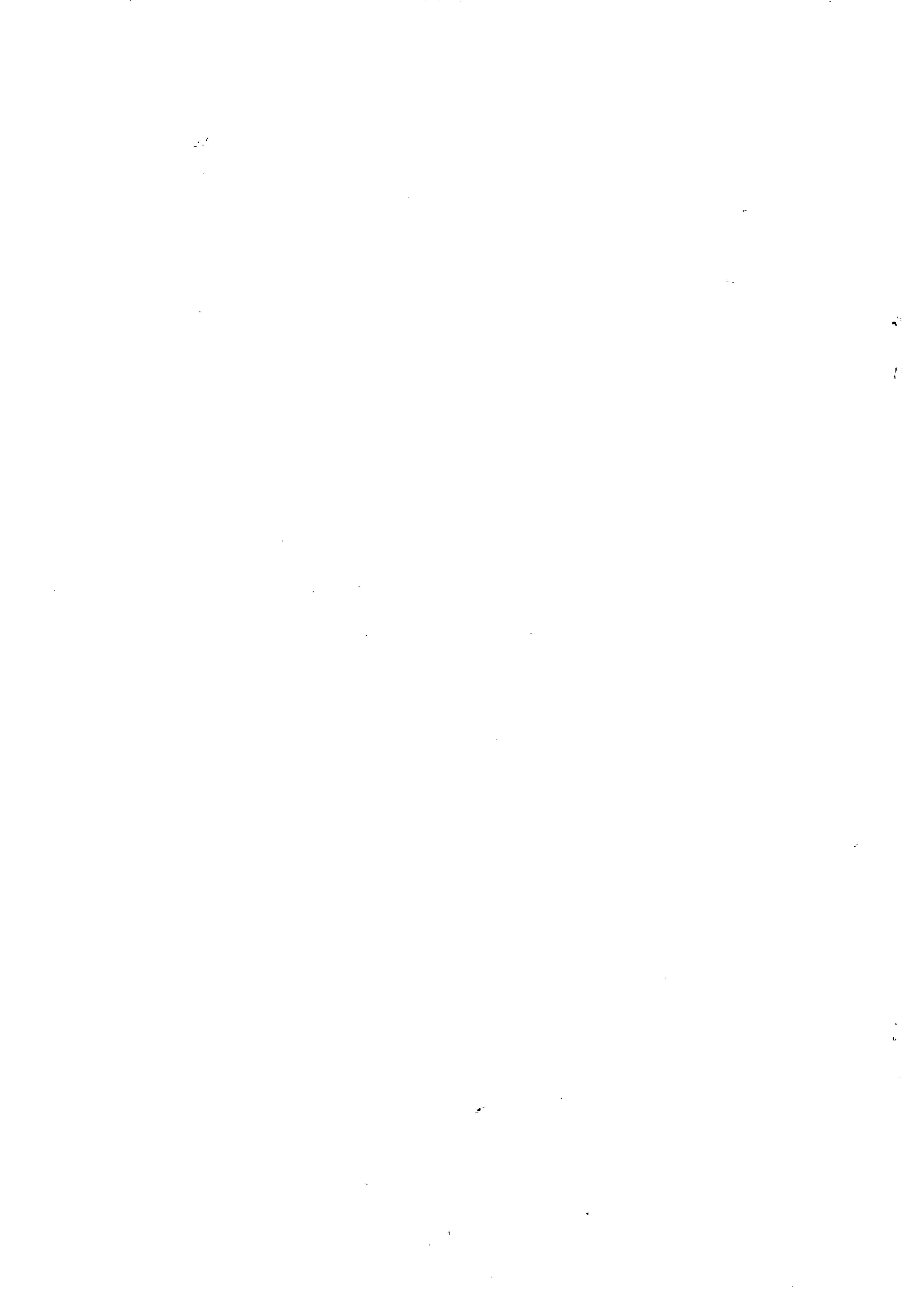
LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON HOSPITAL BED NUMBERS

DECEMBER 1991



COMMITTEE MEMBERSHIP

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Mrs Ellnor Grassby

Dr Hector Kinloch

Committee Secretary:	Mr Rod Power
Research Officers:	Ms Anna Pagel Ms Vicki Salkin
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TERMS OF REFERENCE

1. To inquire into the proposed reduction in bed numbers in the Territory's hospital system and to inquire into and report on the consequences of this proposal with particular reference to:

(a) the impact on the quality of patient care;

(b) the impact on available hospital bed numbers;

(c) the impact on hospital waiting lists;

(d) the public/private hospital bed mix;

(e) the appropriate level of bed availability for 1991–92 in public and private hospitals; and

(f) the need to cut health expenditure.

(2) The Committee may examine other related matters which it considers should be drawn to the attention of the Assembly.

The Committee to report by 12 December 1991.

ACKNOWLEDGEMENTS

The Committee wishes to record its appreciation of the following organisations and persons who – at short notice – provided informal briefings to Members of the Committee:

ACT Department of Health

Ms G Biscoe, Secretary
Dr V McLoughlin, Executive Director, Health Services Development
Dr J O'Donnell, Executive Director, Clinical Services, Hospital Services Division

Calvary Public Hospital

Mr M Avery, Chief Executive Officer
Mr L Sales, Director of Administrative Services
Sr J O'Shannassy, Sister Administrator
Sr B Neill, Director of Nursing Services

Illawarra Area Health Service

Mr J Rasa, Chief Executive Officer
Ms K Eagar, Director of Health Services Development

National Health Strategy

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Mr J Dunlop, Director, Commercial Development
Ms J Hamilton, Director, Physical Resources

St George Hospital

Mr O Thomas, Acting General Manager
Mr P Lemon, Assistant General Manager, Corporate Services

St Vincent's Private Hospital

Sr P Grantham, Sister Administrator
Mr J Brooker, Executive Officer

St Vincent's Public Hospital

Dr D Robinson, Director of Medical Services
Dr G Bearham, Deputy Director of Medical Services
Ms R Brown, Director of Nursing
Ms M Goodwin, Acting Deputy Director of Nursing
Ms S Woods, Nursing Unit Manager

The Committee also records its appreciation of the courtesy and helpfulness of staff of the Executive Coordination Section, Health Services Development Branch, ACT Board of Health. In particular, the Committee thanks Ms D Donovan, Ministerial Liaison Officer in the Executive Coordination Section.

RECOMMENDATIONS

The number in brackets after each recommendation shows the location of the recommendation in the text of the Report.

Recommendations relating to a common theme are grouped together.

The Committee recommends:

In relation to bed numbers:

* the Board of Health, in conjunction with the Government, reconsider its program of bed reductions as a matter of urgency (4.45)

* the Board reassess its long–term strategy for bed numbers to the year 2000 to take into account the low bed/population ratio existing in the ACT at the commencement of the bed cuts (7.13)

* the Board provide a detailed rationale to the Government before closing any intensive care beds (4.21)

* a detailed study be undertaken of the impact on nursing homes and hostels in the ACT consequential upon any reduction in the number of acute and long term stay hospital beds in the ACT. Further, the Committee recommends that nursing homes and hostels operating within the ACT be involved in the study and be invited to participate in discussions.(4.31)

* the Board of Health not reduce nursing–home type beds in the public hospital system until alternative facilities are in place.(4.33)

In relation to relation to the quality of care:

* the Board of Health provide the ACT community detailed information on quality of health indicators (3.25)

* the Board construct annual statistical information on ACT health in a form comparable to information produced in NSW.(3.26)

* the Board of Health make every effort to facilitate the grant of accreditation status to Woden Valley Hospital in 1993 and in each ensuing year.

* the ACT Board of Health develop an overall strategy for assessing the quality of health – the strategy to utilise demonstrable indicators able to be monitored by the community, including comment on the significance to be accorded to hospital bed numbers.(4.5)

* the Board of Health prepare and issue discussion papers on the factors and directions affecting the future of the ACT health system. (7.16)

In relation to hospital costs:

* the Board of Health make the achievement of more efficient staff/patient ratios its primary focus in reducing the overall costs of the health system. The Committee considers this should take priority over bed reductions. (5.40)

* the Government compile the relevant information on the case–mix of NSW patients treated in ACT hospitals with a view to seeking compensatory funding in the next Grants Commission investigation of ACT financing.(8.9)

In relation to the new facilities:

* the Government re–open tenders for additional private hospital facilities in the ACT, preferably to be located adjacent to an existing public hospital. Further, the Committee recommends that the bed capacity of such a private hospital should be not less than 100 (6.22)

* the Government, as a matter of priority, pursue negotiations leading to the establishment of a clinical school in the principal hospital.(10.10)

* the Government examine, as a matter of priority, the provision of suitable facilities for convalescent/rehabilitation patients – possibly at Acton Peninsula.(4.38)

* the building of a hospice proceed as a matter of urgency.(10.13)

In relation to operating theatres:

* the Board of Health advise the Minister about the feasibility of using operating theatres in public hospitals on weekends.(4.11)

* the Board does not reduce the number of operating theatres, particularly day–surgery theatres, in use in ACT public hospitals.(4.19)

In relation to emergency facilities:

* pending completion of the new diagnostic block at Woden Valley Hospital the Board of Health urgently updgrade the present facilities in the Emergency Department of Woden Valley Hospital.(4.23)

* the Board of Health urgently develop appropriate procedures to facilitate in–patient admissions through the Emergency Department of Woden Valley Hospital.(4.26)

In relation to structures:

* the next Legislative Assembly consider setting up an inquiry into the appropriate structure to meet the health needs of the ACT and adjoining regions. (9.12)

* the Government and the Board of Health clarify the role and responsibility of the Board and senior management of the Board; and also clarify the status of the term 'ACT Health'.(11.5)

* the Board liaise with the Community Health Association about the resources able to be made available to meet community health needs.(11.17)

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1 BACKGROUND

Conduct of the Inquiry

1.1 On 16 October 1991 the ACT Legislative Assembly formally resolved to establish the Select Committee on Hospital Bed Numbers. By a resolution of the Assembly on the following day, the Assembly determined that Mrs Grassby, Mr Humphries and Dr Kinloch be members of the Committee.

1.2 The Committee held its first meeting on 22 October 1991 and elected Mr Humphries Chairman.

1.3 Advertisements calling for comment on the Committee's terms of reference were placed in the Canberra Times on Wednesday 23 October 1991 and in the Canberra Chronicle and Valley View on Wednesday 30 October 1991. The terms of reference were also circulated to local community groups and to the local and national offices of prominent health organisations. In addition, the terms of reference were circulated to Federal, State and Territory Health Ministers and their Opposition counterparts.

1.4 A list of submissions received by the Committee is at Appendix 1.

1.5 On Tuesday 12 November 1991 the Chairman and Secretary to the Committee met informally with Ms Jenny Macklin, Director, National Health Strategy. Notes on this meeting were subsequently made available to all Members of the Committee.

1.6 On Wednesday 13 November 1991 the Committee visited the two principal public hospitals in the ACT (Woden Valley Hospital and Calvary Public Hospital). Members received briefings on developments in both hospitals by Ms G Biscoe, Executive Director of the ACT Board of Health, and by senior Department of Health officials. The senior staff of Calvary Public Hospital also provided an informal briefing.

