REVIEW OF THE *HOSPITALS ACT 1918* AS IT RELATES TO THE REGULATION OF PRIVATE HOSPITALS

Tasmania

DEPARTMENT *of*
HEALTH *and*
HUMAN SERVICES

FINAL REPORT

July 2001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

EXECUTIVE SUMMARY

This Final report provides a summary of the public consultation process and the deliberations of the independent Hospitals Act Review Group (as the Act pertains to the licensing of private hospitals). It also contains the final recommendations to Government from the independent Review Group.

The need for a Review

In 1995 at a meeting of the Council of Australian Governments (COAG), Heads of Government agreed to a National Competition Policy (NCP). One of the agreements signed was the *Competition Principles Agreement (CPA).* The *CPA* requires all Governments to review and, where appropriate, reform all existing legislation that restricts competition. As the *Hospitals Act 1918* contains restrictions on competition, it was necessary to review the Act to fulfill Tasmania's NCP obligations. It has also been recognised that the current Act has failed to keep up with changes in the hospital sector and requires a thorough overhaul to reflect contemporary practice.

The Public Benefit Test

Clause 5 of the *CPA* specifies that the guiding principle to be followed by jurisdictions in this reform area is that legislation (both primary and subordinate) should not restrict competition unless it can be demonstrated that:

a) the benefits of the restriction to the community as a whole outweigh the costs; and

b) the objectives of the legislation can only be achieved by restricting competition.

Issues

Apart from addressing the fundamental question of to what extent, if any, should the private hospital sector be regulated, the Review also addressed issues around:

- consistency in the application of any regulation to private hospitals and stand alone day hospitals;
- the introduction of advanced technology;
- the use of private hospital premises by third parties;
- the applicability of regulation to public hospitals;
- whether there should be any restrictions on private hospital bed supply;
- the need to regulate management;
- whether the focus of any future regulation should be on physical facilities or service quality; and
- the removal or update of archaic provisions

- the cost of regulation and appropriate fee structures
- the appropriate type of regulatory body
- the need for a separation of regulatory and service delivery functions.

Restrictions on competition contained within current legislation

The *Legislative Review Program Manual* specifies the following restrictions on competition:

- Restrictions on Market Entry;
- Restrictions on Competitive Conduct;
- Restrictions on Product or Service Innovation;
- Restrictions on the Entry of Goods or Services; and
- Restrictions on Competition through Administrative Discretion.

The *Hospitals Act 1918* was identified as containing restrictions on market entry, restrictions on competitive conduct and has at times been used to allow restrictions on competition through administrative discretion. By the limited applicability of the Act to private hospitals, without similar requirements for public hospitals, questions around competitive neutrality were raised by the application of the Act and potential conflicts of interest were identified as the Act is administered by the same Departmental area as that responsible for public hospitals which are in competition with the private sector for private and compensable patients and services to veterans.

Objectives of the Legislation

The Review Group identified four broad objectives that any new regulatory framework would need to meet. These were:

1. protecting the safety of the public;
2. ensuring the quality of services provided;
3. ensuring the appropriate ownership of facilities;
4. making the best use of resources available.

In addition to these major objectives, other useful criteria that should be satisfied to the greatest extent practicable by any new regulatory framework were:

- consumer choice;
- the consistent application of the option to private hospitals, private stand alone day facilities, public hospitals etc.;
- acceptable cost to Government and industry.

Regulatory Impact Statement

The Review Group prepared a Regulatory Impact Statement discussing the Review Group's views on six options for future regulation/deregulation. These options were:

Option 1 - A Fully Deregulated Model
Option 2 - Self Regulation

Option 3 - Regulation by the Ombudsman/Health Complaints Commissioner
Option 4 - Negative Licensing
Option 5 - Licensing for quality with the Government as the Regulator
A. No prescriptive controls on bed numbers
B. Prescriptive controls on bed numbers
Option 6 - Licensing for quality with an Independent Regulator
A. No prescriptive controls on bed numbers
B. Prescriptive controls on bed numbers

The Regulatory Impact Statement considered Option 6, the regulation of private hospitals for quality by an independent regulator, to be the least cost/greatest benefit option. This model was favoured over option 5 as it removed any perceived conflict of interest on the part of the Minister for Health and Human Services and the Department of Health and Human Services by providing for a clear administrative separation of the regulatory and service delivery roles of Government.

The Regulatory Impact Statement recommended that the application of strict bed caps on private hospitals should not be included in the new regulatory framework. Such bed caps were not considered to be in the public interest as restrictions on the bed supply were likely to lead to an artificially created market in bed licences leading to additional costs to private hospitals which would be likely to be passed through as additional costs to consumers. However, the Review Group considered that a strong case could be made for limiting the availability of some specialty services where there were insufficient patients available to provide a critical mass to ensure the maintenance of skills, the recruitment and retention of specialist staff and support for teaching and research.

The Regulatory Impact Statement recommended that decisions on the limiting of specialty services would need to be based on clinical considerations around service quality and be dependent on established clinical practice and service provision guidelines (e.g. Australian Health Technology Advisory Committee superspecialty guidelines, National Health and Medical Research Council clinical practice guidelines, Royal Colleges guidelines on clinical practice, State Health Authorities specialty service planning guidelines etc.).

Market entry would be controlled to ensure that only reputable operators would be allowed to provide private hospital services.

Fees

The RIS recommended that fees should reflect full cost recovery.

Public Consultation

On 26 June 1999 the Regulatory Impact Statement was released for public comment. The period for public comment closed on 12 August 1999. A total of 11 submissions were received from the following organisations:

- Australian Council on Healthcare Standards;
- Australian Institute of Surveyors, Tasmanian Chapter;
- Australian Medical Association;

- Australian Society of Anaesthetists Inc, Tasmanian State Committee;
- Commonwealth Department of Health and Aged Care;
- Department of the Premier and Cabinet;
- Hobart Clinic;
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists;
- Royal College of Nursing Australia;
- St Luke's Health Insurance; and
- Tasmanian Private Hospitals Association.

The Review Group considered the public responses in its further deliberations on the issues canvassed in the Regulatory Impact Statement. The Final Report reflects the result of the further consideration by the Review Group of the relevant issues.

Recommendations

A summary of the Review Group's recommendations is contained in the next section.

SUMMARY OF RECOMMENDATIONS

1. **That private hospitals and private day procedure centres should be subject to the same regulatory regime.**

2. **That the cut off point to decide if a facility needs to be licensing should be the Commonwealth Medicare Benefits Schedule (MBS) Type A (Overnight Accommodation) and Type B (Day Only) Procedure List. Any centre undertaking Type A or Type B Procedures would require licensing.**

3. **That the Minister be given discretion within the Act as to whether a facility requires licensing.**

4. **That it should be the responsibility of the licence holder to ensure that facilities on the premises of a private hospital/day procedure centre leased to third parties meet required standards.**

5. **That an independent committee be established to undertake the licensing role. This committee is to have an independent chair and representation from both the Department and the industry. The role, functions and membership of this committee are outlined at Appendix 4.**

6. **That the public sector hospitals should not be licensed but should be expected to meet the same standards as the private sector, especially where higher standards required in the private sector could place this sector at a competitive disadvantage.**

7. **That major public hospitals should be accredited.**

8. **That approval for new services or expanded services would need to be obtained from the Independent Licensing Committee (as discussed in section 9.3 and outlined in Appendix 4) to ensure effective planning of health services and minimise costly duplication in both the public and private sectors.**

9. **That specialty and superspecialty services should not be licensed where there are insufficient patients available to provide a critical mass to ensure the maintenance of skills, the recruitment and retention of specialist staff and support for teaching and research.**

10. **That decisions on the limiting of specialty services would need to be based on clinical considerations around service quality and be dependent on established clinical practice and service provision guidelines (e.g. Australian Health Technology Advisory Committee superspecialty guidelines, National Health and Medical Research Council clinical practice guidelines, Royal Colleges guidelines on clinical practice, State Health Authorities specialty service planning guidelines etc.).**

11. **That market entry should continue to be controlled to ensure that only reputable operators would be allowed to provide private hospital services.**

12. **That fees should be based around full cost recovery in the longer term and brought into line with other States/Territories but that new fees should be set about the mid range of what other States and Territories currently levy.**

13. **That it be mandatory that private hospitals provide data for planning and reporting purposes, provided that satisfactory confidentiality procedures and other relevant safeguards are observed in accordance with the Department of Health and Human Services Client Information Guidelines.**

14. **That appeals processes against Government decisions on licensing issues are to be managed by Magistrates Court Administrative Division.**

1. INTRODUCTION

The *Hospitals Act 1918* currently establishes the legal framework for the licensing and monitoring of the private medical establishments which includes private hospitals.

It had been recognised for some time that the Act had not kept up with the changes in the health industry and that the Act should be reviewed. The Department of Health and Human Services had recognised this need and was undertaking a review of regulatory framework for the private hospital sector, including arrangements for private day procedure facilities and major technological equipment.

The review also forms part of the State Government's Legislation Review Program (LRP) and will fulfill part of Tasmania's National Competition Policy obligations, under which the State is required to review all legislation restricting competition.

The Government has established a comprehensive review process under the LRP to ensure wide public consultation is undertaken when legislation is under review (details are contained in the *Legislation Review Program: 1996-2000 Procedures and Guidelines Manual*). For this review of the *Hospitals Act*, these steps have included:

- the development of an Issues Paper (completed March 1998)
- the release of the issues paper for public comment (March/April 1998)
- the preparation of a Regulatory Impact Statement (completed June 1999);
- opportunity for submissions on the RIS from the public (July/August 1999); and
- preparation of a Final Report to the Government containing recommendations for action (this document).

The Government appointed a Review Group of key stakeholders to undertake the review. The members of this group included:

Roger Curtis, Chairman
Ian Braid, Community Representative
Neil Beer, Tasmanian Private Hospitals Association (replaced by Valerie Davie from December 1998 and by Andrew Weston from June 2000)
Andrew George-Gamlyn, Royal Hobart Hospital
Darren Turner, Health Funds Representative
Fiona Calvert, Regulation Review Unit, State Treasury (replaced by Peter Bennett from June 2000)
Paul McCann, Department of Health and Human Services
Paul Geeves, Department of Health and Human Services - ex officio - providing administrative support to the Review Group (assisted by Val Whelan from June 2000)

It is important to note that the Terms of Reference required the Review Group to have regard to the principle that legislation should not restrict competition unless it can be demonstrated that:

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

2. BACKGROUND

In 1995 at a meeting of the Council of Australian Governments (COAG), Heads of Government agreed to a National Competition Policy (NCP). One of the agreements signed was *the Competition Principles Agreement (CPA).* The *CPA* requires all governments to review and reform all existing legislation that restricts competition. New legislative proposals also have to be examined.

According to the National Competition Policy Agreements, legislation must not restrict competition unless:

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

The following list of issues, whilst not exhaustive, can be used to assist in determining whether a legislative restriction on competition is in the public benefit. That is, whether the benefits of the restriction outweigh the costs.

Does the restriction:

- promote competition in an industry;
- assist economic development (for example, in natural resources through the encouragement of exploration, research and capital investment);
- foster business efficiency, especially where this results from improved international competitiveness;
- encourage industry rationalisation, resulting in more efficient allocation of resources and lower, or contained, unit production costs;
- expand employment growth or prevent unemployment in efficient industries or particular regions;
- foster industry harmony;
- assist efficiency in small business (for example, by providing guidance on costing and pricing or marketing initiatives which promote competitiveness);
- improve the quality and safety of goods and services and expand consumer choice;
- supply better information to consumers and business, thereby permitting more informed choices in their dealings at a lower cost;
- promote equitable dealings in the market;
- promote industry cost savings, resulting in contained or lower prices at all levels of the supply chain;
- encourage the development of import replacements;

- encourage growth in export markets;

- implement desirable community standards with the minimum impact on competition in the marketplace; or

- take essential steps to protect the environment.

The view has existed within the health industry for sometime that many sections within the *Hospitals Act 1918* represent an outdated approach to licensing and monitoring of private hospitals.

Before October 1986 responsibility for controls over private hospitals were shared between the Commonwealth and the State Government. In October 1986, the Commonwealth withdrew its claims to responsibility leaving controls pertaining to supply of beds, standards of physical facilities, quality of patient care and provision of services of private hospitals to the State. The most significant event in the Commonwealth's withdrawal was the abolition of the occupied bed day subsidy.

The Commonwealth's role is now mainly limited to the recognition of private hospitals for health insurance purposes. Until a private hospital is given a provider number by the Commonwealth Department of Health and Aged Care and declared to be a private hospital for health insurance purposes, patients will not be able to be paid hospital accommodation benefits by Private Health Funds. Before issuing a provider number the Commonwealth Minister ensures that the State has issued a licence.

The Commonwealth also has the power under the *National Health Act, 1953* to preclude the payment of Medicare benefits for services provided in a particular hospital.

In Tasmania, until 1991 private hospitals, public hospitals and nursing homes were regulated under the *Hospitals Act 1918*. The *Health (Regional Boards) Act* was enacted in 1991 to cover the administration of the public hospital system, and the *Hospitals Act* retained the legal framework to regulate the private hospital sector, private nursing homes, hostels and other accommodation for aged and/or disabled persons. The *Health (Regional Boards) Act* was replaced by the *Health Act 1997*.

2.1 Coverage

The definition of what constitutes a private medical facility under the Act has been the subject of criticism. The focus of the definition is symptomatic of the problems with the *Hospitals Act* licensing framework, as it does not accurately describe and cover all the types of facilities and types of services which have developed over time, for example, day surgery units and the use of high cost technologies.

The most obvious reason for this is that the sections within the Act referring to licensing criteria have not been amended or reviewed for many years, thus provisions have not been established to make the *Hospitals Act* more relevant to changing health care requirements.

2.1.1 Day Procedure Centres

The role of day surgery units has become increasingly important in the health system. Such units can assist in reducing waiting lists and reducing health costs of medical facilities, through a reduction in in-patient services usage or over night care and less need for 'around the clock' catering and other support staff.

Same-day admissions for surgical or endoscopic procedures are a significant component of the workload of most private hospitals. In most Australian States a considerable amount of same-day work is performed in free-standing day procedure centres. Recent changes to the funding arrangements for day procedures are likely to encourage an increase in the use of same day services.

