to make provision to ensure that …]: • health care agencies are structured and funded in the most appropriate manner to meet the needs of the community they serve; • clinical research and teaching and training of health professionals is facilitated.
DP Rec 1 Consideration should be given to the development of measures to enhance the capacity and accountability of boards of all public statutory bodies.	Amended, and renumbered as Final Rec 2: Measures should be developed to enhance the capacity and accountability of boards of all public statutory bodies, including articulation of governance principles.
DP Rec 2 Division 3 of Part 6 of the *Mental Health Act 1986* should be repealed. All mental health and other health care agencies should be funded under health service agreements made pursuant to section 26 of the *Health Services Act*.	Already implemented therefore deleted from our recommendations
DP Rec 3 All agencies receiving a requisite level of funding from the Department of Human Services should be issued with a certificate of registration under the *Health Services Act*. A central registration unit should be re-established by the Department of Human Services.	Retained unchanged
DP Rec 4 Section 83(1)(b) of the *Health Services Act* should be repealed. The Secretary of the Department of Human Services should no longer be able to take into account adequacy of health services in an area when considering applications for registration of new private hospital developments. The Department should remove the bed cap by withdrawing the existing Guidelines for the Development of Acute Hospital Beds.	Amended to include reference to approval in principle: Sections 83(1)(b) and 71(1)(a)(iii) of the Health Services Act should be repealed. The Secretary of the Department of Human Services should no longer be able to take into account adequacy of health services in an area when considering applications for registration of new private hospital developments. The Department should remove the bed cap by withdrawing the existing Guidelines for the Development of Acute Hospital Beds.

DP Rec 5 Building standards for hospitals should be incorporated into the Victorian Building Regulations. Once this occurs, the Department of Human Services should no longer approve the design and construction of private hospital premises. The sole criterion for registration under what is now section 83 of the *Health Services Act* should be whether the applicant is a fit and proper person to operate, or be a director of a private hospital. The Secretary of the Department of Human Services should retain the power to set conditions under section 85. Criteria for renewal under section 89 should be fitness and propriety of the principal, conformity with the law and compliance with conditions of registration. The Department should retain the power to inspect premises pursuant to section 147 of the Act to determine compliance with the Act and Regulations.	Retained but re-worded to clarify meaning: Building standards for hospitals should be incorporated into the Victorian Building Regulations. Once this occurs, the Department of Human Services should no longer approve the design and construction of private hospital premises. The sole criterion for approval in principle and registration under sections 71 and 83 of the Health Services Act should be whether the applicant is a fit and proper person to operate, or be a director of, a private hospital. The Secretary of the Department of Human Services should retain the power to set conditions under section 85. Criteria for renewal under section 89 should be fitness and propriety of the principal, conformity with the law and compliance with conditions of registration. The Department should retain the power to inspect premises pursuant to section 147 to determine compliance with the Act and Regulations.
DP Rec 6 Exemptions from input taxes represent an unfair advantage which not for profit private hospitals have over their for profit counterparts. That advantage should be removed.	Amended to read: Exemption from input taxes represents a competitive advantage which not for profit private hospitals have over their for profit counterparts in the private patient market. Government should establish a working party to quantify the benefits of the tax exemption to the public. These benefits could then be made explicit in a 'Community Charitable Return' for not for profit hospitals. The Community Charitable Return should not be less than the tax revenue forgone. The issue of input tax exemptions should be re-visited in the light of the working party's conclusions.
DP Rec 7 The State should renegotiate with the Commonwealth to ensure that the maximum fee requirement imposed on public hospital charging practices for private patient services is removed. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income received by public hospitals should be retained by them and the State should cease to make WIES payments in connection with those services.	Amended to read: The State Government should no longer prescribe fees for private patients in public hospitals and should not set targets for private patient activity. Targets for public patient activity should be retained. Public hospitals should be required to set fees for private patient services in accordance with normal commercial practices. All private patient fee income received by public hospitals should be retained by them and the State should cease to make WIES payments in connection with those services.
DP Rec 8 The State should negotiate with the Commonwealth to ensure that: • private inpatients of public hospitals are not disadvantaged in comparison to private hospital patients in accessing subsidised pharmaceuticals; and • public and private hospitals are treated equivalently for health insurance purposes.	Retained unchanged