1.7 On Thursday 14 November and Friday 15 November 1991 the Committee travelled to Sydney and Wollongong to receive informal briefings by senior representatives of the following organisations:

- the NSW Department of Health;
- St Vincent's Public Hospital;

- St Vincent's Private Hospital;
- Southern Sydney Area Health Service;
- St George Hospital; and the
- Illawarra Area Health Service.

1.8 On Thursday 21 November 1991 the Committee was informally briefed by Mr B McKay and Mr S Solomon, prominent persons in preparing papers for the Macklin inquiry.

1.9 The Committee held three public hearings to hear evidence from the persons and organisations listed at Appendix 2. These hearings took place on Friday 29 November, Wednesday 4 December and Friday 6 December 1991.

Structure of this Report

1.10 The structure of this Report follows the stated terms of reference for the Inquiry. The first matter examined is the actual reduction in hospital beds occurring this financial year (Chapter 2). This is then set in the wider context of ways in which health care authorities are attempting to assess 'quality' issues (Chapter 3). Included in such assessments are matters to do with hospital waiting lists, so this term of reference is included in this Chapter.

1.11 The Report then turns to the appropriate level of bed availability for 1991–92 in public and private hospitals (Chapter 4). Chapter 5 examines some aspects of the relationship between bed numbers and health expenditure. Chapter 6 focuses on the public/private bedmix.

1.12 The Committee's second broad term of reference is to 'examine other related matters which it considers should be drawn to the attention of the Assembly'. Arising out of the Committee's investigation of the matters outlined above, the Committee identified five further issues.

1.13 The first of these issues relates to the nature of bed projections to the year 2000 (Chapter 7). The second issue relates to population trends in the ACT and to the cross–border movement of NSW residents into the ACT hospital system (Chapter 8). The third issue identified by the Committee concerns the appropriate size of the ACT health area (Chapter 9).

1.14 Two additional matters that arose in the course of the Inquiry and that the Committee considers should be brought to the attention of the Assembly are the matter of new facilities for the ACT health system (a medical school and a hospice) and certain structural problems existing in the present health organisation. These matters are examined in Chapters 10 and 11 respectively.

2 THE REDUCTION IN BED NUMBERS

2.1. Both public and private hospital beds need to be considered in assessing trends in bed numbers. The ACT has three public hospitals and two private hospitals:

- Woden Valley Hospital (public);
- Calvary Public Hospital;
- Queen Elizabeth II Hospital (public);
- John James Memorial Hospital (private); and
- Calvary Private Hospital Inc.

2.2. In 1989 the ACT had 914 available beds in its public hospitals and 169 beds in the private sector. The public beds were distributed across hospitals as shown in Table 1.[1] The total number of available beds was 1083.

2.3. By June 1991 the number of public beds had dropped to 897 with no change in the number of private beds. Together, there were 1066 available beds.[2]

2.4. By June 1992 the ACT Board of Health expects the number of public beds to be 'somewhere in the range of 836 to 804'.[3] This means a reduction in public beds of between 61 and 93 beds. On the 1991 public beds figure, it represents a drop of between 6.8 percent and 10.4 percent.

2.5. The reduction in public beds is in part related to the closure of Royal Canberra Hospital and the building demands of work at Woden Valley Hospital. But the reduction cannot wholly be assigned to these circumstances.

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[1] Private beds comprised 119 at John James Hospital and 50 at Calvary Private Hospital [ACT Board of Health submission, p.13].

[2] The figure of 897 public beds was provided by Dr McLoughlin, Executive Director, Health Services Development Branch, ACT Board of Health, Transcript of Proceedings, Friday 29 November 1991, p.46.

[3] Ditto.

TABLE 1

ACT Public Hospitals - Available Beds

	RCHN	WVH	DETOX UNIT RCHS	CALVARY	QE II	TOTAL
The figures below refer to available beds as at 30 June.						
1976	550	411			13	974
1977	531	360			13	904
1978	531	360			13	904
1979	458	360		38	13	869
1980	449	365		121	13	948
1981	449	359		121	13	942
1982	449	355		121	13	938
1983	449	351		121	13	934
1984	449	316		121	13	899
1985	449	356	13	121	13	952
1986	417	375	13	121	13	939
1987	398	375	13	121	13	920
1988	392	375	13	121	13	914
1989	392	375	13	121	13	*914
1990	346	375	13	121	13	868
1991#	288	405	13	178	13	897

Source: ACTPAC available bed weekly figures till June 1991.
From July 1991 the source for the available beds will be Medilinc BEDUSE report

For all years includes: Coronary Care, Geriatric, Intensive Care, Medical, Obstetrics, Psychiatric, Rehabilitation, Surgical;
For this table the time series has been adjusted to include: Day Ward (20), Renal Unit (6), NICU (6), Calvary Nursing Home (20).

Excludes: Special Care Nursery Beds, Psychiatric Day Care places.

As time series is not available, excludes day procedure beds in Gastroenterology and Oncology (WVH)

Reproduced from ACT Board of Health submission to the inquiry.

2.6. In declining to describe the bed reduction as 'exceptional or dramatic' but rather as 'significant... but not entirely unexpected', the Chairman of the Board of Health stated (emphasis added):

> it is **partly** related to the fact that we are now moving to one principal hospital and you can manage a bigger hospital differently – and I do not mean differently just in terms of systems and so forth, but it really does give you a greater flexibility as to how you use it to respond to patient need because doing it in two hospitals clearly led to inefficiencies of use. I am not talking about money now, I am talking about the actual physical processes of using operating theatres and all of those sorts of things...[4]

2.7. The Committee considers the Board has been surprisingly reticent about the nature of the other reasons behind its reduction in public hospital beds.

2.8. 'In terms of managing the 1991–92 recurrent budget' for health[5], the Board outlined its options in a communication to the Minister in late September or October of this year[6].

2.9. The options are to close 20 short stay beds and perhaps two intensive care beds as well; or to keep the 20 short stay beds in use and perhaps open a 10 bed high dependency unit. These options are shown in Figure 1, which is reproduced from the Board's submission.

2.10. The Board comments that these options:

> can be implemented at relatively short notice depending on clinical demand, budgetary performance and the benefits arising from improved efficiency measures such as day surgery, use of the pre–admission clinic and early discharge programs. Budgetary performance will be closely monitored in order to assess the need for further reducing available beds or the possibility of increasing available beds.[7]

2.11. This comment suggests that budget imperatives will determine the Board's choice of options.

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[4] Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.45.

[5] ACT Board of Health, submission, p.20.

[6] ACT Board of Health, Advice to the Minister for Health entitled 'Management Strategy for Beds 1991–92', provided to the Estimates Committee of the ACT Legislative Assembly, October 1991.

[7] ACT Board of Health submission, p.20.

FIGURE 1

Available Beds (WVH/RCH) 1991/92

00
00
00
00
00
.00
00
0

699 700 700 N/A 626

d) 673
a) 663
b) 643
c) 641

Christmas closures to be advised

d) 673
a) 663
b) 643
c) 641

d) 641
a) 631
b) 611
c) 609

d) 641
a) 631
e) 629
b) 611
c) 609

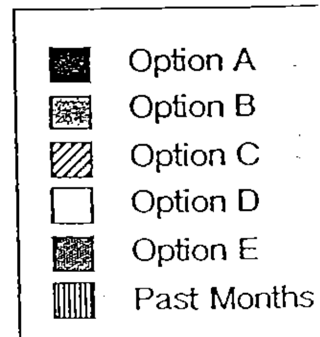
d) 641
a) 631
e) 629
b) 611
c) 609

d) 641
a) 631
e) 629
b) 611
c) 609

July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June

NB: July to October figures are actual monthly average
November to June figures are for the first day of that month

Notes:
(a) Budgeted level
(b) If option A
(c) If option B
(d) If option C
(e) If option D
(f) If option E



Option:
(A) Close 12A 20 short stay beds
(B) Option A and close 2 ICU beds
(C) Open 10 bed HDU
(D) Open 12A 20 short stay beds
(E) Options C and D

Reproduced from Board's submission

2.12. As well as the reduction of public beds at Woden, Calvary Hospital advised the Committee that it has adopted a strategy of reducing 'available beds (seasonally adjusted) throughout the year'.[8] In effect, Calvary Public Hospital is seeking to capitalise on low periods of demand for hospital beds by programming in a reduction of services at certain times (such as Christmas and school holidays).

2.13. It is evident from Table 1 that there has been only one other occasion in the past fifteen years when public hospital beds have declined by the magnitude intended for the current year. That occasion was in 1976–77, when public beds reduced by 70.

2.14. In its discussions with certain hospitals and Area Health authorities in NSW, the Committee heard that a drop in bed numbers during the past year of 10 percent (in the case of St Vincent's Public Hospital) and 8 percent (in the case of the Illawarra Area Health Service) was as much as could be suffered without reducing the quality and range of patient services.

2.15. The Committee notes that the bed reductions in those two places reflect financial stringencies over a longer period than the ACT hospital system has endured; and to that extent, the ACT system may be more able to cope. On the other hand, the bed/population ratio in these areas was significantly higher than that existing in the ACT in 1991 before the current reductions were put in train.

2.16. At this stage in the Report the Committee simply observes that some other health systems have found reductions of the magnitude underway in the ACT very difficult to deal with.

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[8] Calvary Hospital ACT Incorporated, submission, p.3.

3 BED NUMBERS AND THE QUALITY OF PATIENT CARE

3.1. The Committee was made very much aware in its discussions with health officials in the ACT – as well as in NSW – that hospital bed numbers in themselves are an inadequate measure of the quality of health systems. These comments turned the Committee's attention toward examining the broad range of measures seen by health authorities as relevant to an assessment of 'quality'.

3.2. The Committee's observations on this point are not claimed to be authoritative but simply reflect the Committee's efforts to understand the gist of the information put before it.

3.3. The Committee understands that at least five broad types of indicator are currently being used by health administrators to assess a hospital system. These indicators are:

- capacity measures;
- throughput measures;
- target measures;
- peer–assessment measures;
- measures to do with the health status of the population.

Capacity Indicators

3.4. Capacity indicators describe the physical resources available to a hospital system. The resources include beds, operating theatres, staff numbers and budget levels. It does not appear out of place to consider the number and type of patients as a further capacity indicator. In addition, it is possible to view the range and nature of disease as a 'resource' and hence the pattern of casemix becomes a useful indicator of a population's quality of health.

3.5. Each of the capacity indicators needs to be carefully and uniformly defined before it can be properly used to make comparisons between health areas. This is true not just of capacity indicators but of all types of indicators.

3.6. There is an Australia–wide effort to align all data collection systems to the definitions contained in the National Minimum Data Set (NMDS). The submission from the ACT Board of Health states 'the ACT is making good progress in realigning its data collection systems to NMDS definitions'[9].

3.7. In the case of beds, Australian authorities have adopted the term 'approved' beds as a national measure. It means:

> For acute and psychiatric hospitals the number of beds which are immediately available to be used by admitted patients or residents if required. The beds are immediately available for use if located in a suitable place for care, and there are nursing and other auxilliary staff available, or who could be made available within a reasonable period, to service patients or residents who might occupy them[10].

3.8. The submission from the ACT Board of Health comments that problems still remain with this definition, particularly in relation to 'beds' used for day procedures, cots for neonates and clarifying 'what constitutes normal management flexibility in terms of individual bed openings or closures in wards and when the beds are formally available'[11].

3.9. Rather than attempt to work through each of the capacity indicators, the Committee comments on one particularly interesting indicator: that of casemix. A comment on budget resources is made in Chapter 5.