In April 1983, the Australian Health Minister's Conference adopted the recommendation that each State should license day surgery facilities. There were no such facilities in Tasmania at the time, with the first such facility not being established in Tasmania until 1993. In Tasmania, it was thought that these facilities would be covered by existing legislation but a legal opinion on the *Hospitals Act 1918* received in March 1995 concluded that because the Act specified accommodation, day facilities were outside the ambit of the Act. Following this opinion, the Department developed guidelines for day procedure centres and has sought voluntary compliance from operators.

The Department of Health and Human Services also wrote to the Solicitor-General on 10 June 1998 seeking advice on its legislative responsibilities in relation to day hospitals given the previous advice that these centres were outside the ambit of the *Hospitals Act 1918*. A response was received on 18 June 1998 that confirmed there was no legislative mechanism to regulate day procedure centres but that the Department's approach of preparing guidelines and seeking voluntary compliance was a tolerably satisfactory solution to provide for regulation, provided voluntary compliance was forthcoming. However, in the event that guidelines were breached or ignored, no legislative remedy was available.

Although no approval is required before a private stand alone day procedure unit can commence operations, approval from the Department of Health and Human Services is necessary before the Commonwealth Department of Health and Aged Care will approve the payment of benefits by Health Insurance Funds to that facility.

Excluding stand alone day procedure centres from the workings of the Act while subjecting day procedures performed within private hospitals to the workings of the Act creates an obvious inconsistency. It raises specific issues in relation to competitive neutrality in that stand alone day procedure centres have a competitive advantage through not being subject to the requirements of the Act and therefore not subject to the costs of compliance.

2.1.2 Advanced Technology

The Commonwealth Department of Health and Aged Care and the Australian Health Technology Advisory Council have indicated that certain types of equipment should be subject to a needs assessment in order to:

- contain health costs,

- enable greater control over the types of equipment that can be used,
- enable evaluative clinical trials to be undertaken, and
- ensure that staff are trained properly in the use of the equipment.

Examples of the type of technology that may need consideration include Computer Topography Scanners, Extra-corporal Shock Wave Lithotripsy, Magnetic Resonance Imaging, Position Emission Topography, Radiotherapy and Stereoscopic Radiosurgery.

The presence and use of particular types of technology will have an impact on the diagnostic facilities and the types of treatments available to patients. The use of technology may need to be considered for inclusion in any regulatory framework.

2.1.3 Non-licensed use of Private Hospital Premises

The *Hospitals Act* currently defines a private medical establishment as an establishment that provides accommodation for various classes of people. Concerns have been expressed that licensing only covers services provided by the licensee and does not cover services provided by others that lease rooms and facilities within the hospital.

The establishment within private hospitals of facilities that may be owned and/or maintained by third parties has been a noticeable recent trend. For example pharmacy services and radiology and pathology departments of some private hospitals, and which no doubt are used for the benefit of in-patients, are owned and operated by firms of pharmacists, radiologists and pathologists, with the facility not necessarily appearing on the hospital licence. Therefore, these operators and services may need to be included within any regulatory framework for private hospitals.

2.1.4 Public Hospitals

Public hospital activities are not regulated by the *Hospitals Act 1918*. Legislative requirements concerning public hospitals are contained within the *Health Act 1997* but these requirements relate to public hospitals providing services in accordance with the Medicare principles and commitments, fees for services provided by public hospitals, and the establishment of a Hospitals and Ambulance Service Advisory Board. The licensing regime as outlined in the *Hospitals Act 1918* does not have any legislative equivalent in relation to public hospitals.

Consideration needs to be given as to what controls should be applied in relation to public hospitals and to what extent any alternatives to the *Hospitals Act 1918* should apply to public hospitals as well as private hospitals. Specifically, issues of competitive neutrality need to be addressed where public and private hospitals compete as public hospitals may have a competitive advantage through not being subject to the requirements of the Act and therefore not subject to the costs of compliance.

2.2 Guidelines on Hospital Bed Provision

Guidelines in relation to bed provision, particularly general medical and surgical beds, have varied in Tasmania, and throughout the Western world. The Tasmanian *Hospitals Act 1918* does not provide a clear framework for the assessment of applications for the provision of private hospital services but does allow the Minister to withhold approval of an application because there are already sufficient hospital services available in the local area.

Approaches to guidelines for bed provision have varied over time with guidelines sometimes being applied fairly strictly but being relaxed at other times. Over the past few years, guidelines for bed provision have only been applied in relation to specialty services. This application of guidelines for bed provision has not been tight enough to establish a market in private hospital licences as has occurred in some other States where guidelines for bed provision were more strictly enforced.

2.3 Regulation of Management

Provisions requiring managers to live on the premises are archaic, unnecessary and are not strictly enforced under current arrangements.

2.4 Focus on Facilities

The current regulation focuses on the physical facilities to be provided within a private hospital. These requirements largely duplicate accreditation requirements, the compliance criteria for the *Building Code of Australia, Tasmanian Fire Regulations* etc. While the Act focuses on physical facility standards, service standards and service quality and outcomes are largely ignored.

2.5 Utility of the Current Regulation

The current legislation has a number of limitations that affect its utility of application. For example, the penalties that the Minister can apply to a private hospital operator for failing to comply with the Act are a fine not exceeding $100 or the suspension of the relevant private hospital license. Neither penalty provides a workable solution for most cases where non-compliance with the Act might occur. A $100 fine is too insignificant a penalty to achieve compliance while the suspension of the relevant private hospital license is too heavy handed in most cases. A further area where the procedures contained in the Act are cumbersome and restrictive is in relation to the composition, appointment, and replacement of members and operating procedures specified for the Appeals Tribunal.

2.6 Licence Fees

An important issue is the low level of Tasmanian licence fees.

Tasmanian fees in respect of private medical establishments

	$
On a grant of a licence	20.00
On a renewal of a licence	10.00
On the transfer of a licence	10.00
On the amendment of a licence incorporating -	
a) increases to approved bed numbers;	
b) increases to approved resident numbers; or	
c) increases to approved bed numbers and resident numbers	10.00

The fees charged by the Department are clearly inadequate to cover the costs of Government services provided or inspections undertaken by the Department. Increasing fees to a level that would be considered more economically appropriate needs to be given consideration.

3. THE TASMANIAN PRIVATE HOSPITALS SECTOR

As at 30 June 1999 there were 10 private hospitals in Tasmania with 837 approved beds made up of 719 overnight beds and 118 day only beds. In addition there were four stand alone day facilities with a total of 13 beds. Private hospitals in Tasmania provided approximately 40% of the 2091 beds provided in the State. This represents a significant increase on the 25 % of total beds provided by the private sector in 1992.

In 1997/98 private hospitals treated around 56,000 patients or just over 40% of the total number of patients treated in Tasmanian Hospitals.

In 1997/98 a total of $3.2 billion in recurrent expenditure was spent on private hospitals in Australia. Tasmania's recurrent expenditure on private hospitals was over $117 million.

The private hospital sector in Tasmania employed over 1500 full time equivalent staff (FTE) including around 900 nursing FTE, 110 medical and other diagnostic health professional FTE, almost 200 administrative and clerical FTE and around 350 domestic and other FTE.

In addition, all Tasmanian private hospitals have upgraded or extended their facilities over the last decade, representing a significant capital investment. In 1997/98 Tasmanian private hospitals had gross capital expenditure of $8.5 million. The private hospital sector is thus an important sector of the Tasmanian economy.

4. NATURE OF THE CURRENT RESTRICTIONS ON COMPETITION

Legislation was included in the Legislation Review Program timetable if it restricts competition in any of the following ways:

- Restrictions on Market Entry such as licensing or registration requirements for particular occupations, quotas or the allocation of licences that allow the holder access to natural resources;

- Restrictions on Competitive Conduct such as limiting the hours of business operation, restricting permissible advertising or limiting business ownership;

- Restrictions on Product or Service Innovation such as requirements for prescribed quality or technical standards to be observed in the production or packaging of a good;

- Restrictions on the Entry of Goods or Services such as legislation which restricts the entry of goods and services from interstate or overseas; or

- Restrictions on Competition through Administrative Discretion such as preferential purchasing arrangements.

4.1. Restrictions on Market Entry

There are a number of restrictions on market entry contained within the *Hospitals Act 1918.* Firstly, Section 59 states that:

> *"No person shall carry on, or hold out that there is carried on, at any premises, a private medical establishment except under such title and for such purposes as may be specified in a licence held by him in respect of those premises and in accordance with the conditions prescribed therein."*

This requires any person seeking to enter into the private hospital market to apply for a licence to operate a private medical establishment.

Sections 60 and 61 specify the form a licence application must take and allow the granting of the licence to be subject to conditions.

"60. (1) A licence shall be in the prescribed form and shall specify -

a) the person by whom it is held

b) the premises to which it relates; and

c) the purposes for which, and the title under which, a private medical establishment may be carried on at those premises under the authority of the licence,

and may prescribe the conditions subject to which that private medical establishment may be carried on.

(2) The title specified in a licence shall be such as to indicate, subject to any classification made by regulations for the purposes of this Part, the type of

private medical establishment authorised to be carried on under the licence.

(3) Where a person holding a licence in respect of a private medical establishment dies, his executor or administrator or any member of his family (unless disqualified from holding a licence or being a manager of a private medical establishment) may, for a period of 4 weeks after the death of the licensee or for such longer period as the Minister may approve, carry on that private medical establishment; and, for that period, the licence has effect as if that executor, administrator, or member of the family were named therein as the holder thereof.

(4) Subject to subsection (5), a licence expires, unless it is renewed or further renewed, on 31st December next after the date on which it was granted or last renewed.

(5) Where an appeal is made against a refusal to renew a licence or against any alteration of the conditions prescribed in a licence, the licence continues to have effect, and the alteration has no effect, until the appeal is finally determined or abandoned.

61. *(1) An application for the grant, renewal, or transfer of a licence shall be made in writing to the Minister in the prescribed manner, and shall contain such particulars and be accompanied by such statements and plans as may be prescribed in relation to the application.*

(2) An application for the renewal of a licence shall be made within such time as may be prescribed.

(3) Every application under this section shall be verified by the statutory declaration of the applicant.

(4) On an application under this section for the grant or renewal of a licence the Minister shall, subject to this Act, grant or renew the licence.

(5) The Minister shall not grant or renew a licence authorising the carrying on at any premises of a private medical establishment for any purpose if he considers -

a) *that the applicant for the grant or renewal is not a fit and proper person to hold the licence;*
b) *that for reasons connected with the situation, layout, state of repair, accommodation, staffing, or equipment thereof the premises are unsuitable for use for that purpose or could not be used for that purpose in compliance with this Act; or*
c) *that the way in which it is proposed to conduct the establishment is such as would not provide services or facilities reasonably required by persons resorting to such an establishment or would not be in compliance with this Act.*

(5A) In respect of an application for the grant of a licence authorizing the carrying on of a private medical establishment at any premises for any purpose, the Minister may refuse to grant that licence on the ground that

adequate health care facilities already exist, in the locality in which that establishment is proposed to be established, to meet the present and future health care needs of persons who reside in that locality.

(6) On an application under this section for the transfer of a licence the Minister shall, subject to this Act, transfer the licence unless he considers that the person to whom the licence is to be transferred is not a fit and proper person to hold the licence.

(7) On application being made to him in the prescribed manner by the holder of a licence, the Minister may alter the conditions prescribed in the licence.

(8) On the renewal of a licence the Minister may alter the conditions prescribed therein.

(9) Before granting a licence, the Minister shall serve notice on the applicant therefor informing him of the terms of the licence which it is proposed to grant.

(10) Before refusing to grant, renew, or transfer a licence, or altering the conditions prescribed in a licence, the Minister shall serve notice on the applicant for, or the person holding, the licence of his intention so to do.

(11) If, within 14 days after the service of a notice under subsection (9) or (10), the person on whom the notice is served by writing so requires, the Minister shall not grant, or refuse to grant, renew, or transfer the licence to which the notice relates, or make the alterations to which the notice relates, until he has given that person the opportunity of being heard by him, or some person authorized by him in that behalf.

(12) Subsection (10) does not apply in relation to any alterations made in the conditions prescribed in a licence made on the application of the holder thereof, or under section 65 (3)"

Section 61 allows the Minister to refuse market entry on the following grounds:

- the applicant is not a fit and proper person;
- the premises are unsuitable for the proposed services;
- support services or facilities are inadequate; or
- adequate health care facilities are already available.

The first three restrictions clearly relate to ensuring service quality while the fourth restriction is less directly related to quality except in the sense that fragmentation of services could have implications for service quality by dividing the pool of qualified staff available so that no service has sufficient qualified staff or by reducing patient throughput so that no service has sufficient throughput to allow the maintenance of skills and qualifications.

Section 61(5) (a) requires the operator to be a "*fit and proper person*" which also restricts market entry to those operators who can satisfy this standard. Furthermore,

there are no guidelines in the Act for assessing who is a *"fit and proper person"* and so this is a subjective judgment.

A further restriction on market entry is provided by Section 66 that states:

> *"No licensee shall carry on a private medical establishment on any premises unless there is resident on those premises as manager of the establishment a person (who may be the licensee) who has such experience and qualifications as may be prescribed in relation to that establishment and who is approved by the Minister."*

This clearly allows the Minister to restrict market entry to those organisations that have people of the specified qualifications and experience to act as managers.

The *Hospitals Act* contains further restrictions on market entry in that certain services are prohibited through the conditions attached to a private hospital licence. For example, most Schedules of Conditions of Licence contain the following standard exclusions:

> *"a) patients who a medical practitioner has reason to believe is suffering from severe mental illness may not be admitted.*
> *b) coronary angioplasty in its various forms*
> *c) cardiac valvuloplasty*
> *d) radiofrequency catheter ablation*
> *e) all forms of cardiac surgery*
> *g) obstetric cases"*

A limited number of hospitals have less extensive exclusions. For example a number of hospitals Statewide can undertake obstetric care. This could lead to statutory monopolies on the provision of certain services in local areas.

Section 6 of the *Hospitals Act 1918* has been used at times in the past to support guidelines for bed provision to set a ceiling on total hospital bed numbers. Section 6 states that:

> *"(1) It shall be the duty of the Minister to direct some officer, subject to the provisions of this Act:*
>
> *a) to investigate and make inquiry as to the hospital accommodation necessary to meet the needs of the sick or injured persons resident in Tasmania:*
> *b) generally to see that the provisions of this Act are carried out."*

This has provided a restriction to market entry by limiting the total number of private hospital licences available. These guidelines for bed provision have generally only been loosely applied and have not been enforced over the last few years. Tasmania has never created a market in hospital bed licences through its application of guidelines for bed provision. A market in hospital bed licences has been created in some other States through the tight application of guidelines around bed numbers. For example, from 1990 Victoria applied very strict guidelines and imposed a bed cap on the private sector. Private operators who wished to obtain additional licences had no option but to purchase licences from other private operators.