DP Rec 9 Public hospitals should cease to receive exemptions on input taxes. The resultant financial impact of this measure should be reviewed and, in principle, any costs should be fed back into the system in the form of enhanced WIES payments.	Amended to read: Input taxes create an unlevel playing field between public and for-profit hospitals in the private patient market. Given that we have recommended that public hospitals set fees for private patients in accordance with normal commercial practices it is appropriate that this difference be eliminated. However, there are complex interactions involved in implementation and as a first step a levy equivalent to payroll tax should be imputed to reflect private patient and other commercial activity of public hospitals.
DP Rec 10 The *Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991* should be reviewed for relevance and reformulated to apply also to public hospitals. Regulatory standards affecting quality of patient care should, as a general principle, be common standards which apply to public and private hospitals.	Retained unchanged
DP Rec 11 Day procedure centres should continue to be registered by the Department of Human Services but the current definition of a day procedure centre should be amended to delete any reference to the volume of activity. Consultation should take place as to the most appropriate manner of determining what procedures should be prescribed.	Retained unchanged
DP Rec 12 The bed cap should not apply to day procedure centres. The necessary steps should be taken to remove the bed cap, pending the repeal of section 83(1)(b) of the *Health Services Act* (refer to Recommendation 4).	Minor amendment to make it clear that applications for approval in principle should also not be subject to the bed cap: The bed cap should not apply to day procedure centres. The necessary steps should be taken to remove the bed cap, pending the repeal of sections 71(1)(a)(iii) and 83(1)(b) of the Health Services Act.
DP Rec 13 The Department of Human Services should review the proximity requirement in the context of any available data on the number of patients who require emergency transfer from a day procedure centre to a proximate hospital.	Minor re-wording to make it clear this recommendation relates to day procedure centres: The Department of Human Services should review the proximity requirement for day procedure centres in the context of any available data on the number of patients who require emergency transfer from a day procedure centre to a proximate hospital.
DP Rec 14 The registration process for day procedure centres should be the same as the process described in Recommendation 5 for private hospitals.	Retained unchanged

DP Rec 15 The Department of Human Services should not pursue development of models that involve competitive purchasers at this stage, but should revisit this issue if the scope of services encompassed by a purchaser is expanded to include key primary care services such as MBS and PBS.	Retained unchanged
DP Rec 16 If competitive purchasing models are introduced, consideration should be given to whether purchasers would also be disallowed from engaging in direct service provision.	Retained but re-worded to link more clearly with Recommendation 15: We have recommended that competitive purchasing models not be introduced at this stage. However, if they are introduced, consideration should be given to whether purchasers should also be disallowed from engaging in direct service provision.
DP Rec 17 The status quo provides for a significant level of competition in public patient services between the for profit and not for profit sectors. Further efficiencies may be achieved by allowing the two sectors to compete for the right to operate existing public hospitals or constellations of services. However, it would be desirable to await evaluation of outcomes at privately operated hospitals before proceeding with further implementation of this model.	Retained but re-worded slightly to emphasise that the Health Services Act provides the capacity for competition between sectors to provide public patient services: The status quo provides the capacity for a significant level of competition in public patient services between the public and private sectors. Further efficiencies may be achieved by allowing the two sectors to compete for the right to operate existing public hospitals or constellations of services, however these efficiencies need to be demonstrated. Evaluation of outcomes at privately operated hospitals should therefore occur before proceeding with further implementation of this model.
DP Rec 18 Training and Development Grants should be available to the private sector.	Amended to read: Subject to developing robust measures of quality of training and research (which should be pilot tested in the public sector), Training and Development Grants should be available to the private sector.
DP Rec 19 The outcomes of the PHACS redevelopment process should be evaluated before further competitive elements are implemented in this area. Progress towards the application of contestability principles to PHACS should also be reviewed when the current PHACS redevelopment has been completed.	Amended slightly to take account of the recently announced PHACS review process: The outcome of the PHACS redevelopment and review processes should be evaluated before any competitive elements are implemented in this area.
DP Rec 20 Consideration should be given to legislation to allow PHACS agencies serving a single catchment to establish data integration mechanisms.	Amended to read: Consideration should be given to enabling designated agencies funded for provision of public services (including public hospitals, PHACS agencies and other relevant agencies) to establish data integration mechanisms. Such mechanisms should ensure appropriate protection of consumers' rights to privacy and access to services.