3.10. Analysis of casemix data includes the preparation of diagnosis–related groups of illnesses (DRGs). The Committee was told by senior staff of St George Hospital in Sydney that the use of DRGs has taken a year to get up and running, in part due to the need to train doctors to classify their procedures in the appropriate manner.

3.11. The St George Hospital executives commented that they see the use of DRGs as a pre–requisite for funding of hospitals on an output basis, that is, funding being based on estimates of the cost of treatment or diagnosis. The executives added that they expected the Federal and State governments to move to this type of hospital funding in the near future.

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[9] ACT Board of Health Submission, p.15

[10] National Minimum Data Set, recommended by the Australian Institute of Health on behalf of the Australian Health Ministers' Advisory Council. Quoted in the ACT Board of Health submission, p.16.

[11] Ibid, p. 17

3.12. Collection of casemix data also enables a relative stay index (RSI) to be prepared. This index:

> compares the actual length of stay for each individual case at a hospital with the average length of stay for all similar cases throughout all acute hospitals in the State.
>
> The RSI is thus a measure of comparison between an individual hospital and the number of bed days utilised to process all cases, compared to the number of bed days which would have been expected to be used based on the average length of stay for similar cases in other hospitals in NSW. An RSI greater than 1.00 indicates that more bed days have been used at that hospital than expected for that case mix, whilst an RSI less than 1.00 indicates less bed days being utilised than expected.[12]

3.13. The Committee was provided with examples of the use of DRG and RSI data by the St George Hospital and Illawarra Area Health Service (respectively). The Committee considers the information contained in these indicators to be very useful in assessing the relative performance of a hospital system.

Throughput Measures

3.14. Throughput measures assess the efficiency of resource use. Hence they include bed/population ratios, beddays and bed occupancy rates; information on operating theatre usage; staff productivity figures and staff/patient and staff/population ratios; and cost per bed day and cost per admission.

Target Measures

3.15. Target measures refer to the assessment of a hospital system's ability to meet specified targets. The NSW Department of Health utilises this measure as one way to assess how well the Area Health Boards are performing. Of course, the traditional use of target measures relates to ability to live within a given budget.

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[12] Illawarra Area Health Service, Health Development Unit, **Data Bulletin**, Volume 2 No.2, May 1991, p.1.

Peer Assessment Measures

3.16. Peer assessment measures have always existed but the Committee was told of a national model called the Clinical Indicators Program (CIP) 'which all the Royal Australian Colleges have endorsed'[13].

3.17. The CIP comprises numerous throughput measures, such as:

> admission rates, average length of stay, numbers of theatre procedures, but [it] then gets down into the clinical level and talks about things like wound infection rates..., unplanned readmission rates, waiting times to be seen, and accident emergency...
>
> And then there are a series of events that are, one hopes, rare but each one is worth investigating, so-called censorial events. So if someone dies unexpectedly that is a cause for inquiry, and so there needs to be a system that identifies them, monitors them and sees whether there was anything that could have been done to prevent it... And then each of the [clinical] Colleges, individually, has undertaken to put in place a series of speciality specific indicators, so there is surgical, medical and so on... the Colleges are having great difficulty actually describing quality in their own sub-speciality terms as well. Most of them have draft indicators and we are adopting those.[14]

3.18. The Committee understands that these kinds of specific measures will not be in place in the ACT for four to five years. The Committee heard that 'we are just at the point where we can start collecting most of the hospital-wide indicator data...'[15]

3.19. Another kind of peer assessment measure concerns the grant of accreditation status to an individual hospital by the Australian Hospital Standards Association. Accreditation serves to indicate to the community served by that hospital that its standards meet national, uniform criteria.

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13 ACT Board of Health submission, p.8.

14 Dr O'Donnell, Executive Director, Clinic Services, Woden Valley Hospital. Transcript of Proceedings, Wednesday 29 November 1991, pp.40-41.

15 ibid, p.41.

3.20. The Committee understands that Calvary Public Hospital has consistently obtained accreditation status but Woden Valley Hospital has never obtained full accreditation. The Committee further understands that Woden Valley hospital will seek to upgrade its accreditation in 1993.[16]

Measures to do with the Health Status of a Population

3.21. The health status of a population is indicated 'by trends in mortality rates...and average life expectancy rates' as well as by certain other measures.[17] These trends are just that: indicative only – since 'causal relationships are difficult to establish and measure'[18] Nonetheless, the Committee considers this kind of information provides useful insights into the quality of a health system.

Summing Up

3.22. The Committee considers that the full range of indicators noted above is necessary to adequately assess the quality of a hospital system and the quality of patient care existing within it.

3.23. The Committee is struck by the ready availability of such data in publications of the NSW Department of Health and by the absence of such a range of data in publications of the ACT Board of Health. An indication of the NSW data is provided in the four tables attached to this Chapter:

> Table 2: Trends in Health Status and Public Health Services NSW 1984/85 – 1990/91;
>
> Table 3: Key Performance Indicators for NSW Public Hospital Services for the Year Ended 30 June 1991 – State Summary;
>
> Table 4: Key Performance Indicators for NSW Public Hospital Services for the Year Ended 30 June 1991 – State Summary, Adjuncted for Casemix; and
>
> Table 5: Private Hospital Activity Levels – NSW for Year Ended 30 June 1991.

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[16] See ACT Department of Health, **Boardtalk**, Volume 1, No.2, July 1991.

[17] NSW Department of Health, Contracts and Performance Unit, **Health Service Performance 1990/91**, September 1991, p.6.

[18] ditto

3.24. The Committee considers the ACT community is entitled to similar information on health issues to that appearing in NSW. The Committee also considers that the ACT community would benefit from seeing how ACT health indicators compare to those in NSW. The Committee finds it anomalous that Tables 2–5 show information for all the Areas around the ACT but not the ACT itself.

3.25. Therefore, the Committee recommends that:

the Board of Health provide to the ACT community detailed information on quality of health indicators.

3.26. Further, the Committee recommends that:

the Board construct annual statistical information on ACT health in a form comparable to information produced in NSW.

3.27. In relation to accreditation, the Committee considers the ACT community would find reassurance in the progress of the hospital redevelopment project were Woden Valley Hospital to secure full accreditation in the near future.

3.28. Accordingly, the Committee strongly recommends that:

the Board of Health make every effort to facilitate the grant of accreditation status to Woden Valley Hospital in 1993 and in each ensuing year.

3.29. Following its consideration of quality of health issues in this Chapter, the Committee is left with the need to assess the importance of bed numbers to the quality of patient care.

3.30. The Committee readily acknowledges that the material in this Chapter places bed numbers in a realistic light as one of a whole number of measures of quality.

3.31. Yet, the underlying importance of a capacity indicator like bed numbers was suggested to the Committee by a hospital administrator in Sydney who said words to the effect that: 'There must be a minimum number of beds to sustain a quality of service – but we don't know what it is'.

3.32. The Committee remains concerned that the sharp reduction in public hospital beds currently underway in the ACT moves the ACT nearer to that 'minimum number'. The following Chapter elaborates on the 'appropriate' level of bed available in 1991–92.

TABLE 2

TRENDS IN HEALTH STATUS AND PUBLIC HEALTH SERVICES N.S.W. 1984/85 – 1990/91

	1984/85	1985/86	1986/87	1987/88	1988/89	1989/90	1990/91 (6)
HEALTH STATUS							
Death rate (adj. for age and sex)	754.4	767.6	710.8	720.1	720.8	700.3	688.9
Mortality rates – leading causes							
– Ischaemic heart (males)	245.2	243.6	223.6	224.4	217.4	208.4	200.9
– Ischaemic heart (females)	182.9	186.9	179.8	176.3	174.3	171.7	168.9
– Lung Cancer (males)	59.2	59.0	55.3	54.3	54.0	51.8	50.3
– Lung Cancer (females)	14.9	16.3	17.2	16.1	19.6	19.6	20.5
Perinatal death rate *	13.64	12.30	12.81	12.38	12.50	12.1	11.9
Expectation of life at birth (Years)							
– males	72.07	72.10	72.52	72.92	72.56	72.97	73.15
– females	78.60	78.71	78.84	79.32	78.92	79.45	79.51
EFFECTIVENESS							
Admissions	821,910	888,147	912,415	947,024	972,425	990,455	1,035,000
Admissions per 1,000 pop'n	151.0	161.6	163.7	167.3	169.2	170.8	176.7
Day only admissions	136,773	171,083	188,231	205,379	222,528	242,590	276,500
Day only admissions as % of total adm	16.6	19.3	20.6	21.7	22.9	24.5	26.7
Total procedures (1)	422,573	377,203	461,500	436,522	453,085	468,500	487,000
Public hospital market share (%) (2)	81.2	81.5	80.8	82.9	82.6	82.5	n.a.
EFFICIENCY							
Total staff (F.T.E.)	68,386	68,246	71,035	73,159	73,798	74,389	74,724
Staff productivity (3)	14.7	16.2	17.1	18.3	18.7	18.8	19.5
Staff to patient ratio (4)	2.2	2.2	2.3	2.2	2.2	2.5	2.6
Staff to population ratio	12.6	12.4	12.7	12.9	12.8	12.8	12.8
Average length of stay	10.9	10.1	9.5	9.2	8.2	7.7	7.5
General hospital beds	22,630	21,849	21,805	21,475	20,867	20,824	20,900
General hosp. beds per 1,000 pop'n	4.2	4.0	3.9	3.8	3.6	3.6	3.6
Bed occupancy (%)	73.2	71.6	73.5	79.2	78.2	78.9	79.6
Caseflow Rate (5)	25.4	28.2	30.0	30.5	32.3	36.9	38.4
Average waiting time (Months)	n.a.	n.a.	n.a.	n.a.	n.a.	1.0	0.8

Notes

(1) Principal procedures in N.S.W. public hospitals.
(2) Based on the proportion of total bed days in NSW applicable to public hospitals
(3) Represent the number of admissions (adjusted for non–inpatient activity) per full time equivalent staff.
(4) Represents number of staff per adjusted daily average.
(5) Also known as throughput per bed.
(6) Health status indicators for 1989/90 and 1990/91 are projections only.

Source: NSW Department of Health, Health Service Performance 1990/92, Appendix 4.