This created a market in beds where there was a 10% turnover of private hospital beds between 1991 and 1996 or around 2.35 per annum. The majority of the trade was within hospital proprietary groups with only 0.6% per annum traded commercially between hospital groups. The average commercial price paid was around $25,000 per licence.

Section 70 excludes persons or bodies corporate who receive convictions under the *Hospitals Act* or related offences pertaining to private hospitals from holding licences and also may preclude persons or bodies corporate previously disqualified from being granted a licence.

Section 70F permits regulations to be made under the Act. The relevant sections in relation to restrictions on market entry are as follows:

"(1) Regulations for the purposes of this Part may -

(a) classify private medical establishments according to the purposes for which, and the conditions under which, they may be carried on;

(b) prescribe requirements with respect to the site and situation of any building or structure used for the purposes of a private medical establishment, or any room therein, or other part thereof, and the maintenance and repair of any such building structure, room, or part;

(c) prescribe the furniture, fittings, and equipment to be provided in any private medical establishment, and regulate the use and maintenance thereof;

(d) prescribe the facilities to be provided at or in connection with any private medical establishment for, or in connection with, the care or treatment of persons received or accommodated therein, and the accommodation of persons employed in or about the establishment;

(e) prescribe and regulate the provision of heating in a private medical establishment or any part thereof, and the maintenance of means for the prevention or extinguishment of fire, and the means of escape in the event of fire;

(f) regulate the management of a private medical establishment, and impose duties on the licensee and manager thereof, and any person employed in or in respect of the establishment, with respect to the carrying on and management thereof;

(g) prescribe requirements with respect to the numbers and qualifications of the staff to be employed in or in respect of a private medical establishment;

(h) require records to be kept of prescribed particulars with respect to persons received or accommodated in a private medical establishment, and notifications to be made of persons in the establishment suffering from, or suspected to be suffering from, any disease, and of any birth,

still-birth, miscarriage, or death occurring in the establishment, and regulate the manner in which those records are to be kept and notifications made;

(I) require the surrender of licences on their expiry or on their otherwise ceasing to have effect, and their submission to the Minister for the alteration of the conditions prescribed therein.

(2) Regulations for the purposes of this Part may make provision for the imposition of a fine not exceeding 5 penalty units on any person contravening any provision of the regulations.

(3) Regulations for the purposes of this Part may make different provision with respect to different private medical establishments according to the purposes for which, and the conditions in accordance with which, they may be carried on."

The Department has received a legal opinion from the Solicitor General that the current appeals procedures contained within Part IIIA of the Act allow third party appeals. In particular Section 70I (1) states that:

"A person who is aggrieved by a decision of the Minister -

(a) in respect of an application for the grant, renewal, or transfer of a licence;

(b) in respect of the refusal to approve any plans, specifications, or descriptions for the alteration of, or addition to, any premises;

or

(c) in respect of an inquiry under section 68 (2),

may appeal to the Tribunal."

This constitutes a restriction on market entry by allowing existing private hospital operators or other interested parties to appeal against a prospective operator being granted a licence, and on a successful appeal, preventing the prospective operator from entering the market.

4.2. Restrictions on Competitive Conduct

The *Hospitals Act 1918* does not contain specific provisions that prevent competitive conduct across the industry. However, the requirements under Section 65 of the Act in relation to alterations to premises may restrict the ability of an organisation to introduce new service innovation. Section 65 states:

"(1) No person shall make or cause to be made any alteration or addition to any premises in respect of which a licence is in force except in accordance with plans, specifications, and descriptions approved by the Minister.

Penalty: Fine not exceeding 5 penalty units.

(2) When the Minister approves for the purposes of subsection (1) any plans, specifications, or descriptions for the alteration of, or addition to, any premises he may notify the person holding the licence in respect of those premises, in writing, of the alterations that may be, or will have to be, made in the conditions prescribed in the licence if the alterations or additions are carried out.

(2A) The Minister may refuse to approve any plans, specifications, or descriptions for the alteration of, or addition to, any premises for the purposes of increasing bed accommodation on the ground that adequate health care facilities already exist, in the locality in which the premises are situated, to meet the present and future health care needs of persons who reside in that locality.

(3) On the completion of any alterations or additions in accordance with plans, specifications, and descriptions approved under this section, the Minister may, and if required by the licensee shall, alter the conditions specified in the licence in accordance with the notification made to the licensee under subsection (2).”

Restrictions on bed numbers in Sections 6 and 61, as previously discussed, and the need to apply for increases in bed numbers or to add additional services can also be seen as limiting competitive behaviour, especially in the area of specialty services where not all hospitals may be permitted to provide the same services, lessening the potential level of competition between hospitals.

Third party appeals have already been discussed in relation to restricting market entry but third party appeals also have the potential to restrict competitive conduct by an operator through a third party preventing or delaying an increase in bed numbers, the introduction of a new service, the upgrading of facilities, the prevention of the transfer of licences to another operator etc.

Regulations made under Section 70F also contain restrictions that may prevent competitive conduct.

4.3 Restrictions on Product and Service Innovation

The *Hospitals Act 1918* does not contain restrictions on product and service innovation.

4.4. Restrictions on the Entry of Goods or Services

There are no restrictions on the entry of goods or services contained in the *Hospitals Act 1918.*

4.5. Administrative Discretion

The legislation does admit administrative discretion that can lead to different treatment for the public and private sectors. This raises issues around competitive neutrality. Only private hospitals are regulated through the *Hospitals Act 1918*.

Public hospitals are not subject to the same transparent approval process in relation to additional beds or expanded services, though guidelines relating to bed supply have been applied administratively in the public sector and has lead to major reductions in bed numbers over recent years.

Competitive neutrality between the public and private sectors is an important principle incorporated into National Competition Policy. The objective of competitive neutrality is the elimination of resource allocation distortions arising out of public ownership of entities engaged in significant business activities: Government businesses should not enjoy any net comparable advantage simply as a result of their public sector ownership.

There are often advantages or disadvantages which affect either the public sector or the private sector which must be removed to ensure direct comparability between the public and private sectors on a "level playing field" basis.

In relation to licensing, public hospitals do not face any State Government legislative barriers to market entry, competitive conduct, or product and service innovation. However, the public sector is subject to public interest considerations, public scrutiny through freedom of information requirements and the Parliamentary process, and other administrative requirements which place limitations on its ability to compete in relation to the private sector.

In the past, competition between public and private hospitals was fairly limited, and largely confined to private patients. However, in recent times, competition has been extended to compensable patients, eligible veterans and, in some cases to competition for public patient. There are cases where the private sector could maintain that the current licensing regime may unfairly restrict competition and this must be taken into account and weighed against the public interest when considering any alternatives for regulation or deregulation of the private hospital sector.

4.6 Separation of Regulatory and Service Delivery Functions

In addition to the five restrictions on competitive conduct discussed so far a further important principle of National Competition Policy which needs to be considered is the separation of regulatory and commercial functions.

Historically, many Government agencies have been responsible for regulating the technical aspects of a particular industry as well as providing services that were subject to or affected by those regulations.

In a competitive environment, such a dual role creates a potential conflict of interest between advancing the commercial interests of the enterprise and advancing wider public interests through the exercise of regulatory powers, presenting opportunities for incumbents to misuse control over regulatory standards to frustrate the actions of actual or potential competitors.

Placing regulatory responsibilities in a Government Department may create concerns that regulatory decisions will be exercised to the benefit of the Government owned business - and hence maximise Government revenues - rather than in a more even-handed manner. A technical regulator at arm's length from Government is generally preferred.

This principle regarding the separation of regulatory and commercial functions of public monopolies may impact within the health and hospitals sector in relation to the licensing of private hospitals. Currently licensing powers reside with the Minister for Health and Human Services who also has the responsibility for service provision by public hospitals. To the extent that public and private hospitals are in competition with each other, this creates what could be perceived as a potential conflict of interest for the Minister.

Public and private hospitals already compete to at least some extent for compensable, Department of Veterans Affairs (DVA) patients and private patients and there has been a recent trend towards the open tendering of some public patient services. Where open tenders are called for service provision to public patients, public hospitals may be competing with private operators for the business of providing hospital services to public patients. This has in fact already occurred in Tasmania in the case of maternity and neonatal care at Burnie and Launceston. In one case future service provision was awarded to a private provider and in the other to the public sector bidder. To avoid potential criticism of such tender processes, clear structural splits between service provision and regulatory functions may need to be established.

To ensure the complete separation of licensing from service provision to private patients it may be necessary to remove the licensing function to an independent authority or remove the licensing requirements completely. There may be further structural alternatives to achieve the separation of service provision and regulatory functions such as clear funder/purchaser/provider splits within the Department.

To some extent, the appeals provisions within the Act do provide independent scrutiny of the Minister's decisions if an appeal is lodged. However, this may involve the appellant incurring significant financial costs to pursue an appeal.

5. OBJECTIVES OF THE CURRENT LEGISLATION

All private medical facilities are licensed through the Minister for Health and Human Services under the *Hospitals Act 1918*. The licensing of all private medical establishments in Tasmania are administered under Part III of the *Hospitals Act*.

The *Hospitals Act* defines a "private medical establishment" as:

> *"an establishment the sole or main objective, or one of the main objects, of which is, or is held out to be, the provision of accommodation (whether with or without medical or other treatment) for*
>
> *(a) persons suffering from any illness, injury, or infirmity, or from mental disorder within the meaning of the Mental Health Act 1963;*
>
> *(b) pregnant women or women immediately after childbirth;*
>
> *(c) persons who are blind, deaf, or dumb, or who are substantially and permanently handicapped by illness, injury, or congenital deformity, or by an other prescribed disability; or*
>
> *(d) persons who are aged, but does not include any establishment maintained by the State, any public hospital, any school registered under Part IV of the Education Act 1932".*

The role of the *Hospitals Act* is to provide a legal framework to ensure private facilities maintain an acceptable standard of care. Besides the *Hospitals Act*, however, there exist further legal standards developed in common law and the torts of civil negligence concerning the provision of quality service delivery and care. In brief, both legal standards concern the provision of services assessed against reasonable care expected through the standards of a profession.

The Department of Health and Human Services performs a number of functions in the area of licensing private medical facilities.

- The agency provides advice to local governments and licensees on the requirements for licensing.
- It advises the Minister about applications and other matters relating to the services provided by the private sector.
- Department of Health and Human Services staff are involved in inspections, as are local government staff as part of the building approval and health inspection procedures.

The objectives of the current Act are ambiguous but include:

- investigation of the hospital needs of Tasmanians;

- regulation of the geographic distribution of private hospital services;
- regulation of private hospital provision;
- regulation of the type of private hospital services provided;
- ensuring the safety of patients;
- ensuring adequate records are kept;
- regulation of ownership and management of private hospitals;
- ensuring the adequacy of facilities to provide the specified types of services;
- provision for closures of private hospitals to control outbreaks of infectious diseases;
- ensuring appropriate staffing levels are maintained and appropriately qualified staff are employed within private hospitals;
- ensuring quality services are provided;
- the maintenance of ongoing quality facilities (through the power to inspect premises)

The Review Group extensively considered these objectives. The current objectives were grouped under broad headings and the continued need for each of these broad objectives was extensively discussed with regard to the current and expected future role of the private hospital sector. After considerable debate, the Review Group agreed on the following four broad objectives contained within the *Hospitals Act 1918* that needed to be satisfied by any alternative to this Act. These broad objectives are:

1. protecting the safety of the public;
2. ensuring the quality of services provided;
3. ensuring the appropriate ownership of facilities;
4. making the best use of resources available.

These objectives are listed in the order of importance as established by the Review Group. The next chapter will consider how these objectives would be met by the various possible alternative options to the *Hospitals Act 1918*.

In addition to these major objectives, other useful criteria for considering the advantages and disadvantages of various alternatives to the *Hospitals Act 1918* include:

- the level of consumer choice;
- the consistent application of the option to private hospitals, private stand alone day facilities, public hospitals etc.; and
- the cost to Government and industry.

6. POSSIBLE ALTERNATIVES TO THE *HOSPITALS ACT 1918* CANVASSED IN THE REGULATORY IMPACT STATEMENT

6.1 Current Situation

The present model for regulating the private hospitals is through a licensing act (the *Hospitals Act 1918*) with the Minister for Health and Human Services administering the Act. Although the Act does allow the Minister to restrict bed numbers, in practice no restrictions have been applied in recent times. The provision of services by private hospitals is only restricted where the Minister considers there is an insufficient critical mass available to support a specialty service in a particular geographical area.

6.2 Some Possible Alternatives

In undertaking this review, the Review group considered a broad range of possible options that could be applied to the private hospital sector. These ranged from a fully deregulated model, industry self-regulation, regulation by the ombudsman, "negative licensing", licensing by the Minister through legislation, or licensing by an independent body. For the last two items, sub-options were developed which considered a licensing regime with and without explicit caps on bed numbers. These are but a few of a number of possible licensing models that may be considered but all potential models for future alternatives to the *Hospitals Act* would fall somewhere on the continuum between these options.

The various options were released for public comment. The details of these options were as follows:

OPTION 1 - A Fully Deregulated Model

This option would involve total State deregulation of the private health care sector. Under this option the current State legislation would be repealed and no alternative regulatory model would replace it. However, the current Commonwealth Government controls on the issue of provider numbers for private hospitals before health benefits are paid by funds would remain, as would Commonwealth regulation with regard to service quality.

The costs and benefits of this option are outlined in the following table. The principle difficulty in assessing the costs and benefits is that in most instances they have not or cannot be quantified. However, the Review Group does not believe that this prevents these costs and benefits being identified and an assessment made of the net cost or benefit.