DP Rec 21 Consideration should be given to establishing a 24 hour call centre in Victoria on a pilot basis to assist consumers to be better informed about health care, health care providers and health choices.	Amended to read: A 24 hour call centre should be established in Victoria on a pilot basis for a 5 year period to assist consumers to be better informed about health care, health care providers and health choices. Measures should be taken to ensure confidentiality of information identifying any consumer.
DP Rec 22 The pilot call centre should receive information from each public hospital waiting list and advise patients of waiting times at alternative locations. The centre should also maintain and release data on accreditation status of public and private hospitals, the health insurers with whom the hospitals have contracts, and the relative performance of public and private hospitals on the indicators developed pursuant to Recommendation 24.	Retained unchanged
DP Rec 23 The pilot scheme should be subject to evaluation. If the pilot is successful, and the call centre established on a non-pilot basis, section 141 of the *Health Services Act* should be amended to impose a statutory obligation of confidentiality on staff of call centres.	Re-worded slightly to make it clear recommendation refers to call centres: The pilot call centre scheme should be subject to evaluation. If the pilot is successful, and the call centre established on a non-pilot basis, section 141 of the Health Services Act should be amended to impose a statutory obligation of confidentiality on staff of call centres.
DP Rec 24 The Commonwealth and the States should collaborate to develop by 1 July 2000 a set of risk adjusted clinical performance indicators which are comprehensive, consumer focused and current. From that date, the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres. In the absence of an agreed national set of indicators, Victoria should develop and publish its own set for use by that date.	Amended to read: The Commonwealth and the States should collaborate to develop by 1 July 2001 a set of indicators of organisation and management of care including risk-adjusted clinical performance indicators which are comprehensive, consumer focused and current. Hospitals and day procedure centres should have one year to validate the indicators and review their performance. From 1 July 2002, the Department should publish annually comparative performance information on the indicators for public and private hospitals and day procedure centres. In the absence of an agreed national set of indicators, Victoria should develop and publish its own set.
DP Rec 25 The Secretary to the Department of Human Services, public and private hospitals, and day procedure centres should be empowered to report to the Medical Practitioners Board or to the relevant learned College any medical practitioner whose performance against the specified indicators is significantly below the average outcome.	Deleted (elements of this rec are now contained in Final Rec 29)
DP Rec 26 The *Health Services Act* should be amended to require health providers regulated under the Act to provide information to enable the Department of Human Services to measure performance against the specified indicators.	Retained, but renumbered as Final Rec 25

DP Rec 27 The *Health Services Act* should be amended to enable consumers of health services to have an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner (medical or otherwise). The scope of the legislation should be similar to the *Health Records (Privacy and Access) Act 1997* (ACT). Appeals should lie to the Victorian Civil and Administrative Appeals Tribunal against a refusal to provide access.	Amended and renumbered to read: Final Rec 26 Legislation should be enacted to enable consumers of health services to have an enforceable right of access to their health records held by health providers, whether the provider is a public or private sector agency or an individual health practitioner (medical or otherwise). The scope of the legislation should be similar to the Health Records (Privacy and Access) Act 1997 (ACT). Appeals should lie to the Victorian Civil and Administrative Appeals Tribunal against a refusal to provide access.
DP Rec 28 The Department of Human Services should not introduce an enforceable Patient Charter.	Amended and renumbered Final Rec 27: Legislation should not be introduced to create a legally enforceable patient charter. The Department should review the existing patient charter to take account of the suggestions raised in submissions to this Review. The proposed call centre should publicise the existence of the patient charter.
DP Rec 29 Quality assurance committees established under section 139 of the *Health Services Act* should be subject to formal review to determine whether the object of peer review on a multidisciplinary basis has been achieved.	Amended, and now becomes two related recommendations: Final Rec 28 There should be a formal review of the operation of quality assurance committees declared under section 139 of the Health Services Act, with the reviewer given authority by legislation to examine relevant documents, including documents generated by those committees. Final Rec 29 Section 139 of the Health Services Act should be amended to require health agencies which have committees declared under that section to report to a new peak quality committee established by the Department. Reporting details should include: • actions arising out of the quality assurance process, both agency-wide and on a unit basis; and • information on units or individuals whose performance is below average and the steps taken for improvement. Consideration should also be given to imposing a statutory duty of quality improvement on (at least) public sector health care providers. The Secretary should have the power to direct a specific committee (or specified like classes of committees) to review data or investigate a matter referred by the Secretary and to report to him/her on the outcomes of their deliberations or proposed actions. The Secretary should also be empowered to call on a specific committee or committees to supply data to him/her.