TABLE 3

A. KEY PERFORMANCE INDICATORS FOR N.S.W. PUBLIC HOSPITAL SERVICES FOR THE YEAR ENDED 30 JUNE 1991 – STATE SUMMARY
PROGRAM 2.3

AREAS/REGIONS	Bed Occupancy Rate	Staff to Patient Ratio	Admissions per Staff**	Caseflow Rate**	Admission Elasticity	Cost per Bed Day ($)**	Cost per Admission ($)*++	Variation from Budget++
Central Sydney	84.1	3.7	19.2	55.1	0.51	510	2,653	0.9
Northern Sydney	84.5	3.3	21.1	57.2	0.31	492	2,614	0.5
Southern Sydney	86.8	2.9	23.5	58.8	0.07	425	2,274	–0.2
Eastern Sydney	82.5	3.3	21.3	56.3	0.64	487	2,504	–0.4
Western Sydney	84.0	3.4	20.8	57.8	0.46	485	2,497	–0.6
Wentworth	80.5	2.6	28.6	59.9	0.16	373	1,810	–1.4
South Western Sydney	80.2	2.6	26.1	54.0	0.87	377	2,023	–1.8
Central Coast	90.2	3.1	23.5	65.4	0.77	400	2,001	0.8
Hunter	74.6	3.2	21.7	50.4	0.35	436	2,274	1.8
Illawarra	77.3	3.2	23.7	57.0	0.36	426	2,066	1.6
TOTAL AREAS	82.2	3.2	22.1	56.3	0.34	454	2,354	0.1
North Coast	74.8	2.3	32.2	55.2	0.01	361	1,739	0.0
New England	74.9	2.2	27.0	44.0	0.39	307	1,848	–0.6
Orana & Far West	58.6	2.7	31.0	48.5	0.28	360	1,593	–0.2
Central Western	69.5	2.3	24.8	39.9	0.34	303	1,928	–1.1
South West	73.0	2.4	22.0	37.9	0.33	307	2,136	–1.0
South Eastern	65.9	2.4	27.5	43.7	0.28	307	1,675	0.0
TOTAL REGIONS	70.6	2.4	32.6	45.0	0.25	324	1,828	–0.5
OTHERS	75.7	4.4	18.7	62.4	1.00	613	2,705	0.1
TOTAL NSW	78.2	3.0	23.2	52.5	0.32	418	2,215	0.0

* Include Programs 1.3, 2.2, 2.3, 2.5, 2.6, 2.8, 2.9, and 2.10.
** These ratios were adjusted for non–inpatient activity.
\+ Cost are based on gross operating payments.
++ (–) indicates underbudget while (+) overbudget (unfavourable).

Source: NSW Department of Health, Health Service Performance 1990/91, Appendix 1

TABLE 4

B. KEY PERFORMANCE INDICATORS FOR N.S.W. PUBLIC HOSPITAL SE
FOR THE YEAR ENDED 30 JUNE 1991 – STATE SUMMARY
PROGRAM 2.3
ADJUSTED FOR CASEMIX

Area/Region	Staff to Patient Ratio	Admissions Per Staff*	Cost per Bed Day ($)+	Cost per Admission ($)*+	Casemix Index **
Central Sydney	3.8	18.6	525	2,734	0.97
Northern Sydney	3.6	19.1	541	2,886	0.91
Southern Sydney	3.2	21.4	463	2,494	0.92
Eastern Sydney	3.8	18.5	558	2,879	0.92
Western Sydney	4.3	16.6	606	3,132	0.80
Wentworth	3.5	21.7	491	2,390	0.76
South West Sydney	3.3	20.5	477	2,567	0.79
Central Coast	3.6	19.9	471	2,363	0.85
Hunter	4.0	17.2	545	2,870	0.80
Illawarra	3.9	19.2	519	2,545	0.82
TOTAL AREAS	3.7	18.7	533	2,772	0.86
North Coast	3.0	25.4	457	2,210	0.79
New England	3.1	19.7	420	2,529	0.73
Orana & Far West	3.7	22.4	500	2,206	0.72
Central Western	3.1	18.6	404	2,564	0.75
South West	3.1	17.1	394	2,744	0.78
South Eastern	3.3	20.1	421	2,288	0.73
TOTAL REGIONS	3.1	20.8	426	2,397	0.76
OTHERS	3.4	14.1	906	3,643	0.74
TOTAL N.S.W.	3.6	19.1	507	2687	0.83

* These ratios were adjusted for non-inpatient activity.
+ Costs are based on gross operating payments.
** Refers to 1989/90 data.

Source: NSW Department of Health, Health Service Performance 1990/91, Appendix 1

TABLE 5

PRIVATE HOSPITAL ACTIVITY LEVELS - N.S.W.
FOR YEAR ENDED 30 JUNE, 1991

Area/Region	Admissions	% var. over 1989/90	Market Share %	Day Only Admiss.	% var. over 1989/90	Market Share %	Daily Ave.	No. of Lic. Beds	Bed Occ. Rate	Total Bed Days (000)
Central Sydney	30,213	9.8	28.0	14,984	26.5	35.7	320	546	58.6	116.7
Northern Sydney	77,967	9.9	45.4	31,042	17.8	53.4	942	1,773	53.1	343.7
Southern Sydney	28,955	11.3	35.5	11,710	43.0	47.4	232	407	57.0	84.7
Eastern Sydney	43,777	8.7	28.7	19,099	22.5	34.0	566	863	65.5	206.4
Western Sydney	30,595	-1.3	22.6	12,157	2.9	25.8	215	412	52.2	10.5
Wentworth	7,258	24.9	18.7	1,782	187.9	21.7	102	165	61.6	37.1
South West Syd.	22,424	-4.1	22.0	9,082	8.9	31.3	145	375	38.7	52.9
Central Coast	14,088	21.1	30.1	4,318	24.4	30.4	144	288	50.0	52.6
Hunter	35,296	15.3	28.9	17,079	45.7	42.1	306	427	71.7	111.8
Illawarra	17,422	2.1	28.0	4,135	36.2	25.9	158	262	60.5	57.8
All Areas	307,995	8.3	30.1	125,388	24.2	37.3	3,129	5,518	56.7	1074.2
North Coast	18,754	47.9	20.1	6,237	35.1	29.7	209	379	55.1	76.2
New England	9,625	9.2	14.8	2,592	26.7	18.2	96	158	60.9	35.1
Orana & Far Wes	1,383	-4.0	3.6	311	46.0	5.6	17	40	42.0	6.1
Central Western	4,153	0.7	9.2	324	14.9	3.5	45	72	62.1	16.3
South West	12,659	9.6	20.5	5,550	19.1	37.2	118	184	63.9	42.9
South Eastern	745	21.3	2.0	745	21.3	11.1	n.a.	0	n.a.	0.7
All Regions	47,319	20.6	13.9	15,759	26.8	22.1	486	833	58.4	177.3
TOTAL N.S.W.	355,314	9.8	25.7	141,147	24.4	34.1	3,615	6,351	56.9	1251.5

Source: Activity data - D.O.H.R.S.
Bed numbers - Commercial Development Branch

Reproduced from NSW Department of Health, Health Service Performance 1990/91, Appendix 3.

4 THE APPROPRIATE LEVEL OF BED AVAILABILITY FOR 1991–92

4.1. The 'appropriate' level of bed availability should take account of factors listed in the preceding Chapter. The Committee's attention has not been drawn to a thorough and topical study of all these factors in the ACT in the context of the number of beds which should be in place.

4.2. The Committee expresses concern that the submission to the Inquiry by the ACT Board of Health appeared quite dismissive of bed numbers yet did not adequately indicate what more appropriate measures are available to be used at this time. The Board's submission states that:

> bed numbers are not related to the capacity of the system to increase the services to clients.
>
> There is also no evidence that bed numbers or changes in bed numbers are directly related to either booking lists or the quality of patient care. This is because both bed numbers and booking lists are too crude to be useful measures of performance. The number of patients admitted is not a product merely of bed capacity or even of available beds, but of operating theatre time, the types of procedure required, availability of appropriate specialists etc. The number of patients actually seen is also not related to those booked on the appointments list.[19]

4.3. The Board's submission and its oral testimony shows it is relying greatly on the development of the Clinical Indicators Program. In discussions during the Committee's visit to Calvary Hospital, the Executive Director of the ACT Board of Health, Ms G Biscoe, indicated these kinds of specific measures would not be in place in the ACT for four to five years.

4.4. The Committee is concerned the Board's submission did not provide details on the range of indicators able to be utilised in lieu of beds. It seems to the Committee that the Board is in effect advising the Government and the ACT community that the quality of the health system is unable to be assessed until the Clinical Indicators Program is in place The Committee urges the Board to expedite the collection of such data.

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[19] ACT Board of Health submission, pp.7–8

4.5. **The Committee recommends that:**

the ACT Board of Health develop an overall strategy for assessing the quality of health – the strategy to utilise demonstrable indicators able to be monitored by the community, including comment on the significance to be accorded to hospital bed numbers.

4.6. In October 1991 the ACT public hospital booking lists comprised 1644 people[20] Of those waiting for admission to Woden Valley Hospital, 89 percent had waited less than six months. The Board considers this 'is a very good result indeed'.[21]

The Committee is not in a position to comment on whether the size of the booking list is a 'very good result'. The Committee was advised by senior staff of the Illawarra Area Health Service that its booking list was 1500 (of whom 500 cases were orthopaedic in nature) and that the Illawarra Board was not happy with this figure. The Board's submission to the Inquiry also commented that in the ACT 'there is no waiting list for urgent cases'[22].

4.7. The Committee was told by NSW Department of Health officials that an average wait of six months for admission to hospitals was not an indication of the hospital system having difficulty in coping with demand. However, waiting times in excess of six months tended to attract adverse media and political comment.

4.8. The Committee was also told it is important to look at the percentage change in waiting lists for each clinical speciality. The Committee is not in receipt of the relevant ACT figures.

4.9. The significance of operating theatre time was raised by NSW health officials in discussions with the Committee. Some Sydney public hospitals have made theatres available at weekends in order to facilitate elective surgery and hence to reduce waiting lists and times. The Committee was told that many patients appreciate the convenience of surgery performed on weekends because it facilitates child-care arrangements for working parents and reduces the time that patients are away from their work. The Committee understands that hospitals are pleased with the results.

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[20] Dr O'Loughlin, Transcript of Proceedings, Friday 29 November 1991, p.38.

[21] ibid, p.39.

[22] ACT Board of Health Submission, p.8.

4.10. In response to a question by Mrs Grassby MLA on the possibility of doing this in the ACT, the Chairman of the ACT Board of Health commented 'in a small community [like Canberra] I think it would be impossible to achieve in practice'.[23] The Committee would be pleased to have this matter investigated in greater detail by the Board.

4.11. Accordingly, the Committee recommends that:

the Board of Health advise the Minister about the feasibility of using operating theatres in public hospitals on weekends.

4.12. The Committee notes with concern that one type of option developed by the Board to handle the 1991–92 recurrent budget involves reducing the number of operating theatres in use. The Board's options in relation to theatre availability are outlined in advice from the Board to the Minister for Health:

> In addition to management options for available beds there are also options for theatre availability.
>
> A two theatre Day Surgery suite will be commissioned in March 1992. Options at this time are:
>
> > To open two Day Surgery theatres;
> >
> > To open two Day Surgery theatres and decommission one main Operating Theatre;
> >
> > Open two Day Surgery theatres and decommission two main Operating Theatres;
> >
> > Open one Day Surgery theatre and close one main Operating Theatre; and
> >
> > Open one Day Surgery theatre.[24]

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[23] Mr Service, Transript of Proceedings, Friday 29 November 1991, p.29.

[24] ACT Board of Health, Advice to the Minister for Health entitled 'Management Strategy for Beds 1991–92', provided to the Estimates Committee of the ACT Legislative Assembly, October 1991.

4.13. The Committee considers the effect of closing operating theatres would be to lengthen waiting lists and increase community concern about the quality of patient care . The Committee is also concerned that the proposal to close operating theatres runs directly counter to the comment by the Chairman of the Board that 'we need less beds and more operating theatres'.[25]

4.14. The Committee is particularly concerned that closure of a day surgery theatre would impact adversely on the Board's overall strategy for reducing the demand for in–patient admissions (and hence the demand for beds).