Advantages	Disadvantages
Increased consumer choice.	No State based controls to ensure that an appropriate quality and standard of health care is provided. This may result in a substandard quality of care by some participants in the market.
Possible decrease in the cost of private hospital stays and a resultant reduction in private health insurance costs - reduced costs to consumers.	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised without regulation.
No restrictions on bed numbers or services. Allows market forces to determine the appropriate level of bed provision. No approval process to offer a new service. Therefore no restrictions on competitive conduct. May result in more innovative practices by some participants in the market.	No control over service provision or distribution. Focus on public/private service mix poor. May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
The legislation cost of market entry is nil.	No controls over who enters the market.
The Tasmanian Government would save the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	Reliance on costly litigation to ensure public health and safety. This will usually be reactive and may require a major error such as a patient death prior to any action being taken. Poor protection of consumers from unsafe procedures/practices
Private hospitals would be saved the administrative costs associated with complying with regulation, including the paperwork burden and cost of licence fees.	There is an information asymmetry between buyers and sellers as it is difficult for consumers to acquire equivalent technical knowledge prior to purchase, e.g. neurosurgery. Without some independent controls consumers would not be able to have confidence in the service provided.
Lowers barriers to entry.	No price watch.
Removes the problem of captured regulation (either by Government or industry).	No mandatory global benchmarks or quality standards. No quality control.
Removes the overlapping responsibilities between State and Commonwealth Governments.	No monitoring system to ensure compliance with standards. Limited Commonwealth controls in relation to facilities that wish to charge health funds for the treatment of their contributors.
Removes the difference in regulation between private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres by deregulating the entire sector.	No controls over the introduction of high technology. Different regulatory regimes may apply to the public and private sectors.

Initial Conclusion of the Review Group put forward for public comment

This model does not meet any of the major objectives of protecting the safety of the public, ensuring the quality of services provided, ensuring the appropriate ownership of facilities or making the best use of resources available.

It does treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner, and is likely to increase consumer choice but at the same time it removes any consumer protection.

While removing the cost of compliance to industry and the cost of enforcing compliance from Government, it is likely to lead to Government, industry and consumers becoming involved in costly litigation.

Deregulation may be an option for some aspects of management of the private hospital sector. Provided appropriate quality and safety standards are met, Governments do not necessarily need to be involved in maintaining controls on hospital bed numbers. This could be left to market forces to determine. However, this may not be the best way to optimise the use of resources and ensure a good geographical distribution of services at all times.

Because this model does not ensure the safety of the public and provides no controls to ensure service quality it is not recommended.

OPTION 2 - Self Regulation

This option involves industry specifying the appropriate actions or procedures that may be appropriate. This may be in the form of a Code of Practice or agreement between industry members that would be developed via a consultative process between all interested parties. The private hospital system for example, could undertake self regulation through compliance with agreed industry standards.

Advantages	**Disadvantages**
Private hospitals would be saved the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees. However, there would be still some costs associated with administering any industry scheme.	Compliance could be low if a sense of commonality amongst those affected is not present.
Increased consumer choice.	The cost of non-compliance is very high.
Possible decrease in the cost of private hospital stays and a resultant reduction in private health insurance.	Industry codes of practice or agreements could be used to promote anti competitive behaviour by setting too stringent conditions of entry, benefiting those already in the industry.

Advantages	Disadvantages
This option would utilise the expertise of the industry in the formulation of any code or agreement. It provides a market solution for the regulation of ethical behaviour.	May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
May result in more innovative practices by some participants in the market, particularly in performance based.	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised under industry self regulation.
The Tasmanian Government would save the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	There are no legal remedies for breaches of any code or agreement. There will therefore be a reliance on costly litigation to ensure public health and safety. This will usually be reactive and require a major error such as a patient death prior to any action being taken.
May result in higher compliance without resorting to penalties as industry participants develop the regulatory framework.	No controls over the introduction of high technology. Different regulatory regimes may apply to the public and private sectors.
Greater flexibility to change the regulation if it is not enshrined in legislation.	
Removes the conflict of interest between the Government as regulator and service provider.	
Barriers to entry are low.	

Initial Conclusion of the Review Group put forward for public comment

This model does treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner, and is likely to increase consumer choice but at the same time it weakens consumer protection.

While removing the cost of enforcing compliance from Government, the cost of compliance to industry to a voluntary code may still be substantial. A voluntary code of conduct raises issues in the case of non-compliance. It would be difficult to enforce penalties to ensure compliance or remove a non -compliant operator from the industry. This model therefore has weaknesses in ensuring the major objectives of protecting the safety of the public, ensuring the quality of services provided, ensuring the appropriate ownership of facilities or making the best use of resources available.

The interests of industry participants may not be the same as the interests of the community. Governments have historically accepted responsibility for ensuring the community interests are protected. Australian communities in particular have regarded intervention in health matters to be an important role of government.

Self-regulation may be an option for some aspects of management of the private hospital sector. Provided appropriate quality and safety standards are met, Governments do not necessarily need to be involved in limiting bed numbers and this could be left to the industry to determine. However, there is a danger that existing operators could make it difficult for new operators to enter the market to protect their existing investment.

In general, self-regulation is an inappropriate option for the management of the private hospital sector because of the concerns about public safety.

OPTION 3 - Regulation by the Ombudsman/Health Complaints Commissioner

This option proposes that the Ombudsman's Office/Health Complaints Commission should be responsible for the regulation of the private hospital sector through investigation of complaints and making recommendations to service providers to improve services subject to complaint. Existing State legislative controls would be removed.

Advantages	**Disadvantages**
No restrictions on bed numbers or services. Allows market forces to determine the appropriate level of bed provision. No approval process to offer a new service. Therefore no restrictions on competitive conduct. May result in more innovative practices by some participants in the market.	No control over service provision or distribution. Focus on public/private service mix poor. May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
The legislation cost of market entry is nil.	No controls over who enters the market.
Lowers barriers to entry.	No price watch
Removes the problem of captured regulation (either by Government or industry).	No global benchmarks or quality standards. No quality control
The Tasmanian Government would save some of the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	There are no legal remedies for breaches of any code or agreement. There will therefore be a reliance on costly investigation and recommendations without legislative backing to ensure public health and safety. This will usually be reactive and require a major error such as a patient death prior to any action being taken. This is likely to give control by the Ombudsman/Health Complaints Commissioner a low community acceptance, as remedying an error after a mistake that could cost a human life is unlikely to be considered appropriate.
Removes the overlapping responsibilities between State and Commonwealth Governments.	No monitoring system to ensure compliance with standards

Advantages	Disadvantages
Possible decrease in the cost of private hospital stays and a resultant reduction in private health insurance costs - reduced costs to consumers.	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised without regulation.
Removes the difference in regulation between private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres by deregulating the entire sector.	No controls over the introduction of high technology. Different regulatory regimes may apply to the public and private sectors.
Private hospitals would be saved the administrative costs associated with complying with regulation, including the paperwork burden and cost of licence fees.	There is an information asymmetry between buyers and sellers as it is difficult for consumers to acquire equivalent technical knowledge prior to purchase, e.g. neurosurgery. Without some independent controls consumers would not be able to have confidence in the service provided.
Increased consumer choice.	No monitoring system to ensure compliance with standards. Limited Commonwealth controls in relation to facilities that wish to charge health funds for the treatment of their contributors.

Initial Conclusion of the Review Group put forward for public comment

This model does treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner, and is likely to increase consumer choice but at the same time it weakens consumer protection.

While removing the cost of compliance to industry and the cost of enforcing compliance from Government, it is likely to lead to Government, industry and consumers becoming involved in costly investigation and in potential litigation arising from unresolved complaints.

It would be difficult to enforce penalties to ensure compliance or remove a non - compliant operator from the industry, as the Ombudsman/Health Complaints Commissioner would have the power to report to parliament and recommend changes but would not have powers of enforcement. This model therefore has weaknesses in ensuring the major objectives of protecting the safety of the public and ensuring the quality of services provided

Appropriate ownership of facilities or making the best use of resources available would also not be controlled under this option.

The option is reactive, as it is dependent on complaints being made. There are two major problems with this approach in relation to public safety. Firstly, the damage has been done before action can be taken to correct the problem and secondly, consumers may not make complaints either through a fear of retribution, insufficient knowledge

of complaints procedures or through insufficient knowledge of clinical procedures and the expected outcomes.

In general, regulation by the Ombudsman/Health Complaints Commissioner is an inappropriate option for the management of the private hospital sector because of the concerns about public safety and ensuring quality services are provided.

OPTION 4 - Negative Licensing

Essentially, negative licensing enables a person to undertake an activity provided they comply with relevant statutory provisions. In the event that they fail to comply, they are prohibited, or negatively licensed, from continuing to provide that service, if necessary, for life.

This option is designed to ensure that individuals or companies that have demonstrated by their prior action that they are incompetent or irresponsible are precluded from operating in a particular industry. This option ensures that individuals and firms with certain characteristics are removed from the industry without, at the same time, placing an undue burden of registration on the entire industry.

Advantages	**Disadvantages**
Private hospitals would be saved the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees.	As no screening occurs the number of inappropriate participants initially entering the market may be higher than under a legislation process.
The easing of restrictions on market entry may result in an increased number of operators entering the market and hence lead to increased consumer choice.	Some agents may be able to operate undetected or act inappropriately before they are detected. Licence removal will only occur after the detection of a breach.
Possible decrease in the cost of private hospital stays and a resultant reduction in private health insurance.	Enforcement activities may need to be increased, thereby increasing monitoring costs.
Dominant industry bodies can not seek to restrict competition by setting too stringent conditions of entry.	May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
May result in more innovative practices by some participants in the market.	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised under industry self regulation.
The legislated costs of entry are low.	There is no control over service distribution or public/private service mix.

Advantages	Disadvantages
The Tasmanian Government would save some of the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	There are no legal remedies for breaches of any code or agreement. There will therefore be a reliance on costly litigation to ensure public health and safety. This will usually be reactive and require a major error such as a patient death prior to any action being taken. This is likely to give negative licensing a low community acceptance as remedying an error after a mistake that could cost a human life is unlikely to be considered appropriate.
Barriers to entry are low.	

Initial Conclusion of the Review Group put forward for public comment

This model does treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner, and is likely to increase consumer choice but at the same time it weakens consumer protection.

While removing the cost of routine procedures for enforcing compliance from Government, it is likely to still have high compliance costs for industry.

Negative licensing assumes that all operators possess the same competence to manage private hospitals. This approach may be acceptable for other, low risk activities, such as pawn broking. However, the possible consequence of waiting for detection of a breach involving high risk private hospital activities is somewhat analogous to waiting for a disaster to occur, and then legislating to correct it.

Negative licensing is reactive, relying heavily on detection through inspection, and therefore does not provide the range of 'intervention' opportunities required to minimise risks across the private hospital sector.

On the other hand, positive, co-operative approaches are justified for managing private hospital safety issues because: breaches of standards are often very difficult to identify, the cost of mistakes is very high - the cost to society of waiting for a breach to occur before taking action is a significant detraction to adopting a reactive approach initial mistakes are costly to businesses to rectify subsequently - a positive approach prevents business inadvertently establishing premises or process that subsequently create hazards and which require high cost adjustments to bring into compliance. This not only saves businesses' money from avoiding mistakes, but also encourages ongoing compliance as the cost of doing so is much lower

Reliance on negative licensing is not preventative and to be effective, would rely mainly on labour intensive and expensive inspections. Nowadays, State and local governments are not resourced to undertake sufficient inspections to provide the level of protection advocated by a negative licensing approach.

There is also a concern that full reliance on an inspection-based approach could expose Councils and the State Government to increased liability under the general duty of care principles. This is particularly significant in the event of a serious incident where a lack of 'adequate' resources may result in insufficient inspections being undertaken.

This model therefore has weaknesses in ensuring the major objectives of protecting the safety of the public and ensuring the quality of services provided.

Appropriate ownership of facilities or making the best use of resources available would also not be well controlled under this option.

In general, negative licensing is an inappropriate option for the management of the private hospital sector because of the concerns about public safety and ensuring quality services are provided.

6.3 Legislative Options

In looking at the following two options, it is important to distinguish between safety regulation and economic regulation:

- safety regulation includes controls over the skill and integrity of the hospital operator and over hospital quality, while

- economic regulation includes controls over hospital numbers and setting maximum charges.

Based on the net costs of the previous three options, it is considered that safety regulation is necessary. The question is what is the most efficient way to achieve it? Safety and quality concerns can be met by requiring hospital standards to be met and ensuring that all operators are "fit and proper" persons.

OPTION 5 - Licensing for quality with the Government as the Regulator

A. No prescriptive controls on bed numbers

This option proposes the licensing of hospitals (including day surgery units) by the Government in order to ensure patient safety. Appropriate incentives/penalties would need to be factored into this model to ensure compliance. The regulation would also be performance based rather than the traditional prescriptive input controls. This option does not include restricting numbers based on the Government's ability to determine what is the optimum size of the market. In practice, this is the current model of regulation.

Advantages	Disadvantages

Advantages	Disadvantages
Appropriate penalties would be available to ensure compliance.	Private hospitals would be required to pay the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees, based on full cost recovery.
This option may provide a dispute resolution mechanism through an independent arbitrator such as the ombudsman.	Increased cost of administration would flow through into increased costs for patients.
All day surgery units would be operating on the same basis, i.e. those operating within hospitals would not be at a competitive disadvantage.	Potential to result in decreased consumer choice and a reduction in innovation.
Consumers can have confidence that they are receiving a quality service, despite the information asymmetry inherent in the market.	The Government as regulator would have a conflict of interest in that it would be regulating its competitors in some markets. This is not consistent with the policy of separating the regulatory and service delivery functions of government.
	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised with only controls on quality.
Patient safety and quality of service would be protected through compliance with appropriate quality standards. This approach would be proactive.	The Tasmanian Government would be required to fund the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.
Enforceable quality standards would apply.	May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
Controls over who enters the market	Barriers to entry are high.

Initial Conclusion of the Review Group put forward for public comment

This option has substantial benefits and would amount to a modernising and tidying up of the current *Hospitals Act 1918*. However, this model, like the current legislation, has high compliance costs for industry and high administrative and inspection costs for Government.

This model meets the major objectives of protecting the safety of the public, ensuring the quality of services provided and ensuring the appropriate ownership of facilities. It does not necessarily optomise the use of resources, as these would only be controlled by market forces. This could result in costly duplication and the division of

expertise that could impact on quality. It also does not necessarily result in the best geographical distribution of services.

This framework could be designed to treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner. However, the option has high compliance costs for government and industry.

Despite these disadvantages, this model contains enough benefits to be a workable model that meets most major objectives and most secondary selection criteria. In effect it virtually amounts to the current status quo but with a changed emphasis from facilities and equipment to the quality of service provision. However, this model does raise the issue of a potential conflict of interest. This arises because the Department of Health and Human services would be both the regulator of the private hospital sector and, as a provider of hospital services to private, compensable and DVA patients, a competitor to the private hospital sector. It is a core principle of National Competition policy that where Government has the responsibility for regulation and service provision responsibilities these should be clearly separated.