DP Rec 30 The Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in the supported residential sector. This process should involve some form of public consultation.	Amended to reflect concerns about the scope of the review: The Government should review the existing regulatory and policy framework to ascertain whether there is an appropriate level of protection for vulnerable people paying for personal care services in supported accommodation. This process should involve some form of public consultation.
DP Rec 31 The Secretary of the Department of Human Services should not be able to take into account the adequacy of services in an area when considering applications for approval of supported residential services. Sections 71(1)(a)(iii), 71(1)(c)(iii) and 83(1)(b) should not apply to supported residential services.	Amended to include reference to approval in principle: The Secretary of the Department of Human Services should not be able to take into account the adequacy of services in an area when considering applications for approval in principle and registration of supported residential services. Sections 71(1)(a)(iii), 71(1)(c)(iii) and 83(1)(b) of the Health Services Act should therefore not apply to supported residential services.
DP Rec 32 The criteria set out in sections 71(1)(a)(i), (ii) and (iv) and section 83(1)(c) should be retained in relation to applications for approval of supported residential services but the process should be streamlined.	Retained but re-worded to clarify meaning: Residents of supported residential services are particularly vulnerable (unlike patients of a private hospital or day procedure centre). The criteria set out in sections 71 and 83, other than those specified in Final Recommendation 31, should therefore be retained in relation to applications for approval in principle and registration of supported residential services. Section 89 should be retained in full for supported residential services.
DP Rec 33 Consideration should be given to developing outcome-based controls to supplement and, where appropriate, replace input controls.	Retained but re-worded to clarify meaning: Consideration should be given to developing outcome-based controls in relation to the supported accommodation sector to supplement and, where appropriate, replace input controls.

APPENDIX 4: LIST OF SUBMISSIONS

Ms M Nethercott

Mr M Freeman

Mr M Croxford, Commissioner, Building Control Commission

Mrs H Dindas

Dr J de Campo, CEO, Women's & Children's Health Care Network

Sister P Stone

A/Prof B B Davies, Head of Cardiothoracic Surgery Services, The Alfred

Maternity Coalition, Australia

Ms J Smith, Proprietor, Hawthorn Lodge SRS

Mr G Kelly, CEO/DON, Robinvale District Health Services

Dandenong District Division of General Practice

Peninsula Health Care Network

Dr S Russell, Research Matters

Australian Association of Surgeons

Mr D Buchanan, Director, Green Ridge Retirement Home (SRS)

Confidential report from a Day Procedure Centre

Drs Jensen, Goergen and Chong, Department of Diagnostic Imaging, Monash Medical Centre and Prof B Tress, University of Melbourne, Department of Radiology, Royal Melbourne Hospital (Drs Jensen et al)

C C Murphy

Cabrini Hospital

Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Victorian State Committee

Ministerial Rural Health Advisory Group

Mr A Baigel and Ms S Baigel

North Western Health

Murray Valley Private Hospital

Melbourne University Medical Students' Society

City of Whittlesea

Australian College of Midwives Inc, Victorian Branch

Health Benefits Council of Victoria

Mrs Fran Devlin

Breast Cancer Action Group

Southern Health Care Network

Australian Hospital Care Limited (AHC)

The Church and Charitable Private Hospitals Association Ltd

Inner and Eastern Health Care Network

Society of Hospital Pharmacists of Australia, Victorian State Branch

Epworth Hospital

Association of Supportive Care Homes Ltd

Faculty of Medicine, Monash University

Medibank Private

Private Hospitals Association of Victoria
Australian Dental Association Victorian Branch (ADA Victoria)
Royal Australasian College of Surgeons
J D Parkin
Ramsay Health Care
Mr Phil Lowen, CEO, Hunter Valley Private Hospital (HVPH)
Tenants Union of Victoria Ltd
Mental Health Legal Centre Inc
Disability Working group, Federation of Community Legal Centres (Vic) Inc
Villamanta Legal Service Inc
AMA Victoria
Victorian Healthcare Association Limited
Mr J Gardner, President, Mental Health Review Board
Ms Denise Carter
Mrs Judith Ann Rainbow
Dr John Curtin, Oral and Maxillofacial Surgeon
St Vincent's Hospital Melbourne and Caritas Christi Hospice
Dental Health Services Victoria
North Yarra Community Health
Victorian AIDS Council/Gay Men's Health Centre
Medical Practitioners Board of Victoria
Professor Zalcberg, Peter MacCallum Cancer Institute
Mr Ivor Davies, St John of God Health Care
Royal Australasian College of Physicians
Barwon Health
Victorian Catholic Health Care
Commonwealth Department of Health and Aged Care
National Council of Women of Victoria Inc
New Zealand consumer - via VICCAG
Health Services Commissioner
Nolch & Associates, Solicitors
Moreland City Council
Health Issues Centre
Mr Nick Matteo, Co-ordinator Human Services Planning, City of Yarra
Council on the Ageing
Dr S Bolsin