4.15. The Board's submission describes elements of the strategy as:

- significantly increasing day surgery (which should increase rather than decrease throughput in the hospital system);
- increase in admissions through the pre–admission clinic which will remove the need for overnight stays prior to surgery in a number of cases;
- introduction of early discharge programs; and
- support service efficiencies which will reduce the cost per unit of care provided.[26]

4.16. The Chairman of the Board commented that:

> day admissions and day surgery...is clearly an area where there are dramatic changes occurring; and to some extent that will help us contain costs.[27]

4.17. The ACT Board of Health is reviewing its plans for day–procedure units at Woden Valley and Calvary Hospitals. The review is expected to be finalised early in 1992. The Committee was informed that the Board of Management of Calvary Hospital hopes a day–procedures unit 'can be established at the hospital in the current year'.[28]

4.18. The Committee understands that the present level of day–procedures performed in the ACT is probably half the Australian average figure of about 25% of all procedures. Clearly, the ACT has some catching–up to do in terms of promoting day–surgery. The closure of one of the specialised day–surgery theatres could hardly be said to encourage this catching–up.

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[25] Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.8.

[26] ACT Board of Health submission, p.21.

[27] Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.8.

[28] Calvary Hospital ACT Incorporated, submission, p.2.

4.19. **The Committee recommends that:**

the Board does not reduce the number of operating theatres, particularly day–surgery theatres, in use in ACT public hospitals.

4.20. The Committee was told that the number of beds available in intensive–care environments is critical to the quality of care able to be provided to patients. The Committee notes that one of the Board's options in managing the 1991–92 budget involves a possible loss of two intensive care beds.[29]

4.21. The Committee recommends that:

the Board provide a detailed rationale to the Government before closing any intensive–care beds.

4.22. Following its visit to Woden Hospital the Committee became concerned at the apparent shortage of beds in the Accident and Emergency Department of that hospital. The existing cramped conditions will not be adequately remedied until the new diagnostic block is opened in over two years time. The Committee would be concerned if the present situation was allowed to continue for this time.

4.23. The Committee recommends that:

pending completion of the new diagnisotic block at Woden Valley Hospital the Board of Health urgently updgrade the present facilities in the Emergency Department of Woden Valley Hospital.

4.24. In its discussions with senior management of both St Vincent's Public Hospital and the St George Hospital, the Committee was made aware of the difficulties associated with the management of beds for patients admitted through Emergency Departments. Both hospitals have developed clear strategies to ensure sufficient inpatients beds are available for such admissions.

4.25. These strategies include procedures to enable the Medical Registrar to discharge a ward patient in order to make room for an Emergency admission. This means speaking to the clinician responsible for the ward patient. The Committee was told the procedure can work very quickly if senior consultants are involved at an early stage but is considerably slower if junior doctors are involved.

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29 Board of Health advise to the Minister for Health, Management Strategy for Beds 1991/92, tabled in the Estimates Committee of the Legislative Assembly, October 1991, p.2.

4.26. The Committee is not aware whether similar procedures are in place in Woden Hospital. If they are not, **the Committee recommends that:**

> **the Board of Health urgently develop appropriate procedures to facilitate in-patient admissions through the Emergency Department of Woden Valley Hospital.**

4.27. The Committee received a submission from the Aged Services Association of NSW and ACT Incorporated commenting on the relationship between hospital beds, long-term stay beds, nursing homes and hostels. The submission pointed out that:

> the Association's members are very sensitive to any change in the number of hospital beds for both acute and long term stay. Any change in the availability of these beds immediately reflects upon the demand and utilisation for nursing home beds and to a lesser extent hostel beds in the area...
>
> In the ACT there are waiting lists for admission to most frail aged care facilities and any disruption to the existing supply of long term stay beds in hospitals would have an immediate effect on the waiting lists and waiting times for people to be admitted to nursing home or hostel occupancy.[30]

4.28. The Board of Health estimates that the ACT public hospital system has about 44 'more or less nursing-home type beds'.[31] The Aged Services Association states that 20 aged persons are currently in the ACT public hospital system pending their admission to a nursing home. These people have been assessed by the geriatric assessment team as eligible to enter a nursing home but there are no places for them.[32]

4.29. The Association's key concern is that:

> if there is any reduction in the long-term care beds in the hospital system, without a commensurate increase in alternative options in hostel and nursing home, or an expanded Home and Community Care Program or a Hostels Options Program, where are these people going to be located.[33]

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30 Aged Services Association of NSW and ACT Incorporated, submission, p.2.

31 Dr O'Donnell, Transcript of Proceedings, Friday 29 November 1991, p.59.

32 Mr Keats, Executive Director of the Aged Services Association of NSW and ACT Inc, Transcript of Proceedings, Wednesday, 4 December 1991, p.133.

33 Mr Keats, ibid, p.134

4.30. The Committee shares the concern of the Aged Services Association.

4.31. The Committee recommends that:

a detailed study be undertaken of the impact on nursing homes and hostels in the ACT consequential upon any reduction in the number of acute and long term stay hospital beds in the ACT. Further, the Committee recommends that nursing homes and hostels operating within the ACT be involved in the study and be invited to participate in discussions.

4.32. The Committee recognises that, although hospitals are inappropriate accommodation for non–acute geriatric patients, the unavailability of alternative accommodation in sufficient numbers presents a problem in removing nursing–home beds from hospitals.

4.33. The Committee recommends that:

the Board of Health not reduce nursing–home type beds in the public hospital system until alternative facilities are in place.

4.34. During the course of its Inquiry the Committee heard repeated comment about the need for convalescent (or slow–stream) rehabilitation beds. The Committee understands that this type of facility enables patients to be treated more appropriately and at less cost than in hospitals equipped to provide acute care. If this type of bed is not available in sufficient numbers, then unnecessarily high bed levels have to be maintained in the acute care hospitals.

4.35. The Committee was told:

> there is very little room in the acute care sector in Australia these days for convalescence either in the private or the public sector. We just do not have the beds or the money to allow people to stay in hospital for 5 or 6 days and recuperate.
>
> The provision of private hospital services is too expensive to establish and the funding of sub–acute patients would be not sufficient to allow either the public or the private sector to provide those sorts of services.[34]

4.36. The Committee is concerned about this situation. The Committee realises that there is a national emphasis on moving non–acute patients, especially slow–stream patients, out of acute–care hospitals. This move is driven by the need to hold the growth of hospital costs.

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34 Dr Herring, Executive Director, Australian Private Hospitals' Association Limited, Transcript of Proceedings, Friday 29 November 1991, pp.84–85.

4.37. However, the Committee considers this budget–driven imperative may threaten the well–being of the convalescent/rehabilitation class of patient – just as it does the nursing–home type patients.

4.38. The Committee recommends that:

the Government examine, as a matter of priority, the provision of suitable facilities for convalescent/rehabilitation patients – possibly at Acton Peninsula.

4.39. The Committee's attention has been drawn to the use of bed/population ratios to indicate the appropriate level of bed availability. The Board's submission includes a comparison of bed/population ratios in the States in 1989/90 (Figure 2). The ACT is shown to have the lowest bed/population ratio (3.72).

4.40. The current reduction in public bed numbers will lower this ratio as will the changes taking place in the ACT's population since 1989/90. If the ACT's population in 1992 is assumed to be 296,000 (based on figures from the Australian Bureau of Statistics for the past year – see Chapter 8) then the bed/population ratio in 1992 will be about 3.3 beds per thousand people. The ratio would move even lower if the population figure is adjusted upwards to reflect the cross–border movement of NSW patients into the ACT (see Chapter 8).

4.41. The bed/population ratios (public and private beds) in NSW Health Areas are shown in Table 6. Only four of the eleven Health Areas have a ratio at or below the expected figure for the ACT in 1992. One of the four (Southern Sydney) is significantly lower than all other areas. However, the Committee notes this Area is greatly expanding its major hospital (St George) and is hoping to attract a large private hospital of over 200 beds.

4.42. The Committee was advised by officials of the Illawarra Health Area Service that its bed/population ratio (shown as 3.6 in Table 6) has dropped to 3.1 following the closure of 70 beds since July 1991. The Illawarra officials consider they are unable to close further beds without significantly reducing patient services.

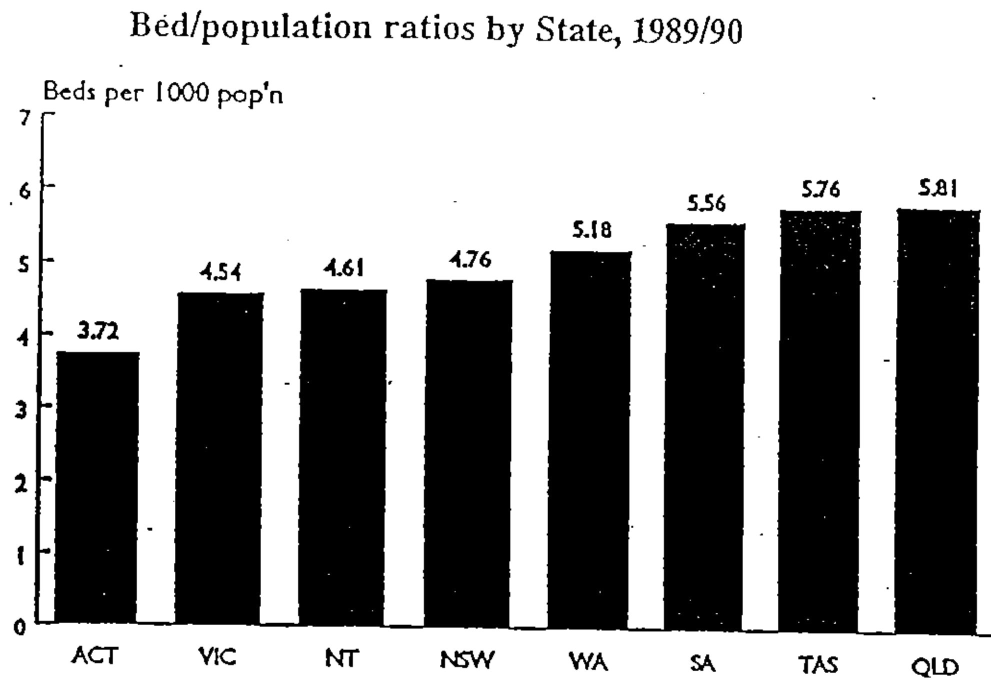
4.43. The NSW Department of Health is aiming for a State–wide average of 3.5 beds/population in the year 2000. The National Health Strategy's Issues Paper No 2 suggests a target of 3.3 is appropriate for the year 2000. The ACT will reach this target figure next year (1992).

4.44. The Committee is concerned the bed reductions underway in the ACT appear to move the ACT too quickly to a target level that may be more appropriate for the latter 1990's.

4.45. The Committee recommends that:

the Board of Health, in conjunction with the Government, reconsider its program of bed reductions as a matter of urgency.

Figure 2



Source: *State Health Authorities, 1991*

TABLE 6

NSW BEDS PER 1,000 POPULATION BY HEALTH AREA

Area/Region	General Public Hospitals 1990/91	Public & Private 1990/91
Central Sydney	4.0	5.6
Northern Sydney	2.4	4.6
Southern Sydney	1.9	2.6
Eastern Sydney	6.2	8.6
Western Sydney	3.2	3.9
Wentworth	2.4	3.1
South Western Sydney	2.8	3.4
Central Coast	2.0	3.1
Hunter	3.5	4.4
Illawarra	2.7	3.6
All Areas	**3.0**	**4.3**
North Coast	3.4	4.3
New England	5.0	5.7
Orana & Far West	6.9	7.2
Central Western	6.1	6.5
South West	5.6	6.3
South Eastern	4.4	4.4
All Regions	4.9	5.5
Total Areas/Regions	3.5	4.5

Source: NSW Department of Health, Health Service Performance 1990/91, September 1991, p.4.