The right of appeal to an independent appeals body potentially provides a mechanism whereby a Government decision can be challenged and overturned ands a conflict of interest thus negated. However, this can only be achieved through a potentially long and expensive appeals process. It would be preferable if any potential conflict of interest could be removed from the original administrative decision rather than just allowing the decision to be challenged through an appeals process.

B. Prescriptive controls on bed numbers

This option proposes the licensing of hospitals (including day surgery units) by the Government in order to ensure patient safety. Appropriate incentives/penalties would need to be factored into this model to ensure compliance. The regulation would retain and extend the traditional prescriptive input controls. This option does include restricting numbers based on the Government's ability to determine what is the optimum size of the market.

Advantages	**Disadvantages**
This option may provide a dispute resolution mechanism through an independent arbitrator such as the ombudsman.	Increased cost of administration would flow through into increased costs for patients.
All day surgery units would be operating on the same basis, i.e. those operating within hospitals would not be at a competitive disadvantage.	Potential to result in decreased consumer choice and a reduction in innovation.
Consumers can have confidence that they are receiving a quality service, despite the information asymmetry inherent in the market.	The Government as regulator would have a conflict of interest in that it would be regulating its competitors in some markets. This is not consistent with the policy of separating the regulatory and service delivery functions of government.

Advantages	Disadvantages
Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This could be effectively ensured through the approval process.	Public and private sector special interest groups and /or existing private operators may be able to influence the outcomes of decisions on whether new entrants be accepted into the market and what services a private operator may provide.
Ensuring the fragmentation of services does not occur may lead to economies of scale in service provision and to a reduced cost for services.	Limiting market entry to provide services may restrict competition and thus increase the costs of services to consumers.
Patient safety and quality of service would be protected through compliance with appropriate quality standards. This approach would be proactive.	The Tasmanian Government would be required to fund the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.
Appropriate penalties would be available to ensure compliance.	Private hospitals would be required to pay the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees, based on full cost recovery.
Government would have effective control over service distribution and public/private mix.	Barriers to entry are high.
	Likely to create a market in bed licences. The additional costs to private hospitals for the market value of bed licences would be passed through as an additional cost to consumers.

Initial Conclusion of the Review Group put forward for public comment

This model meets the major objectives of protecting the safety of the public, ensuring the quality of services provided and ensuring the appropriate ownership of facilities. It does also provide for some optomisation of the use of resources by controlling bed numbers and distribution.

This framework could be designed to treat private hospital facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner. However, the option has high compliance costs for government and industry.

This option would constitute a more restrictive licensing regime than that contained in the current *Hospitals Act 1918* as this Act, while allowing the Minister to restrict bed numbers on the basis of sufficient services being available in a geographic area, has not been applied in such a way as to provide an explicit cap on bed number approvals. Some other States, notably Victoria, New South Wales and South Australia have applied explicit bed caps with the result that a market has been created in bed licences. This has occurred because new licences were not being issued and so a new private hospital or an existing private hospital seeking to expand could only gain bed licences by inducing another private hospital to relinquish some bed licences.

Victoria estimated that the average price paid per bed licence was around $25,000, giving a paper value of around $160 million for Victorian private hospital beds. The States with explicit bed caps are faced with a problem in attempting to remove the bed caps, as this action would result in a write down in the value of the private hospital sector. For Victoria alone the value of the writedown would be $160 million. This could well create problems for private hospitals as the valuation of private hospitals in these States is based on the paper value of the licences as well as the valuation of the hospital building and equipment. A writedown in the value of licences through the removal of the bed cap would constitute a loss in value for private hospitals.

Tasmania does not have the problem of having created a market in bed licences and reform of the licencing arrangements should avoid creating such a market due to the difficulties of later trying to remove the market. There are no compelling arguments for regulating numbers of private hospital bed licences except in specialty areas where a critical mass of patients is required to ensure optimisation and maintenance of skills and the ability to recruit and retain suitably qualified staff. Unless the capping of bed numbers is confined to specialty areas, this option is not considered a viable option. The same arguments around a conflict of interest on the part of Government also apply as for option 5A.

OPTION 6 - Licensing for quality with an Independent Regulator

A. No prescriptive controls on bed numbers

This option proposes the licensing of hospitals (including day surgery units) by an Independent Regulator established to ensure patient safety. Appropriate incentives/penalties would need to be factored into this model to ensure compliance. This does not include restricting numbers based on an independent regulator's ability to determine what is the optimum size of the market.

Advantages	**Disadvantages**
Appropriate penalties would be available to ensure compliance.	The costs of establishing an independent regulator may be greater than the Government as regulator option due to economies of scale. This may flow through to a marginal increase in licence fees.
This option may provide a dispute resolution mechanism through an independent arbitrator such as the ombudsman.	Increased cost of administration would flow through into increased costs for patients.
Any conflict of interest between the regulator and the service delivery components would be removed.	Decreased consumer choice and a reduction in innovation.
The Tasmanian Government would save the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This may be compromised with only controls on quality.

Advantages	Disadvantages
All day surgery units would be operating on the same basis, i.e. those operating within hospitals would not be at a competitive disadvantage.	May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
Patient safety and quality of service would be protected through compliance with appropriate quality standards. This approach would be proactive and wouldn't be dependent on someone dying before any action could be taken.	Private hospitals would be required to pay the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees, based on full cost recovery.
Consumers can have confidence that they are receiving a quality service, despite the information asymmetry inherent in the market.	Barriers to entry are high.

Initial Conclusion of the Review Group put forward for public comment

This option has substantial benefits as well as significant costs and would form a reasonable basis for an alternative to the current *Hospitals Act 1918*.

This model meets the major objectives of protecting the safety of the public, ensuring the quality of services provided and ensuring the appropriate ownership of facilities. It does not necessarily optomise the use of resources, as these would only be controlled by market forces. This could result in costly duplication and the division of expertise that could impact on quality. It also does not necessarily result in the best geographical distribution of services.

This framework could be designed to treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner. However, the option has high compliance costs for government and industry.

It has the additional advantage over option 5A of separating the regulatory and service delivery functions by transferring the regulatory function to an independent body.

Despite some disadvantages, this model contains significant benefits and would be a workable model that meets the major objectives and most secondary selection criteria.

B. Prescriptive controls on bed numbers

Regulation of private and public sector facilities and services by a body applying prescribed standards to location, bed numbers, range of services etc. This option proposes the regulation of private and public sector facilities and services by a body applying prescribed standards to location, bed numbers, range of services etc. This option does include restricting numbers based on the body's ability to determine what is the optimum size of the market.

Advantages	Disadvantages

Advantages	Disadvantages
Patient safety and quality of service would be protected through compliance with appropriate quality standards. This approach would be proactive and wouldn't be dependent on someone dying before any action could be taken.	Private hospitals would be required to pay the administrative costs associated with complying with Government regulation, including the paperwork burden and cost of licence fees, based on full cost recovery.
Appropriate penalties would be available to ensure compliance.	The costs of establishing an independent regulator may be greater than the Government as regulator option due to economies of scale. This may flow through to a marginal increase in licence fees.
This option may provide a dispute resolution mechanism through an independent arbitrator such as the ombudsman.	Increased cost of administration would flow through into increased costs for patients.
Any conflict of interest between the regulator and the service delivery components would be removed.	Decreased consumer choice and a reduction in innovation.
The Tasmanian Government would save the cost of regulating the private hospitals sector, approx. $5,000-10,000 per annum.	Likely to create a market in bed licences. The additional costs to private hospitals for the market value of bed licences would be passed through as an additional cost to consumers.
All day surgery units would be operating on the same basis, i.e. those operating within hospitals would not be at a competitive disadvantage.	May impose additional costs on the Government through a removal of the current cross subsidy between public and private patients if some services are offered in both the public and private system, e.g. cardiac surgery.
Consumers can have confidence that they are receiving a quality service, despite the information asymmetry inherent in the market.	Barriers to entry are high.
Some specialist services require a certain volume to reach and maintain a satisfactory level of competence and quality. This could be effectively ensured through the approval process.	Public and private sector special interest groups and /or existing private operators may be able to influence the outcomes of decisions on whether new entrants be accepted into the market and what services a private operator may provide.
Ensuring the fragmentation of services does not occur may lead to economies of scale in service provision and to a reduced cost for services.	Limiting market entry to provide services may restrict competition and thus increase the costs of services to consumers.
There would be independent effective control over service distribution.	There would potentially be no focus on public/private service mix.

Initial Conclusion of the Review Group put forward for public comment

This model meets the major objectives of protecting the safety of the public, ensuring the quality of services provided and ensuring the appropriate ownership of facilities. It does also provide for some optomisation of the use of resources by controlling bed numbers and distribution.

This framework could be designed to treat private hospitals, facilities leased by third parties within private hospitals and private stand alone day procedure centres in the same manner. However, the option has high compliance costs for government and industry.

It has the additional advantage over option 5B of separating the regulatory and service delivery functions by transferring the regulatory function to an independent body.

The same arguments apply to this model as for option 5A in terms of the effect of an explicit bed cap in creating an undesirable market in hospital bed licences. Unless the capping of bed numbers is confined to specialty areas only, this option is not considered a viable option.

7. OTHER ISSUES CANVASSED IN THE REGULATORY IMPACT STATEMENT

The following initial conclusions of the Review Group were also put forward for public comment:

7.1 Scope of any Future Regulatory Regime

As noted in section 2.1.1, having different standards for stand alone day procedure centres to those applying to day procedure units in private hospitals creates an obvious inconsistency.

The current regulatory regime under the *Hospitals Act 1918* only covers private hospitals providing overnight accommodation. Should full deregulation apply, then private hospitals would be treated the same way as private day only facilities are currently treated, i.e. outside any regulatory control.

For any other regulatory option, the issue of coverage arises as the decision will need to be made as to whether any proposed regulation should only cover private hospitals providing overnight accommodation or also extend to stand alone private day hospitals.

There is a strong argument the same regulatory regime should apply to private hospitals and private day procedure centres as these facilities provide the same types of services and compete with each other for the same patients. To provide a different regulatory regime to day procedure units in private hospitals as to that applying to private day procedure centres could result in a competitive advantage being obtained by one group of facilities over the other.

7.2 Third Party Use

As noted in section 2.1.3, the establishment within private hospitals of facilities that may be owned and/or maintained by third parties has been a noticeable recent trend which creates problems in relation to licensing as the current *Hospitals Act* only covers services provided by the licensee and does not cover services provided by others who lease rooms and facilities within the hospital.

If the option of deregulation were pursued, then services provided by third parties would not be an issue. However, for other regulatory options, to overcome these third party facilities within private hospitals, it should be the responsibility of the private hospital to ensure third parties supplying services on behalf of the hospital meet the standards required for private hospitals.

7.3 Public Hospitals

As noted in Section 2.1.4, the licensing regime as outlined in the *Hospitals Act 1918* does not have any legislative equivalent in relation to public hospitals.

However, although public and private hospitals do undertake similar activities, there are significant differences in the regulatory arrangements applied to the public and private sector and the level of competition between the two sectors is limited.

The public health sector has the responsibility for the treatment of public patients, and through agreement to the Medicare Principles, States have the responsibility for all patients who wish to elect to be public patients to receive services free of charge and are to make public patient services universally accessible. Given these requirements enshrined in legislation through both the *(Commonwealth) Health Insurance Act 1973* and the *(Tasmanian) Health Act 1997*, any restrictions on market entry for public hospitals would be inappropriate. Public hospitals already service rural and isolated areas where a private hospital would not be viable financially.

To examine whether restrictions on competitive conduct which were to apply to private hospitals should also apply in relation to public hospitals, it is necessary to examine the extent to which private and public hospitals compete for patients and the nature of the market. State Governments can either provide services to public patients directly or purchase services for public patients from the private sector. This decision will be based on how a State Government can best meet its obligations under the Medicare Principles and there is not normally a free market for public patient services. Although outsourcing of public patient services from private hospitals is a growing trend, it still only accounts for just over 8% of all public patient services in Tasmania.

With regard to private patients, health funds will pay for the costs of hospital care at a public or a private hospital, dependent on where their contributors present for treatment. In 1996/97 around 87% of Tasmanian private patients were treated in private hospitals. Over time the trend has been for private patients to increase their utilisation of private hospitals at the expense of public hospitals. This trend has occurred even though there is a price distortion in the market through the Commonwealth regulation of the private health insurance sector where funds are only obliged to pay public hospitals less than half what they are obliged to pay private hospitals.

Department of Veterans Affairs patients are split relatively evenly between public and private hospitals. In 1996/97 private hospitals had 45% of the market for veterans' hospital care and public hospitals 55%. The trend in recent years has been towards private hospitals. The Department of Veterans Affairs is moving towards becoming a full economic purchaser of services for veterans and so there is a competitive market in relation to services for veterans. However, in 1996/97 DVA patients only accounted for around 9% of private hospital separations and around 6% of public hospital separations.

Compensable patients (patients whose illness or injury is the subject of workers compensation or Motor Accident Insurance Board payments) also are treated in both public and private hospitals. In 1996/97 private hospitals had around 70% of the market for compensable patient care and public hospitals 30%. The trend in recent years has been towards private hospitals. However, in 1996/97 compensable patients only accounted for around 6% of private hospital separations and around 1.5% of public hospital separations.

The extent of unfettered competition between public and private hospitals is limited to compensable and DVA patients who account for 15% of private hospital

separations and 7.5% of public hospital separations. Applying the same regulatory regime to private and public hospitals is not justified on the extent of the market competition. However, it should be incumbent on the State Government to ensure competitive neutrality applies to the maximum extent possible when the public sector competes with the private sector. Recent decisions by State Treasury to remove payroll tax exemptions for public hospitals and transfer responsibility for workers compensation, medico-legal liabilities, insurance and superannuation contributions to public hospitals have been major steps towards competitive neutrality.

The one remaining concern in relation to competitive neutrality is ensuring that being required to meet more stringent requirements in terms of service standards and quality than public hospitals does not disadvantage private hospitals. This could be done by the State requiring its hospitals to seek accreditation and by issuing guidelines for service standards which mirror the quality standards placed on the private sector, but given the overriding responsibility of the State to provide services for public patients it is not considered appropriate to apply restrictions on the introduction of new services to the public sector.

7.4 Licence Fees

As mentioned in section 2.6, an important issue is the low level of Tasmanian licence fees. Tasmania's fees are $20 for a new licence and $10 for a renewal or amendment of an existing licence. This compares with the fees for other States/Territories shown in Table 6.1. Tasmania is clearly out of step with other States and the fees charged are inadequate to cover the cost of regulation.