5 HOSPITAL BEDS AND HEALTH EXPENDITURE

5.1. Expenditure on hospitals is a significant proportion of public sector spending. In the ACT in 1990–91, spending on public hospital services accounted for 14% of total government spending.[35] The level of expenditure in 1990–91 ($231m) is budgeted to drop by 8% in the current year (to $212m).[36]

5.2. The Chief Minister state in the 1991–92 Budget Speech that the Budget reduction reflects:

> substantial productivity improvements. In particular, the Board will commence an integrated day surgery service at Woden Valley Hospital. The improvements will allow the Board to reduce the number of beds required to be opened and staffed, and to pull back from last year's spending level, which included an unauthorised $6 million overexpenditure.
>
> The Board of Health will be attempting to maintain elective services at current levels. Overall admissions will be at or above 1989–90 levels.[37]

5.3. In a separate Budget Paper, the Government notes that the 1989–90 admission level was some 4% below 1990–91 levels. The same Budget Paper also makes the following comment on the outlook for 1991–92:

> maintenance of acute services and maintenance of elective and support service levels to the extent possible while decreasing the marginal number of beds through productivity gains.[38]

5.4. The reference to maintenance of services 'to the extent possible' implies that the services will be reduced if budget pressures blow out in any way. The reference to 'marginal number of beds' is puzzling. The Committee does not consider it likely that either the ACT Government or the Board of Health would view a reduction of 61 to 93 beds as 'marginal'. Indeed, at one point in his testimony before the Committee, the Chairman of the Board described the reduction as 'significant...[though] not entirely unexpected'.[39]

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35 ACT, **Budget Overview 1991–92,** Budget Paper No. 2, p.39.

36 Ibid, p.51.

37 Ms Follett, MLA, Chief Minister, **Budget Speech 1991–92,** Budget Paper No.1, p.18.

38 ACT Budget, **Program Information and Estimates 1991–92,** Budget Paper No.5, p.249.

39 Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.45.

5.5. The Board's strategy for achieving significant productivity gains rests not just on increasing day surgery procedures but on reducing the number of in–patient days through use of the pre–admission clinic and early discharge program. As well, the Board proposes to 'support service efficencies which will reduce the cost per unit of care provided'.[40]

5.6. The Committee noted in Chapter 3 that the Board's hopes for increasing day surgery procedures would be adversely affected by any proposal to close day–surgery operating theatres. The Committee is concerned about other elements of the emphasis upon day–surgery procedures as a way of holding costs down in 1991–92.

5.7. One area of concern relates to the time needed to 'develop incentives to get the medical profession to move away from in–patient surgery to day surgery'.[41]

5.8. The Committee was told by Dr Herring, who is a member of the National Day surgery Committee, that:

> I think it is going to take probably another 10 years before day surgery develops sufficiently in Australia to make even a small dint on the necessity for inpatient beds or even the provision of day surgery facilities within a private hospital or indeed a public hospital.[42]

5.9. Dr Herring observed that 'five years ago' 18 percent of total procedures in Australian hospitals were day–surgery cases and 'we are now running at about 26 percent.'[43] The Committee understands that the relevant ACT figure may be about half the national average. The long–run target for day–only procedures as a proportion of total procedures may be about 50 percent.

5.10. It is possible that the ACT Board of Health is over–estimating the extent to which local doctors will turn to day surgery in the current year. The Committee notes, however, that some hospital systems have utilised sharp reductions in bed numbers in order to hasten the pace of adjustment by doctors.

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40 ACT Board of Health submission, p.21.

41 Dr Herring, Transcript of Proceedings, Friday 29 November 1991, p.82.

42 Ditto

43 ibid, pp.82–83

5.11. A more important concern in relation to the Board's estimate of the impact of day surgery, the pre–admission clinic and the early discharge initiatives is in relation to their impact on current hospital expenditure.

5.12. The Committee was told by senior staff of the Illawarra Health Area Service that increasing the number of day surgery cases means an increase in Visiting Medical Officer (VMO) payments which are a significant component of hospital costs. The Illawarra experience is that one additional VMO costs the Area about $250,000 in direct and indirect costs; hence, there is a move to not replace VMOs when they leave.

5.13. But it is not just the additional VMO costs that rise when day surgery procedures are promoted in a public hospital. Increasing the number of day–only surgical procedures means that a hospital system is handling a greater number of patients requiring higher intensity care. Such care is among the most expensive elements of a hospital's operations. Also, greater demands are placed on staff due to the higher patient turnover; this can lead to a greater number of staffing difficulties.

5.14. A further point in relation to day–only patients was mentioned by a Sydney hospital executive. It is that the revenue derived from treating day–only patients tends not to be high – except in the case of certain specialities.

5.15. Taking all these factors into account it is not surprising that the Committee was told by one Area Health executive that day surgery enables a reduction in costs only if admissions can be controlled.

5.16. The Committee concludes that the emphasis by the ACT Board of Health upon cost savings following the introduction of day surgery, a pre–admission clinic and early discharge is misplaced. The cost savings appear to be dependant upon holding down the level of admissions.

5.17. This was confirmed by the Board in testimony before the Committee. When the Chairman, Mr Humphries MLA, commented:

> Your budget has been predicated on a decrease in admission levels – your floor...

The Acting Chief Executive of the Board responded:

> Yes, that is our floor. If we cannot achieve other efficiencies, then that is the floor as the consequence, yes.[44]

5.18. The Committee acknowledges that all health systems discourage demand for hospital beds 'by making it more difficult for people to achieve non-essential intervention'.[45] The latter expression refers to hospital admission via elective surgery and Accident and Emergency admissions. But the Committee considers the Board should be more up-front in telling the ACT community about the effect of budget constraints in important areas like hospital admissions.

5.19. **The Committee recommends that:**

> **the Board provide information to the public on the effect of budget constraints, including the effect on admission levels for 1991–92 and on bed numbers.**

5.20. In this regard the Committee was disappointed to hear the comment of the Chairman of the ACT Board of Health that 'there are probably more important health issues to educate [the community] about than the complexity of bed numbers.[46] The Chairman's remark followed his broader observation that:

> in terms of educating people about the health system...we are, I think, not going to have much success with that until we have basically finished the work at Woden when people can actually see that hospital finished..[47]

5.21. The Committee disagrees with the view that public education will be fruitless until the hospital project is completed. The Committee considers the current community concern about bed numbers reflects genuine unease about some developments in the health system and warrants a thoughtful response by the Board.

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44 Mr Woods, Transript of Proceedings, Friday 29 November 1991, p.42.

45 Mr Service, Transript of Proceedings, 29 November 1991, p.25.

46 Ibid, p.48.

47 Ibid, p.47.

5.22. For example, a submission to the Inquiry from a pensioners' association stated:

> the impact of a reduction in hospital bed numbers on patients and the community in general must be adverse...[The bed reduction arouses] fear in the community, of parents, the chronically sick, the disabled and the aged.[48]

5.23. When the author of the above submission was asked:

> Would it help with these people if somebody say from the Health Department went out to one of your meetings and had a talk to them?...

The response was 'possibly'.[49]

5.24. The Committee recommends that:

the Board of Health engage in a public education program about the difficult financial choices facing the Board, so as to ease community concern and place the health debate in a clearer context.

5.25. The Committee considers the 'productivity improvements' featured in the Government's Budget Papers are unlikely to be realised for two reasons. The first is that the cost effects of day surgery, the pre–admission clinic and the early discharge program are under–estimated (see above). The second is that the fourth element of the Board's budget–management strategy (service efficiencies to reduce the cost per unit of care provided) is running behind schedule.

5.26. The Committee understands that about 75 percent of the recurrent costs of hospitals relates to labour costs. And:

> If you cut bed numbers, you will certainly cut the staffing requirements. The trouble is that unless you address the specific source of the inefficiency, and if you simply cut the number of beds and retain the same number of staff per bed, you do not improve productivity, at all.[50]

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[48] Submission by Mrs W Tate, President, Canberra Pensioners Social and Recreation Club.

[49] Transcript of Proceedings, Friday 29 November 1991, p.116.

[50] Dr Butler, Transcript of Proceedings, Friday 29 November 1991, p.93.

5.27. The Board is working to reduce its staff numbers:

> if you close down a 20 bed ward, you do not instantly reduce your primary cost, being your labour cost, but you can work towards, through natural attrition, voluntary redundancy and the like, by your end, to get it.[51]

5.28. The Committee notes that the Government in this year announced an intention to shed 275 staff from the health system. The Committee is not aware that significant progress has been made in meeting this target. Of course, the expected level of savings accompanying bed closures cannot be realised unless staff numbers and/or other types of staff costs are reduced.

5.29. The Board's submission referred to 'the high costs per occupied bed day of services in the ACT'.[52] The data supporting such a conclusion, however, is 1987–88 data. A table included in the Board's submission is reproduced as Table 7 of this Report.

5.30. The Committee expresses its surprise that the Board has not provided an update on the indicators show in Table 7. Information on cost indicators like nursing dollars per occupied bed day and administration costs per occupied bed day assists in assessing the financial performance of the hospital system.

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51 Mr Woods, Transript of Proceedings, Friday 29 November 1991, p.24.

52 ACT Board of Health submission, p.5.

TABLE 7

SELECTED STATISTICS PREPUBLICATION - HOSPITAL UTILISATION COST STUDY 1987/88

	ACT (RCH/WVH)	Australian Average Type 2 Hospitals	Type 1
. Cost per adjusted bed day	443	286	373
. Cost per adjusted separation	2640	1710	2269
. Total staff $ per OBD	335	220	272
. Salaried Medical Officers	32	26	42
. VMOs $ per OBD	13	11	9
. Nurses $ per OBD	138	93	102
. Diagnostic $ per OBD	33	27	41
. Admin $ per OBD	42	20	28
. Domestic $ per OBD	58	37	44
. Other staff costs $ per OBD	19	6	6
. Total non-salary $ per OBD	108	66	101

Definition of Type 1 hospital - major teaching and specialist hospitals

Definition of Type 2 hospital - large metropolitan acute general hospitals

Reproduced from the ACT Board of Health submission, p.5.

5.31. On the basis of the 1987–88 data the Committee was advised that:

the ACT has 20 percent more full–time equivalent staff per occupied bed than the Australian average. Excess staffing is...particularly evident in the 'administration and clerical' category.[53]

5.32. This is shown in the following Table based on the 1987–88 data:

Table 8
STAFF PER OCCUPIED BED
(Full–time equivalent staff)

	ACT	Aust.	ACT/Aust %
Salaried medical officers	0.23	0.21	109.5
Nursing staff	1.95	1.72	113.4
Diagnostic, professional & technical	0.52	0.56	92.9
Admin. & Clerical	0.83	0.45	184.4
Domestic & other	1.12	0.95	117.9
Total	4.65	3.88	119.9

SOURCE: Australian Institute of Health, Hospital Utilisation and Cost Study, 1991, Table 7.1, Reproduced in the submission by Dr Butler, p.2.

5.33. Although the Board's submission comments that 'significant micro–economic reforms have been put in place in many of these areas since 1987',[54] the Committee's attention has not been drawn to the up–dated figures.

5.34. The 1991 report of the Commonwealth Grants Commission calculated the 'standardised' expenditure on general medical services for all States and Territories. The standardised expenditure is 'expenditure a State would incur if it were to follow standard expenditure policies, allowing for the specific disabilities it faces in providing services.[55] The Grants Commission then compared this figure to the actual level of expenditure.

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[53] Dr BJ Butler, submission, p.2.

[54] ACT Board of Health submission, p.5.

[55] Commonwealth Grants Commission, **Fourth Report 1991 on Financing the ACT**, 1991, p.218.

5.35. The term 'general medical services' used by the Commission covers 'expenditure on hospitals, nursing homes, mental health and community health services'. The hospitals sub–category 'comprises 55 percent of total standard expenditure in the general medical services category.'[56] Therefore, the following comparisons should be cautiously used.

5.36. For 1989–90 the ACT's standardised expenditure on general medical services was $168 million compared to actual expenditure of $210 million.[57] On a per capita basis, the figures were $600 compared to $748.[58] This amounts to about 25 percent 'overspending'.

5.37. Dr Butler's submission to the Inquiry considered that this over–spending did not result in better health services being available to ACT residents but instead reflected 'relatively high staffing numbers per bed combined with a slightly higher than average salary structure'.[59]

5.38. The Committee was told that:

> the full impact of this [overspending] has not hit, because the Grants Commission has allowed 75 percent of this overspending to be written off as a transitional allowance. So, really, at the moment, only one quarter of the [overspending] is actually impacting on the ACT.[60]

5.39. The Committee considers it is imperative the Board of Health take every possible step to achieve efficiencies in the operation of the hospital system.

5.40. The Committee recommends that:

the Board of Health make the achievement of more efficient staff/patient ratios its primary focus in reducing the overall costs of the health system. The Committee considers this should take priority over bed reductions.

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[56] Ibid, p.147.

[57] Ibid, p.172

[58] Ibid, p.177.

[59] Dr Butler, submission, p.3.

[60] Dr Butler, Transcript of Proceedings, Friday 29 November 1991, p.97.

6 THE PUBLIC/PRIVATE HOSPITAL BED MIX

6.1. The submission by the ACT Board of Health includes a chart (reproduced in this Report as Figure 3) showing that:

> the ACT has the lowest provision of private hospital beds per thousand population. It also has a low ratio of private to public beds (15.8%) as opposed to an Australian average of around 22.5%. There are 119 operational beds at John James with approvals for an additional 31...[There are] 50 [operational] beds at Calvary Private Inc, with 64 additional approvals. The ratio of approved private to available public beds is 22.4%.[61]

6.2. The Board advised the Committee that the number of private patients seeking treatment in ACT public hospitals is declining:

> in 1989–90, the percentage of private patients to total patients at Woden Valley–Royal Canberra Hospital combined was 38%. By 1990–91 it had fallen to 32 percent. The figures I have are for the first three months of 1991–92 show that in those three months it was down to 26 percent.[62]

6.3. The effect of the decline upon the Board's budget was described in the following way:

> Private beds cost the health system less than public beds or public patients...Where you have a public patient there are two additional cost impacts on the hospital system as opposed to a private patient: one is on the revenue side, clearly you do not get the $204 that would come in through reimbursement through the fund per bed day but what you also do is that you directly incur the expenses of the Visiting Medical Officers and your diagnostics in your radiography and pathology and those sorts of expenses. So that there is a double effect of having a public patient. And so, as these numbers are declining and, certainly, they are declining a lot more steeply for the start of this year than our discussions during the budget process had indicated, then it is having an impact on both the cost side and the revenue side.[63]

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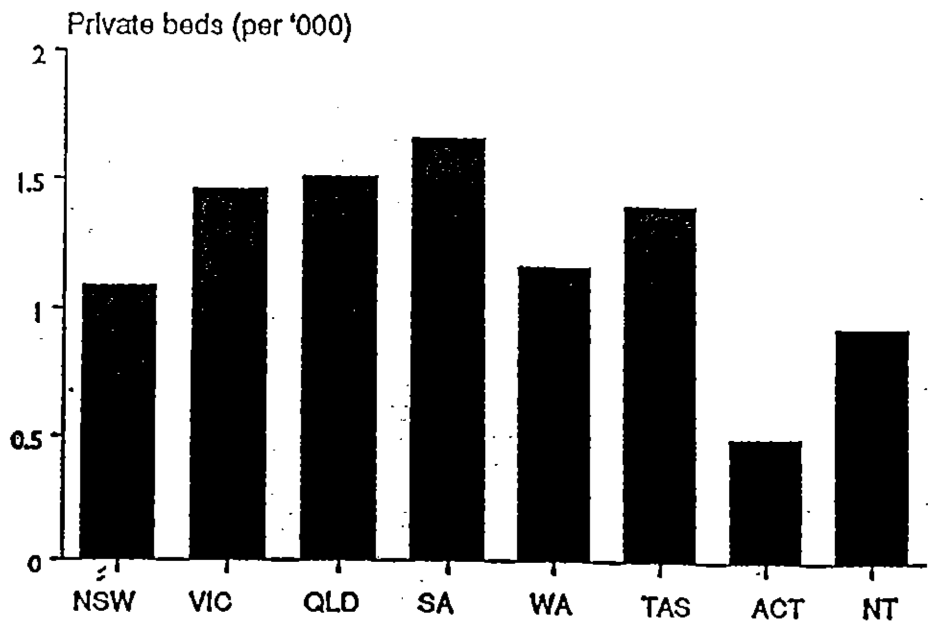
61 ACT Board of Health Submission, p.13.

62 Mr Woods, Transript of Proceedings, Friday 29 November 1991, p.35.

63 Mr Woods, Transcript of Proceedings, Friday 29 November 1991, p.36.

Figure 3



Source: *State Health Authorities, 1991*

6.4. The Board informed the Committee that its funding agreement with the ACT Government establishes 'a base level of public/private patient mix and...the budget for the Board is constructed on that basis'.[64]

6.5. Included in the funding agreement are certain 'business rules' agreed to by the Board and the ACT Government. The purpose of these rules is:

> to establish what it was that the Board was funded for and what would constitute normal supplementation as distinct from some recognition that the Board had been unable to manage within its budget.[65]

6.6. The 'rules' state:

> Variations on the agreed activity level resulting from changes in demand for services outside the control of the Board will be considered for supplementation...
>
> The agreed ratio of Public to Private patients is to be costed as the revenue estimate. Variations on the actual public/private ratio to the estimate will be the mechanism for adjustment to revenue estimates.[66]

6.7. The downward trend in the number of private patients admitted to ACT public hospitals is likely to cause the ACT Board of Health to exceed its budget and hence seek supplementary funds from the ACT Government.

6.8. Consideration of the revenue effects of these private patients should not obscure the fact that the ACT Government is still out of pocket when treating private patients. It is just that the Government is less out of pocket than it would be if the patients were public (that is, if the patients lacked any private health insurance or chose not to use it).

6.9. A submission to the Inquiry from the Australian Private Hospitals' Association Limited commented:

> Every privately insured patient treated in a public hospital effectively costs the Government about $280 per day ($440 actual cost – $160 – return from

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64 Transcript of Proceedings, Friday 29 November 1991, p.35.

65 Mr Woods, transcript of proceedings, Friday 29 November 1991, p.37.

66 ACT Board of Health Business Rules: 1991–92 Funding Assessment

health insurance). If the patient could be treated elsewhere, the Government could either treat a public patient (thus reducing rationing and discrimination) or close the bed (thus saving $440 per day).[67]

6.10. The Association contends that the issue of public/private bed mix is 'of much more concern...than absolute numbers [of beds] in the long run.'[68]

6.11. The broad context of developments affecting the public/private mix is described by the Private Hospitals' Association as:

> with beds and bed days becoming more and more expensive, and the amount of money devoted to health, particularly acute care, not increasing at the same rate that costs are – and that is likely to continue – unless there is a substantially greater commitment to health expenditure in this country, then the provision of public hospital facilities is going to suffer in one way or another, either there is going to be more rationing, the continuous...depletion in capital stock will be more and more evident or, indeed, beds will have to be closed.[69]

6.12. These circumstances have led some if not all State governments to actively promote private hospital development. The National Health Strategy Inquiry indicates the Federal Labor Government is heading in the direction of encouraging the more efficient utilisation of the private sector. The Federal Opposition has a policy of actively promoting more private facilities. Locally, the Liberal Party and the Residents Rally favour the continued development of a more appropriate mix of public and private hospitals.

6.13. The policy of the NSW Department of Health is to encourage:

> Better utilisation of the private system...because it would allow a smaller public infrastructure with lower capital, operating and maintenance costs...[70]

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[67] Australian Private Hospitals Association submission, p.6.

[68] Dr M Herring, Transcript of Proceedings, Friday 29 November 1991, p.75.

[69] Ibid, p.75.

[70] NSW Department of Health, Services and Capital Planning Branch, **Strategic Issues for Acute Hospital Services to the Year 2001,** August 1991, p.21.

6.14. Initiatives of this Department include contracting the treatment of some public patients to private hospitals if it is cost effective to do so. And:

> Another avenue for further exploration is the construction and operation of public hospitals, particularly district style hospitals, by private operators if they are more efficient.[71]

6.15. The Committee heard that a further impetus for the State Government encouraging private facilities is to sharpen the pace of change in the public sector – in the words of one Area Health official, the private sector can usefully act as 'a burr in the saddle' of the public hospital sector.

6.16. In NSW the results of these efforts to date have been disappointing, reflecting the:

> difficulties faced by private health insurers in meeting the needs of their ageing memberships, the additional uninsurable out–of–pocket expenses patients incur in private hospitals and the limited range of services offered by most private hospitals. An important factor is that many private hospitals avoid the costs associated with weekend work by running on a five day week basis – this generally sets an upper limit on their occupancy rates to 50–60%.[72]

6.17. The Committee was told by NSW health and hospital officials that there is little interest in constructing new private facilities at this time but that circumstances were likely to change in the medium–term and prospects for new developments may improve markedly.

6.18. The Committee also heard that the present financial difficulties of the private sector were particularly affecting small hospitals. Institutions run by non profit bodies were said to be coping better than the profit organisations.

6.19. The Committee also heard that financial viability improved if a private hospital of fairly large size (at least 100 beds) is located adjacent to a large public hospital. This facilitates sharing of expensive medical equipment as well as offering doctors and patients the convenience of a shared location.

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[71] Ibid, p.21.

[72] Ibid, p.21.

6.20. Relating these observations to the situation in the ACT, the Committee was informed:

> Citizens of the ACT have access to only limited services in the private hospital sector. If private hospitals provided a wider range of services in the right location, sufficient demand would be present.
>
> If a private hospital had accident and emergency services, a tremendous load would be removed from Calvary Hospital. Much of the current difficulty with staffing levels, funding etc, would not exist. The regulated growth of high quality, private Accident and Emergency services in Victoria has led to a significant decrease in waiting times in public casualties with associated better access for Medicare patients.[73]

6.21. Dr Herring also advised the Committee that he had contacted:

> in the past 24 hours the two major companies that were interested...in providing a new hospital service in this city and both are still extremely interested.[74]

6.22. In the light of these factors the Committee recommends that:

the Government re–open tenders for additional private hospital facilities in the ACT, preferably to be located adjacent to an existing public hospital. Further, the Committee recommends that the bed capacity of such a private hospital should be not less than 100.