In any alternative to the *Hospitals Act 1918*, involving the licensing of private hospitals, the fees charged should cover the costs of regulation. This is an especially important principle if an independent body was to be formed to regulate private hospitals as any such new body would be expected to be largely self funded through charging for services provided.

On the basis of the current procedures, the renewal of licences involves around a total of 3 working days total for the 11 private hospitals. The processing of new licences or variations to existing licences would generally involve 3 working days per application (around 3 per annum) and is also likely to include an inspection (by several persons with specialist expertise) of the facility and the preparation of an inspection report totaling a further 3-4 working days per facility. Tasmania currently does not undertake annual or random inspections of facilities, even though the Hospitals Act 1918 provides the powers to conduct inspections of premises. If annual or random inspections were introduced, then the fees needed to cover the cost of inspections would need to be consequently higher.

It is estimated that the minimum amount needed to cover the basic costs of licensing (excluding the costs of amending legislation, drafting new standards etc.) is around $5,000 per annum and would be a minimum of $10,000 per annum if annual or random inspections of facilities was introduced. Based on the approximate current number of private hospitals, fees of the order of $500 to $1000 per facility would be required to meet basic licensing costs.

This represents a huge increase on current fees but would bring Tasmania into line with most other States. In terms of the total costs of running a private hospital, increased fees of the order proposed would not represent a major impost.

Table 7.1 Licensing Fees for Private Hospitals

State/Territory	Licensing Fees					
	Approval in Principle or Approval of premises	Issue of new Licence	Renewal	Annual Fee	Transfer	Variations
New South Wales	X	$610	X	$1115- $4210*	$610	X
Victoria	$504	$441	$504	$477.50 plus $3.15 per bed	$378	$126
Queensland	$223	$223	$57	X	X	X
Western Australia	$60	$1100	$100	X	N/A	X
South Australia	X	$126.50	$126.50	X	$20	X
Australian Capital Territory	X	X	X	X	X	X
Northern Territory	X	+	X	X	X	X
Tasmania	X	$20	$10	X	$10	$10

* For private hospitals there is a sliding scale dependent on bed numbers - day surgeries pay a flat fee of $1115.
\+ Fee determined by the Minister when applicable.

8. SUMMARY OF THE CONSULTATION

Submissions in response to the Regulatory Impact Statement were received from the following organisations:

Australian Council on Healthcare Standards (ACHS);
Australian Institute of Surveyors, Tasmanian Chapter;
Australian Medical Association (AMA);
Australian Society of Anaesthetists Inc, Tasmanian State Committee;
Commonwealth Department of Health and Aged Care;
Department of the Premier and Cabinet (DPAC);
Hobart Clinic;
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG);
Royal College of Nursing Australia;
St Luke's Health Insurance;
Tasmanian Private Hospitals Association (TPHA).

The major issues identified by respondents to the Regulatory Impact Statement were:

Scope of the licensing regime;
The need for independence in regulation and how this might be achieved and funded;
Application of regulation to the public sector;
Restrictions on market entry/capping of bed numbers;
The basis of regulation;
Fees; and
Third party ownership of facilities in private hospitals;

A summary of the issues raised by each respondent is shown in Table 8.1

8.1 Scope of the licensing regime

This was the issue of what types of facilities should be covered by regulation. There was basic agreement from respondents who addressed the issue that regulation should be extended to cover stand alone day facilities as well as private hospitals.

One respondent suggested that the scope of regulation should include birthing centres and that consideration should be given to regulating home births while another respondent suggested that all potentially harmful procedures or treatments including laser treatments should be regulated. A single submission also commented on the need for licensing to be flexible to meet future changes in health services delivery.

8.2 The need for independence in regulation and how this might be achieved and funded

Most respondents supported the separation of the private hospital regulatory and public hospital service provision functions within DHHS. However, the cost to the industry of a fully independent regulator was also an issue identified by a number of respondents.

The ACHS submission noted that the ACHS could play a major role as an independent regulator. St Luke's Health Insurance suggested a regulatory body with representation from government and the private sector with independent representation (such as the state Ombudsman) if required. The Australian Society of Anaesthetists saw the need for an impartial body that represented the interests of all parties in a fair and equitable manner. The Commonwealth Department of Health and Aged Care noted that the minimisation of any conflict of interest within the Department of Health and Human Services by the separation of private hospital licensing and public hospital service delivery functions was an important issue. However the submission suggested that this could be achieved by clear funder/purchaser/provider splits within the Department as well as by a separate regulator.

The RANZCOG submission raised concerns about the cost to private hospitals of an independent regulator as these costs would be passed through to health funds and then through to consumers by increased private health insurance premiums. This would adversely affect the attractiveness of private health insurance. The TPHA submission also raised concerns around the costs of regulation and that these costs would be passed through to consumers. It recommended that the Review Group more fully explores this issue and produce detailed costings. DPAC also raised concerns about the cost effectiveness of independent regulation.

8.3 Application of regulation to the public sector

Only four of the respondents directly addressed this issue. The Australian Society of Anaesthetists felt that all hospitals, both public and private, should be subject to the same regulative process. The Royal College of Nursing observed that this was required for competitive neutrality. The TPHA agreed that the public and private sectors should be subject to the same regulative process in relation to quality and preserving a minimum volume of activity but that it should not extend to fees charged for private patients.

The DPAC submission recognised the limited nature of the competition between the public and private sectors and therefore did not see the need for the public and private sectors to be subject to the same regulative process. However, the submission observed, that in the interests of competitive neutrality, public hospitals should at least be required to be accredited.

8.4 Restrictions on market entry/capping of bed numbers

From the submissions received, this is the most contentious issue. Some respondents wanted the Government to maintain strict controls over the bed supply for all beds, rather than the RIS preferred option of only limiting the bed supply where there were issues of critical mass in relation to specialty services, while other respondents supported the notion of no prescriptive controls on bed numbers

RANZCOG, DPAC and the Commonwealth Department of Health and Aged Care opposed limits on market entry. The DPAC submission observed that there should not be controls over matters that do not impinge on public safety and quality of service. The Commonwealth Department of Health and Aged Care observed that there was no net public benefit in limiting the availability of beds.

The AMA, the Hobart Clinic, the TPHA, the Royal College of Nursing and St Luke's Health Fund put the contrary view. The Hobart Clinic raised arguments around critical mass to support restrictions on market entry and that the removal of controls on bed numbers would lead to overbedding in the private sector. The submission concluded that controls on bed numbers would contribute towards rational service planning and more efficient allocation of resources and reduced costs.

The Royal College of Nursing supported restrictions on market entry to allow government to regulate the private hospital sector to ensure the quality of services and the safety of consumers. Restrictions should include the suitability of the licensee, the suitability of the facility and the type of service provision to be undertaken. It also supported restrictions on specialty service provision to ensure a critical mass. The submission also observed that in health care, supply induces demand.

St Luke's suggested that regional bed caps should apply and that bed licences should be site specific and not transferable. This would avoid overbedding within a region but would also help prevent the development of a market in bed licences and would also protect the investment of existing providers.

St Luke's and the TPHA both asserted that overbedding would lead to increased costs to consumers. The TPHA submission also called for the allocation of bed licences on the basis of an overall health services plan for the State and on the basis of clear planning guidelines. The TPHA also supported the option of non transferable bed licences to prevent the development of a market in bed licences. The submission argued that restrictions on bed numbers were necessary to ensure appropriate service volumes at a facility and therefore ensure appropriate service quality. The submission therefore contended that the restriction of bed numbers was justifiable in the public interest.

The ACHS, Australian Institute of Surveyors and Australian Society of Anaesthetists submissions did not specifically address this issue.

8.5 The basis of regulation

The RIS proposal to regulate on the basis of quality was supported by the submissions from the ACHS, the Commonwealth Department of Health and Aged Care, DPAC and the TPHA. These submissions also observed that patient safety was also a key role of regulation. The Hobart Clinic and the Royal College of Nursing commented that the ability to meet accreditation standards should be part of the licensing regime. The St Luke's submission expressed the view that quality should be part of the accreditation process, not the licensing process.

The Australian Society of Anaesthetists stated that patient safety should be the primary role of regulation and that compliance with Australian Standards should be the minimum licensing requirement. Learned college standards and policies should also form part of the licensing regime.

A number of submissions supported the continued regulation of physical facilities but the Australian Institute of Surveyors supported the removal of physical facility standards from the private hospital licensing regime by the inclusion of these requirements within the Building Code of Australia.

8.6 Fees

Only five respondents commented on this issue. Fees based on full cost recovery were supported by two submissions while a further two submissions raised concerns that fee increases would be passed through to consumers. The St Luke's submission concluded that if the fees charged were around the average level of interstate fees, then costs to the industry would not be onerous.

8.7 Third party ownership of facilities in private hospitals

Only one submission commented on this issue. This submission suggested that the onus should be placed on the private operator to ensure that all facilities or services on their private hospital campus met the necessary standards.

8.8 Other Major Issues Raised by Respondents

The TPHA raised the need for a transparent appeals mechanism. The Royal College of Nursing submission suggested the need for adequate sanctions for non compliance while the Australian Society of Anaesthetists suggested the need for a process to evaluate new/complex procedures/treatments.

TABLE 8.1 Summary of responses to the Regulatory Impact Statement

	Regulate day surgeries/ facilities	Fees charged	Third party ownership of facilities in private hospitals	Independent regulator	Application of regulation to the public sector	Restriction on market entry	Capping of bed numbers	Basis of regulation	Other issues raised
Australian Council on Healthcare Standards	Yes	NA	NA	Yes	NA	NA	NA	Quality	Role for ACHS in regulation
Australian Institute of Surveyors Tasmanian Chapter	NA	NA	NA	NA	NA	NA	NA	Remove duplication of building requirements	Retrospective application of BCA, Fire Safety Advice
Australian Medical Association	NA	NA	NA	Yes	NA	Yes?	No	NA	
Australian Society of Anaesthetists Inc. Tasmanian State Committee	Yes plus all potentially harmful procedures including laser treatment	NA	NA	Yes	Yes	NA	NA	Adherence to Australian Standards, Learned College Guidelines, patient safety	Process to evaluate new/complex procedures/ treatments

	Regulate day surgeries/ facilities	Fees charged	Third party ownership of facilities in private hospitals	Independent regulator	Application of regulation to the public sector	Restriction on market entry	Capping of bed numbers	Basis of regulation	Other issues raised
Commonwealth Department of Health and Aged Care	Yes	NA	NA	Yes but could perhaps be achieved by clearer funder/ purchaser/ provider splits within the Department	Yes?	No	No	Explicit quality/patient safety standards	Don't consider AHTAC/ NH&MRC Guidelines as sufficient measures of quality/safety
Department of the Premier and Cabinet	Yes	Based on cost recovery	Onus on operators of private hospitals to ensure third parties meet standards	Yes but concerns about cost and feasibility for a small jurisdiction	No but public hospitals expected to meet same accreditation standards as the private sector	No	No	Public safety/service quality	Options for independent regulation need to be further explored
Hobart Clinic	NA	NA	NA	Yes	NA	Yes	Yes	Building standards, National standards, suitability of licensee, accreditation	Critical mass for services needs to be taken into account

	Regulate day surgeries/ facilities	Fees charged	Third party ownership of facilities in private hospitals	Independent regulator	Application of regulation to the public sector	Restriction on market entry	Capping of bed numbers	Basis of regulation	Other issues raised
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Yes plus birthing centres and home births	Concerned that any fee increases may be passed through to consumers	NA	Yes but concerns about increased costs	NA	No	No		NA
Royal College of Nursing Australia	Yes plus needs to be flexible to accommodate any future changes in service delivery	Based on cost recovery	NA	Yes	Yes	Yes based on suitability of licensee, suitability of facilities and type of services to be provided	Restrictions on specialty service provision. Need for a critical mass before services are approved	Ability to meet accreditation /outcome standards not just the standard of physical facilities	Adequate sanctions for breaches of licensing requirements Ensure rational service provision
St Luke's Health Insurance	NA	To be addressed by the new independent body but the scale of fees suggested in the RIS was not considered onerous	NA	Yes with balanced representation from government and the private sector with independent representation if required	NA	Yes to protect investment of existing operators and to avoid overbedding leading to increased costs to consumers	Yes plus licences to be site specific to avoid creating a market for bed licences	Quality should be addressed through accreditation, not the licensing process	

	Regulate day surgeries/ facilities	Fees charged	Third party ownership of facilities in private hospitals	Independent regulator	Application of regulation to the public sector	Restriction on market entry	Capping of bed numbers	Basis of regulation	Other issues raised
Tasmanian Private Hospitals Association	Yes	Assessment of the costs of an independent regulator needs to be undertaken as any fee increases may be passed through to consumers	NA	Yes but concerns about increased costs	Yes including quality standards and critical mass but not to extend to full economic charging for private patients by public hospitals	Yes	Yes plus non transferable bed licences would avoid creating a market for bed licences. Clear guidelines are needed – beds should only be approved where a demonstrated need exists	To be informed by an overall strategic plan for health services in Tasmania. Focus on quality and safety. Operators not owners should be regulated.	Transparent public consultation and appeals mechanisms required

9. CONCLUSIONS

9.1 Scope of the licensing regime

The Review Group concluded that private hospitals and private day procedure centres should be subject to the same regulatory regime. Respondents to both the RIS and the previously released discussion paper favoured this position. The Review Group supported it on the grounds that it best achieved competitive neutrality between private hospitals and stand alone day facilities.

The Review Group also discussed what the cut off point should be to decide if a facility should be considered a day procedure centre for the purpose of licensing. Some other States have used the level of anaesthesia required as a cut off point for licensing (i.e. centres undertaking procedures using spinal, epidural or general anaesthetic require licensing but centres undertaking procedures only under local anaesthetic do not). However, with the technological developments in anaesthesia, this is probably not a suitable cut off. The Committee favoured using the Commonwealth Medicare Benefits Schedule (MBS) Type B (Day Only) Procedure List. Under this option any centre undertaking Type B Procedures would require licensing. This would be a reasonable approach as the Type B (Day Only) Procedure List is frequently updated.

The Committee also considered that the problem of legislation not keeping pace with technological developments could be countered by allowing discretion within the Act as to whether a facility required licensing or not. This would also allow licensing to be extended to other classes of facilities besides private hospitals and private stand alone day hospitals should the Government see the need to regulate other facilities.

9.2 Third party ownership of facilities in private hospitals

The Review Group discussed the issue of third party ownership of facilities within private hospitals. No respondent to the RIS specifically addressed this issue. There was full agreement that facilities in private hospitals leased to a third party should not be separately licensed but that it should be the responsibility of the licence holder to ensure that such facilities met required standards.

The current legislation is silent on this matter and the Review Group considered that explicit clarification should be contained in any new legislation.

There are precedents for this approach as private hospitals must either directly provide or have access to facilities that meet required standards for their accreditation and for health insurance benefits purposes (e.g. neonatal care).

9.3 The need for independence in regulation and how this might be achieved and funded

There are a number of options for achieving a separation of the regulatory and service delivery functions within DHHS. These include:

- the creation of a new independent statutory authority;

- the establishment of an independent committee supported by DHHS to undertake the licensing role;

- transferring the licensing function to some other suitable existing Government Agency (the Health Complaints Commissioner/Ombudsman?);

- contracting this role to the ACHS or some other suitable independent body.

- establishing clear functional splits within DHHS;

The various options were costed to provide a further guide to the feasibility and the cost to industry and Government of each option.

9.3.1 The Creation of a new Independent Statutory Authority

A new independent statutory authority would at a bare minimum require an executive staff member and clerical support. It is difficult to be precise about a budget for a stand alone statutory authority of this nature when the exact duties have not been specified, but it is expected that the budget would be in the range of $100,000 to $150,000.

To be fully funded by license fees, the costs to private hospitals and day procedure centres based on current numbers would be in the range from $7000 - $11,000 per annum per facility on a flat fee per facility or approximately $120-$175 per bed if fees were applied on the basis of licensed beds. This would make Tasmanian licensing fees the most expensive in the Country and would impose a considerable burden on the private sector. Alternatively, if the Government was to fully, or in part bear the burden of the licensing costs, there would be a considerable impost on Government.

9.3.2 The Establishment of an Independent Committee to Undertake the Licensing Role

The establishment of an independent committee supported by DHHS would be a lower cost option than an independent statutory authority. A budget of $20,000 per annum should cover the costs of a committee and secretarial support. However, there would be additional costs for inspections and these would either need to be contracted from an outside body or performed by DHHS staff.

9.3.3 Transferring the licensing function to some other suitable existing Government Agency

While this would be a cheaper option than setting up a new independent entity, it is difficult to identify any suitable Government authority both in terms of similar role and the ability to absorb the licensing role within its current functions.

9.3.4 Contracting the Licensing Role to the ACHS or some other Suitable Independent Body

The ACHS is probably best placed to take on the inspection function without the administrative licensing functions. The cost of AHCS inspections vary according to the size of the facility and the range of services provided (i.e. $3000 for a 35 bed hospital to $18000 for an 800 bed hospital). Most Tasmanian facilities would be in

the mid range of between $5000- $10,000 an inspection. As the inspection requirements for the State Government overlap with accreditation requirements, the additional costs of licensing if piggybacked with ACHS accreditation would probably be between $1500 and $3000. However, using the ACHS would lock the DHHS and Private Hospitals into future use of the ACHS accreditation model when there are other options available. Also the AHCS is unlikely to want a role in enforcement.

9.3.5 Establishing Clear Functional Splits within DHHS

This option would involve the transfer of licensing functions from the Divisional Support Unit within the Hospitals and Ambulance Division to another area within the Department.

Costs were assessed at around $5,000-$10,000 based on current practice of co opting Departmental staff as required for inspection teams and also on the current hours of Divisional Support Unit Staff dealing with licensing matters.

This is the least change/least cost option as it basically continues current practice but would involve ensuring staff involved in licensing were not involved in service delivery issues where any potential for conflict of interest exists (i.e. collocation proposals, development of new public sector services etc.

It is difficult to identify any suitable alternative area of the Department to take on this function both in terms of similar role and the ability to absorb the licensing role within its current functions.

9.3.6 Recommended Option for Licensing

The general consensus of the Review Group was that the model must be workable and cost efficient and must provide the independence required in respect of a separation of regulation and service delivery functions.

The Review Group considered that the transfer of the licensing function to some other suitable existing Government agency had a number of identified weaknesses primarily;

- No other agency undertakes a similar role, thereby creating a problem in identifying a suitable government body to take on the role;
- The potential creation of conflicts of interest if the licensing role was to be undertaken by the Health Complaints Commissioner or the Ombudsman;
- If there is no capacity to absorb the costs of licensing by combining with another similar function done by another Agency, then costs would rise;
- This is a high cost option.

For these reasons, the Review Group did not favour this option.

Review Group members considered the option of the creation of a new independent statutory authority too costly and too great an impost on the industry to warrant further consideration.

The view of the Review Group was that the option of contracting the licensing role to the ACHS or some other suitable body was not workable. It was unlikely to be an

acceptable option to the industry and it was considered equally unlikely that a body such as the ACHS would be willing to take on an enforcement role within the scope of the regulatory functions. It was therefore agreed that this option would not receive further consideration.

The Review Group concluded that the establishment of clear functional splits within Department of Health and Human Services did not fully remove the perceptions of conflict of interest for the Department.

Review Group members favored the option of an independent Committee to undertake the licensing role in that it provided an opportunity for the election of a Committee with an independent chair and representation from both the Department and the industry. The strengths of this model are that it only requires moderate change with the setting up of an independent Committee to make recommendations to the Minister around licensing matters with the Department continuing to provide administrative support for the licensing role. This model also largely removes perceptions of a conflict of interest for the Department.

The Review Group discussed the model of an independent committee in detail before deciding on a recommended model. The suggested role, function and membership of the independent committee are attached at Appendix 4.

9.4 Application of regulation to the public sector

The Committee discussed the application of regulation to the public sector. The Committee by majority agreement concluded that the public sector hospitals should not be licensed but should be expected to meet the same standards as the private sector, especially where higher standards required in the private sector could place this sector at a competitive disadvantage. However, it should be noted that the Tasmanian Private Hospitals Association strongly supported the view that public hospitals should be responsible to the same regulation as the private sector. It was agreed that major public hospitals should be accredited.

9.5 Capping of bed numbers

The review group concluded that the application of strict bed caps on private hospitals was not in the public interest as restrictions on the bed supply are likely to lead to an artificially created market in bed licences leading to additional costs to private hospitals which are likely to be passed through as additional costs to consumers. However, a strong case can be made for limiting the availability of some specialty services where there are insufficient patients available to provide a critical mass to ensure the maintenance of skills, the recruitment and retention of specialist staff and support for teaching and research.

Approval for new services or expanded services would need to be obtained from the Independent Licensing Committee (as discussed in section 9.3 and outlined in Appendix 4) to ensure effective planning of health services and minimise costly duplication in both the public and private sectors. This is effectively a ‘soft’ cap on bed numbers where applicants would need to show why new services were needed. It would greatly contribute towards rational health planning in Tasmania. Working Group members viewed this as an acceptable compromise between full regulation or full deregulation of the industry.

Decisions on the limiting of specialty services would need to be based on clinical considerations around service quality and be dependent on established clinical practice and service provision guidelines (e.g. Australian Health Technology Advisory Committee superspecialty guidelines, National Health and Medical Research Council clinical practice guidelines, Royal Colleges guidelines on clinical practice, State Health Authorities specialty service planning guidelines etc.).

Market entry should continue to be controlled to ensure that only reputable operators would be allowed to provide private hospital services. This is required due to the strong public safety considerations involved.

9.6 Licensing Fees

The Review Group discussed the matter of licensing fees. It was agreed that fees should be based around full cost recovery in the longer term and brought into line with other States/Territories but that new fees should be set about the mid range of what other States and Territories currently levy.

9.7 Other issues

Morbidity data

The Review Group considered the provision of data from private hospitals. The current process for the provision of morbidity data by Private Hospitals to the Department is on a voluntary basis. There is a provision in the current Act regarding the mandatory supply of information from the private sector to the Department, but at the present time the Department had not used this provision to ensure mandatory provision of data.

The Working Group agreed, that for planning and reporting purposes, it would be appropriate to include the mandatory provision of data within the new legislation, provided that satisfactory confidentiality procedures and other relevant safeguards are observed in accordance with the Department of Health and Human Services Client Information Guidelines.

Administrative Appeals

Currently the Hospitals Act has its own appeals process for parties aggrieved by the Minister's decision in relation to licensing issues. However, the appeals process is unclear in its applicability, and is complex and unwieldy. It is also inconsistent with the current Whole of Government proposal for legislation in respect of appeals processes which will see the abolition of individual appeals tribunals and all administrative appeals processes against Government decisions to be managed by Magistrates Court Administrative Division. The Review Group supports this approach in relation to appeals around Government decisions on hospital licensing issues.

APPENDIX 1: SITUATION IN OTHER STATES

New South Wales

Private Hospitals in New South Wales are regulated through the *Private Hospitals and Day Procedure Centres Act 1988* and the *Private Hospitals Regulation 1996* and the *Day Procedure Centres Regulation 1996.*

The focus of regulation currently reflects the Legislation's 1908 origins though it has moved more towards a quality and outcomes focus in its interpretation rather than what is expressed in the actual provisions. Currently the shift in focus of regulation has been to move away from regulating areas which overlap with local government (i.e. Building Code of Australia) and to concentrate on plant and equipment in relation to clinical care provision, occupational health and safety and infection control points of view. New South Wales requires licensees to be "fit and proper persons"

The New South Wales Act provides the capacity to effectively limit bed supply though the Department has taken an increasingly hands off approach taken to "beds" and their trading over the past few years. Bed planning guidelines are only enforced in relation to the capacity to the organisation being able to appropriately provide the clinical services. There is still a market in bed licences in New South Wales but the Department no longer actively limits bed licences.

Advanced technology is only regulated where it relates to perceived high risk clinical services provision i.e. cardiac surgery, obstetric services, emergency departments, paediatrics etc.

New South Wales is about to enter a major review process. Matters to be considered will include:-

- philosophy of regulation and compliance strategies;
- level of regulation;
- consistency between regulation and standards in the public and private sectors;
- common or different legislation between public and private sector;
- formal connections between the public and private sectors;
- should the notion of day procedure centres be integrated more fully into private hospitals and not have the existing differentiation;
- the definition of a day procedure centre for licensing purposes.

A Draft Discussion Paper has been completed, but this Paper is yet to be issued to the public for comment.

Victoria

Victorian private hospitals are regulated through the *Health Services Act 1988* and the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 1991*.

Victoria has produced a Discussion Paper released in November 1995 on the role of Government in regulating private hospitals. This paper proposes the option that regulation should be confined to regulating for quality except for specialist areas where a minimum throughput is required to maintain service viability. Otherwise there should be no restrictions on private hospital bed licence numbers. Victoria also produced an Impact Assessment released in February 1996 which examined the impact of removing most controls in relation to private hospitals and day procedure centres and in particular the removal of the bed cap applied in Victoria which has created a market in private hospital licenses.

Private hospital licensing has been included as part of the full review of the Victorian Health Services Act 1988. A Discussion Paper entitled *Health Services Policy Review* was released in March 1999 for public comment. The Paper recommends the following major changes to the regulation of private hospitals:

- the removal of the bed cap applied by the Department on private hospital bed numbers;
- the removal of the power of the Secretary, Department of Human Services to take into account the adequacy of local bed provision when considering new private hospital developments;
- the transfer of building standards to the Victorian Building Regulations meaning that the Secretary, Department of Human Services will no longer consider building and design issues and the sole criterion for registration will become consideration of whether the applicant is a fit and proper person. However, the power to attach conditions to the issue of a licence will be retained;
- renewal of a licence to be decided on the basis of the applicant remaining a fit and proper person and complying with licence conditions;
- retention of the power to inspect premises to determine compliance with the Act and Regulations;
- the same regulatory regime to apply to private hospitals, day procedure centres and public hospitals;
- fees for private patients in public hospitals should no longer be subject to Commonwealth control and should be determined on a commercial basis;
- exemptions on input taxes for public and private not for profit hospitals should be removed.

Australian Capital Territory

Private hospitals in the Australian Capital Territory are regulated through the *Public Health (Private Hospital) Regulations 1930*. Day procedure centres are not licensed but the ACT Department of Health and Community Care has developed administrative procedures for the approval of day centres.

Licensing focuses on the adequacy of the buildings and equipment, the qualifications of the applicant to provide private hospital services and arrangements made for the management of the private hospital.

The ACT does not enforce strict limits on the bed supply. Applications for new licences are subject to planning considerations in relation to bed numbers on a case by case basis. There is no market for private hospital bed licences as licences are not transferable.

The ACT, unlike all other States and Territories, does currently charge any fees in relation to private hospital licensing.

When considering an application for a licence the ACT can consider the suitability of the person to become a licence holder in terms of fitness and propriety. However, there is no obligation to require character references.

The Act does not regulate advanced technology.

A Discussion Paper has been completed (July 1998) and released for public comment. New Legislation is currently being drafted and drafting should be completed by the end of May 1999. It is expected that some of the changes to the regulatory regime to be incorporated in the new Act will include:

- the requirement for day procedure centres to be licensed;
- the introduction of licence fees;
- the exclusion of any consideration of bed planning requirements from the approvals process;
- the inclusion of transfer provisions in relation to facilities ownership;
- removal of the "fit and proper person" test for applicants.

Western Australia

Western Australian private hospitals are regulated through the *Hospitals and Health Services Act 1927* and the *Hospitals (Licensing and conduct of Private Hospitals) Regulations 1987*. Day procedure centres are also regulated if they undertake procedures requiring general, spinal or epidural anaesthesia.

The main focus of licensing is on the adequacy of the buildings and equipment, e.g. Private Hospital Guidelines. The Western Australian guidelines incorporate all other standards and codes and where there is any overlap the standards prevail.

The Western Australian Act does not allow a limit on the bed supply and so there is no market for private hospital bed licences.

When considering an application for a licence the Health Department of Western Australia will consider the suitability of the person to become a licence holder in terms of fitness and propriety, sufficiency of material and financial resources, and understanding of the duties and obligations imposed by the Act. However, there are no documented standards against which prospective licensees are assessed for suitability.

There is no provision under the *Hospitals and Health Services Act 1927* for the regulation of high cost equipment in unlicensed premises. However, anybody operating such equipment would have to comply with the *Therapeutic Goods Act* and relevant professional standards. Where such equipment is situated in licensed premises the Health Department of Western Australia can ensure it meets any relevant legislation, codes or standards covering its construction or use.

Private hospital licensing is being examined as part of the review of the Western Australian *Hospital And Health Services Act* A discussion paper, *A Review of the Licensing of Private Sector Health and Other Facilities in Western Australia,* was released in January 1999 for public comment. This Paper recommends some major changes to current licensing arrangements including:

- the introduction of variable duration of licences from one to three years;
- the introduction of conditional licences for facilities who don't completely meet the required standards but the extent of non compliance does not warrant refusal or withdrawal of the licence;
- the requirement for the applicant for a licence to submit to (at the applicant's expense) an independent analysis of financial capacity and a test of character and repute and to submit written references from within the industry supporting the applicant being licensed.;
- the requirement on licence renewal for the operator to provide evidence of client consultation on standards of care provided;
- the requirement for a prospective or existing licensee to obtain a compliance certificate from an accredited certifier (an architect, engineer or building inspector) of their choice;
- strengthening compliance requirements in relation to public health matters;
- applications to be assessed on the basis of the applicant being a fit and proper person, the facilities being suitable for the intended purpose and appropriate arrangements to achieve required clinical standards and for the management, operation and staffing of the facility;
- revised standards to remove the overlap with local government and other statutory requirements;
- the application of the same standards to public hospitals, day procedure centres and private hospitals;
- the introduction of a $100 administrative charge for processing new applications or renewing existing licences;
- random inspection of licensed facilities;
- the introduction of effective and appropriate sanctions for non compliance;

South Australia

Private hospitals are licensed under the *South Australian Health Commission Act 1976* and the *South Australian Health Commission (Private Hospitals) Regulations 1985*.

Day procedure centres are not licensed in South Australia at this stage, but the same criteria as for private hospitals are used when assessing proposals. The South Australian Health Commission is required to write to the Commonwealth Department of Health and Aged Care recommending that a provider number be issued if the proposed centre is satisfactory. Centres are inspected by officers of the Health Commission (the same people who inspect private hospitals) before this letter is sent.

The Health Commission administers the Act, which is now part of the Department of Human Services under the Minister for Human Services, through the Strategic Planning & Policy Division and the Private Hospitals Review Committee.

The Regulations prescribe physical standards, and refer to building codes and national standards etc. and require compliance with appropriate fire and electrical standards etc. The Committee also looks at equipment, staffing, quality assurance etc.

Under the Regulations there is a prescribed limit on the number of public and private hospital beds within the Adelaide metropolitan area, but outside of Adelaide there are no restrictions. Any specialty services require the approval of the Health Commission.

There is a limited market in bed licences in the metropolitan area.

The application form requires information on prospective directors and operators, whether they have a direct or indirect pecuniary interest or whether they are involved in the management and control in the running of the private hospital, whether they have been found convicted or found guilty of any criminal offence in South Australia or any other state or territory of the Commonwealth within the past 5 years, and whether they have a licence to operate a private hospital, nursing home, rest home or hostel in South Australia or any other State or Territory of the Commonwealth, or whether any such licence has been revoked or been the subject of an inquiry in respect of that person's conduct in the operation, management or control of the premises.

The use of advanced technology is monitored and the purchase of major equipment requires the prior approval of the Health Commission.

The part of the Act relating to private hospitals is currently being reviewed, especially in the light of National Competition Policy.

Northern Territory

(Current situation in the NT to be outlined once a response is received).

The review of private hospital licensing in the context of National Competition Policy is not a high priority as the Northern Territory only has one private hospital.

Queensland

Queensland Private Hospitals are regulated through the Health Act 1937 and the Health (Private Hospitals) Regulations 1978. The Act regulates day procedure centres as well as private hospitals.

The focus of Queensland regulation is on the clinical, operational and management issues as well as physical facilities. Prospective operators must submit an application to the Chief Health Officer (which effectively amounts to a business plan with a clinical focus) before a new facility will be approved. Similarly, existing private hospitals must submit an application to support variations to an existing licence. Ongoing monitoring of facilities is achieved through random audits focusing on particular types of clinical services.

Before licences are granted, an applicant must be assessed as being a fit and proper person and analysis of potential applicants is conducted including financial capacity.

The Queensland legislation does not provide for capping of the bed supply and bed licences are site specific and are not legally transferable between facilities.

Private operators are required to meet extra conditions if they are providing tertiary referral services and there are some limits on access to the provision of these services.

Queensland has been reviewing its arrangements for private hospital licensing for the last 10 years or so. Extensive stakeholder consultation has been conducted over the last 2 years and a Regulatory Impact Statement has been submitted to the Government. New legislation is expected to be in place by the end of this year.

APPENDIX 2: STATEMENT OF CONSULTATION PROCESS

The first step in commencing the Review of the *Hospitals Act* has been the Establishment of a Representative Review Group including key stakeholders. The membership of this Review Group is:

Independent Chairperson	Mr Roger Curtis
Community Representative	Mr Ian Braid
Representative from the Major Acute Care Private Sector	Mr Neil Beer, Chief Executive Officer, St Helen's Private Hospital (replaced by Valerie Davie from December 1998 who in turn was replaced by Andrew Weston from June 2000.
Representative from the Major Acute Care Public Sector	Mr Andrew George- Gamlyn, Director, Division of Corporate and Support Services, Royal Hobart Hospital
Representative from the Health Insurance Industry	Mr Darren Turner, Customer Services Manager, Medibank Private
Representative from the Legislative Review Unit, Department of Treasury and Finance	Ms Fiona Calvert, Assistant Director, Legislation Review, Regulation Review Unit, Department of Treasury and Finance (replaced by Peter Bennett from June 2000)
Representative from the Department of Health and Human Services	Dr Paul McCann, Senior Medical Consultant, Hospitals and Ambulance Service, Department of Health and Human Services

The Review Group prepared an Issues Paper which was released for public comment on 28 March 1998. An advertisement calling for comment on the Issues Paper was placed in the Mercury, Examiner and Advocate and copies were sent to identified key stakeholders including private hospitals, health insurers and learned colleges.

Submissions in response to the Issues Paper were received from:

The Hobart Clinic
Workplace Standards Authority
The Royal College of Pathologists
Australian Council on Healthcare Standards
Royal Hobart Hospital
Mersey Community Hospital
Office of Consumer Affairs and Fair Trading
Tasmanian Private Hospitals Association
St Luke's Health Insurance
Commonwealth Department of Health and Aged Care

The review group prepared a draft Regulatory Impact Statement that was released for public comment over July and August 1999.

Submissions in response to the Regulatory Impact Statement were received from the following organisations:

Australian Council on Healthcare Standards;
Australian Institute of Surveyors, Tasmanian Chapter;
Australian Medical association
Australian Society of Anaesthetists Inc, Tasmanian State Committee;
Commonwealth Department of Health and Aged Care;
Department of the Premier and Cabinet;
Hobart Clinic;
Royal Australian and New Zealand College of Obstetricians and Gynaecologists;
Royal College of Nursing Australia;
St Luke's Health Insurance;
Tasmanian Private Hospitals Association.

The Review Group then prepared its Final Report for Government consideration (this document).

APPENDIX 3: SUMMARY OF SUBMISSIONS RECEIVED IN RESPONSE TO THE ISSUES PAPER

The Australian Council on Healthcare Standards (ACHS)

The ACHS saw the central role of Government was to ensure the *basic safety* of those receiving treatment in private hospitals. The Government should therefore place the emphasis of licensing on physical facilities to ensure patient safety. Quality of services (above basic safety) and outcomes should be accommodated by accreditation.

Facilities that have the potential to cause significant harm to consumers should be regulated. These include private hospitals, day procedure centres, abortion clinics and invasive procedures conducted in doctors' rooms.

Bed supply controls may be needed for planning purposes to ensure a rational distribution of public and private services and equity of access without overservicing or oversupply.

Realistic fees should be charged for licensing applications, renewals and transfers. Renewal could be made subject to information provision on services/practice rather than re-inspections (which in practice seldom occur). Accreditation inspections could perform the re-inspection function, but this would need to be specifically resourced.

The ACHS considered the Minister should continue to be the regulator. An industry body was not considered appropriate as a regulator but was considered appropriate for accreditation purposes.

Health Insurance Services Section (HISS), Commonwealth Department of Health and Family Services (now the Department of Health and Aged Care)

The HISS agreed that regulation of private hospitals was a State role but the Commonwealth had an interest in ensuring access to services and the rights of private patients to elect to be a private patient in a public or private hospital or a public patient in a public hospital.

The Hobart Clinic

The Hobart Clinic supported the retention of regulatory controls including regulation of the bed supply and the limiting of access to provide specialist services. Regulation should concentrate on maintenance of standards and quality of service. Duplication of regulatory control should be removed and a clear link to industry accreditation processes should be established.

Mersey Community Hospital

The Mersey Hospital submission supported the retention of State Government licensing and explicit restrictions on the bed supply. Regulation should cover all private facilities undertaking both invasive and non-invasive procedures and be delegated to a suitably representative industry group.

The submission supported the retention of physical facility standards and suggested that quality matters be dealt with by reference in the legislation to accreditation. The submission suggested an improved mechanism for dealing with non-compliance with an appropriate appeals process. Quality should be assured through industry self regulation.

The submission called for the removal of limitations on the level of services provided by private hospitals, but with clear guidelines for the provision of high technology services.

Office of Consumer Affairs and Fair Trading, Department of Justice, Tasmania

The Office of Consumer Affairs and Fair Trading were concerned that safety of consumers be protected and that there be adequate disclosure for consumers around services provided by private hospitals.

The submission supported self regulation unless there was a clear indication that this would not protect consumers.

Royal College of Pathologists of Australasia (RCPA)

The RCPA considered that the Government had a duty to ensure health care facilities (both public and private) met appropriate standards.

The RCPA considered that pathology services were highly regulated on a national basis through NATA/RCPA accreditation. The RCPA endorsed this approach and considered that any laboratory providing services to private hospitals should be accredited. Semi automated and automated ward based testing equipment should only be used in consultation with appropriate pathology staff.

Other aspects of pathology apart from laboratory testing (patient assessment, consultation on the appropriate testing strategy, interpretation, education etc.) should also be included for consideration as part of the regulatory regime.

Royal Hobart Hospital

The Royal Hobart Hospital supported the regulation of the private sector (including all types of providers) with similar standards applying to the public sector.

Regulation should cover physical facility standards, service quality, bed availability and types of services provided.

An independent statutory authority should be responsible for regulation.

St Luke's Health Insurance

St Luke's Health Insurance supported the retention of licensing and its extension to include day procedure centres, abortion clinics and invasive procedures conducted in doctors rooms. St Luke's considered that the number and location of private hospital beds should be regulated.

St Luke's supported the continued emphasis of licensing on physical facilities to ensure patient safety. Quality of services should not be regulated through licensing but through funder contracts with private hospitals. Restrictions on types of services to be provided by individual private hospitals should be removed. Accreditation should be mandatory to provide for improved patient care.

The submission supported the retention of the Minister for Health and Human Services as the regulating authority.

Tasmanian Private Hospitals Association (TPHA)

The TPHA submission noted that the *Hospitals Act 1918* was antiquated and in need of review and had outmoded definitions, outmoded licence conditions and highly regulated and prescriptive licensing arrangements.

The TPHA submission supported the continued licensing of private hospitals, but within a less prescriptive and more outcomes oriented framework. The submission supported the inclusion of private day procedure centres within the new regulatory framework. The submission supported the application of the same standards to the public and private sectors.

The submission supported the use of bed planning guidelines and bed numbers restrictions on private medical establishments. Due to conflict of interest considerations with public sector services, the TPHA supported the regulation of the private hospital industry by an independent regulator. Applications for new licenses should be considered against established and objective criteria.

The TPHA called for a licensing regime that incorporates an increased level of self regulation, an increased role for industry standards (like industry accreditation and industry codes of practice) and a greater emphasis on quality and outcomes , with more stringent standards to apply in relation to specialty service provision.

Workplace Standards Authority (WSA)

The WSA agreed that the current Act was out of date and in need of review. However, the WSA considered that the central question to be asked in any review was whether the Government needed to be involved in regulation of the private health sector and if so, whether the objectives of regulation could be achieved by non-legislative means?

Compliance costs, penalties and fees were other more minor matters that should be included as part of the review.

APPENDIX 4: SUGGESTED ROLE, FUNCTION AND MEMBERSHIP OF AN INDEPENDENT COMMITTEE TO PROVIDE ADVICE TO THE MINISTER IN RELATION TO THE LICENSING OF PRIVATE HOSPITALS

Role

To provide advice to the Minister on matters associated with private hospital licensing and to provide recommendations on the approval or otherwise on all applications for new or expanded private hospital services.

Purpose

To ensure the rational planning of private hospital services by:-

Minimising the over provision of services;
Ensuring a critical mass/volume of service to achieve quality standards;
Optimising service distribution;
Ensuring services meet national guidelines;

Functions

The functions of the Committee would be as follows: -

- to provide advice to the Minister in respect of applications for approval for new, altered or expanded private hospital services taking account of:-
    - relevant hospital services planning guidelines;
    - the critical mass/volume of service required to achieve quality standards;
    - the current availability of services in the local geographical area;
    - the suitability of the applicant to provide hospital services.
- prepare such reports/advice as may be required by the Minister from time to time.

Membership

The membership will be by Ministerial appointment and will be composed of:-

- Independent Chairperson;
- An industry nominee;
- A Department of Health and Human Services representative.

The Tasmanian Private Hospitals Association will provide the industry nominee. Two nominees will be appointed to the membership panel but only one will sit on the Committee at any one time. The two nominees will be drawn from different hospital

catchment areas and will only consider applications from outside the catchment area they are selected from to avoid conflicts of interests between rival hospitals within the same catchment area.

Support

Provision of administrative support by Department of Health and Human Services (Hospitals and Ambulance Service, Divisional Support Unit).

Administrative Structures

Committee could be integrated within the Hospitals and Ambulance Service, Divisional Support Unit Structure with links to the Divisional Clinical Advisory Committee Structure, especially for advice on appropriate planning guidelines.

The Committee will determine its own operating procedures and may vary these from time to time.

APPENDIX 5: SUBMISSIONS RECEIVED IN RESPONSE TO THE REGULATORY IMPACT STATEMENT

Submissions are included from the following organisations:-

- Australian Council on Healthcare Standards
- Australian Institute of Surveyors, Tasmanian Chapter
- Australian Medical Association
- Australian Society of Anaesthetists Inc, Tasmanian State Committee
- Commonwealth Department of Health and Aged Care
- Department of the Premier and Cabinet
- Hobart Clinic
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal College of Nursing Australia
- St Luke's Health Insurance
- Tasmanian Private Hospitals Association