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[73] Dr Herring, submission, p.6.

[74] Dr Herring, transcript of proceedings, Friday 29 November 1991, p.78.

7 BED PROJECTIONS TO THE YEAR 2000

7.1. The submission from the ACT Board of Health gives a figure of 'around 1000 public hospital beds' as the target for the year 2000. The estimate of private beds to be in place is 174 to 269, which essentially amounts to no increase in existing private bed numbers and private bed approvals. These figures are shown in Table 9 which comes from the report of the ACT Public Hospital Redevelopment Steering Committee.[75]

7.2. The projection is 'based on data about current use of the public hospital system' (as of 1989), adjusted for a 1.5 percent reduction in length of stay and annual reductions of 1.25 percent in hospital separation rates.[76]

7.3. The Steering Committee Report states that 80 beds can be deducted from the projected figure to reflect the impact of day surgery. This figure is calculated on the basis of assuming that 40 percent of conventional surgery cases can be converted to day–only status.[77]

7.4. The Board's submission states the figure of 1000 public beds 'is conservative in terms of ensuring sufficient beds for a growing and ageing population'.[78] The submission also indicates the Board would prefer to err on the high side of projected figures rather than the low side:

> With the capital investment involved in ensuring sufficient physical capacity it is preferable to plan conservatively in the sense of adequate building space (within reasonable limits) than to underestimate the space involved. More refined response to demand can then take place at an operational management level of actual beds in use.[79]

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75 ACT Government, ACT Pupblic Hospital Steering Committee, **Report to the Minister for Community Services and Health Mr Wayne Berry**, August 1989, p.20. On p.19 of the report is the statement: 'The total bed requirements projected assume the current private sector use to be constant'. The reference to 'around 1000' public beds is to the Board's submission, p.12.

76 Ibid, pp.18–19.

77 Ibid, p.19.

78 Board of Health submission, p.12.

79 ACT Board of Health submission, p.13.

TABLE 9

ESTIMATED TOTAL ACT PUBLIC AND PRIVATE HOSPITAL BED REQUIREMENTS TO THE YEAR 2000

MODEL	TOTAL NEEDED(1)	ASSUME 15% PRIVATE		ASSUME 22% PRIVATE	
		PUBLIC	PRIVATE	PUBLIC	PRIVATE
1. Same level of use Projection = 1458					
Total needs	1690	1437	253	1318	372
Exist or under construction *3	1133	932	201	932	201
Additional beds	557	505	52	386	171
2. Falling length of stay: projected 1169					
Total Needs	1359	1155	204	1060	299
Exist or in construction *3	1133	932	201	932	201
Additional beds	226	223	3	128	98
3. Falling length of stay as admissions: projected 993					
Total needs	1155	982	173	901	254
Exist or in construction *3	1133	932	201	932	201
Additional beds	22	50	-28	-31	43
4. Model 2. adjusted for day surgery (2)					
Total needs	1279	1105	174	1010	269
Exist or in construction *3	1133	932	201	932	201
Additional needs	146	173	-27	-27	68

(1) Adjusted to include 14% private sector use
(2) Adjusted for 50 public:30 private bed equivalent
(3) Existing approvals are for 271 private beds

This means that the most likely scenario for bed requirements into the year 2000 is for about 1279, once day surgery has been taken into account. There are currently 1133 beds in the ACT hospital system. If the current public:private ratio is maintained no further beds (other than those existing or under construction at John James) will be needed in the private sector. About 1000-1105 beds would be needed in the public sector.

Source: ACT Public Hospital Redevelopment Steering Committee: Report to the Minister, August 1989, p.20.

7.5. In the light of these comments the Committee was surprised to hear the Chairman of the Board advise that:

> There are views developing that suggest that the number of beds for which we have planned is probably if anything going to be too high...[80]

7.6. One possible influence on the Chairman's thinking is contained in an estimate of the number of beds required in the ACT in 2000 undertaken by the NSW Health Services Research Group. Its conclusion was that 'only 950 beds in the ACT across both private and public systems are needed'.[81] If allowance is made for ACT figures on separations from hospitals, the projected figure comes down to 818 beds (both public and private).[82]

7.7. This estimate is for acute care beds only. Thus, it excludes beds occupied by patients with conditions including chronic renal failure; diseases of the oral cavity; pyschoses; patients entered for housing or other psychosocial circumstances; neonates, being patients whose age at admission is less than one year; and nursing home type patients.

7.8. The estimate also assumes an average turnover interval of two days, whereas some private hospitals have a greater turnover interval. (The turnover interval is the average time between a bed being vacated and then occupied.)[83]

7.9. It is possible also that these estimates do not take into account the use of ACT hospital facilities by NSW patients. If this is so, the estimates would significantly understate the demand for beds. In the short time available, the Committee has not been able to check this point.

7.10. If the ACT Board of Health really is aiming for a figure of around 1000 public beds by the year 2000, the Committee expresses its bewilderment at how the current reduction in public bed numbers fits into an overall strategy for the decade of bringing public beds to about 1000.

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80 Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.66.

81 ACT Board of Health submission, p.12.

82 R W Gibberd, D Sibbritt, S Ryan and G Hardes **The Changing Demand for Acute Hospital Facilities in Australia: 1986–2001**, NewStat, University of Newcastle, undated. Reproduced as Appendix I in National Health Strategy, **Hospital Services in Australia: Access and Financing**, Issues Paper No.2, August 1991, A23.

83 Ibid, A23 (excluded patients), A16 (private hospitals' turnover rate), A4 (turnover interval).

7.11. The Committee notes that other States are projecting a gradual decline in public bed numbers over the decade, to arrive at bed/population ratios significantly above that existing in the ACT before the current bed reduction program began.

7.12. The rationale for the Board's moves has not been presented to the Committee nor to the public. The Board's actions invite an assumption that the present cuts in hospital beds are being engineered principally as a cost-containment measure.

7.13. The Committee recommends that:

> **the Board reassess its long-term strategy for bed numbers to the year 2000 to take into account the low bed/population ratio existing in the ACT at the commencement of the bed cuts.**

7.14. In addition, the Committee's attention has been drawn to the booklets regularly published by the NSW Department of Health describing the wider context in which hospital planning takes place. The booklets seek to identify the key trends underlying the State's health planning and describe the strategies available to shape the health system in the future. The booklets:

> aim to stimulate wider discussion by presenting as concisely as possibly the complex factors and directions likely to affect the future of the NSW acute health system.[84]

7.15. The Committee believes the ACT community deserves to be treated in a similar fashion by its Board of Health. The information would facilitate wider understanding of the pressures upon the hospital and health systems and also provide an appropriate avenue for the Board to elaborate on its strategy for arriving at target bed numbers for the year 2000.

7.16. The Committee recommends that:

> **the Board of Health prepare and issue discussion papers on the factors and directions affecting the future of the ACT health system.**

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[84] NSW Department of Health, Services and Capital Planning Branch, **Strategic Issues for Acute hospital Services to the Year 2001**, August 1991, p.2.

8 POPULATION TRENDS AND MOVEMENT

8.1. The Committee's attention was directed to the latest information from the Australian Bureau of Statistics (ABS) on the population of the ACT.[85] The ABS found that:

> The ACT had the highest population growth during the 1990/91 financial year (3.0%)...
>
> The net gain to the ACT also doubled (4,200 in 1990/91 compared to 2,100 in 1989/90) and was the highest figure since 1974/75.[86]

8.2. The ABS estimates the ACT population at June 1991 to be 293,500.

8.3. It was put to the Committee that:

> the Board of Health has said the population is 280,000 in its submission. The Territory Planning Authority says it is 290,000. I suggest to you that the Territory Planning Authority's figure is nearer the truth...
>
> The Board is saying we can do with less services and planning to reduce them. The population figures are indicating a curve in the other direction so if you get, say, notionally a ten percent reduction in beds while you are getting a three percent increase in population, your problems of increasing waiting lists will increase because some of those people who come in will require beds. Even if they area a fairly young population, they will require beds.[87]

8.4. The Committee would be concerned if the Board of Health was basing its estimate of future demand for health services on any other than the latest available statistics.

8.5. A further matter brought to the Committee's attention in both the Board's submission and testimony, as well as by other comment, concerns the nature of the inflow of patients from NSW.

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85 Mr Coates, Transcript of Proceedings, Friday 29 November 1991, p.105.

86 ABS, **Australian Demographic Statistics: June Quarter 1991**, Catalogue No.3101.0, p.1.

87 Mr Coates, Transcript of Proceedings, Friday 29 November 1991, pp.105–106.

8.6. The size of the cross–border traffic was stated by the Chairman of the Board to be:

> in terms of the hospital system, the best numbers that I have... [show that] probably close to 25 percent of the demand in our hospital system is ex–Territory.[88]

8.7. The Committee heard evidence that 'the volume of cross–border admissions is built in [to the Grants Commission formula for recurrent funding] but not the case mix'.[89] The suggestion was made that NSW patients may have a higher level of acuity than the average ACT patient, and hence require more expensive treatment:

> They may in fact be costing us a great deal more and we may in fact be underfunded for the NSW patients.[90]

8.8. The Committee heard evidence that:

> one could certainly investigate the question as to whether the case mix of the Woden Valley Hospital for example is actually more akin to one of the big metropolitan teaching hospitals or to one of the medium–sized base hospitals...
>
> Can I suggest it is more towards a Type 1 hospital and no data has been submitted to the Grants Commission to say it is more to a Type I hospital which should indicate that there should be further funding to the ACT.[91]

8.9. The Committee recommends that:

the Government compile the relevant information on the case–mix of NSW patients treated in ACT hospitals with a view to seeking compensatory funding in the next Grants Commission investigation of ACT financing.

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88 Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.7.

89 Dr Butler, Transcript of Proceedings, Friday 29 November 1991, p.94.

90 Mr Coates, Transcript of Proceedings, Friday 29 November 1991, p.108. Also see p.103.

91 Mr Butler amd Ms Neil, Transcript of Proceedings, Friday 29 November 1991, p.104.

9 APPROPRIATE SIZE OF THE ACT HEALTH AREA

9.1. The Board's submission referred to the 'drawing power' of ACT hospital services:

> The ACT has a population of 280,000 but by providing a base referral hospital service to NSW's South East region also offers a variety of hospital speciality services which would not be viable for a smaller population base.[92]

9.2. In informal discussions with Mr McKay the Committee heard that it is reasonable to postulate the ACT health service would be more efficient if it covered the south–eastern region of NSW – making a population base of half a million. In a de facto sense, the ACT may already be providing such a service (as implied in the Board's comment above); but the ACT's role is not formalised.

9.3. It was suggested to the Committee that a larger population base would enable greater specialisation and hence encourage the establishment of specialities not presently available. Mr McKay commented that while a larger population base may not necessarily be cheaper, it is likely to deliver health services better.

9.4. The Committee notes that this issue is one of the broad options outlined in the National Health Strategy's Issues Paper No.2, namely whether to integrate health service delivery in larger units not necessarily premised on existing State borders.[93]

9.5. The Committee understands that before the last State election the NSW Department of Health was considering some amalgamation of the existing health Areas into larger units of perhaps one million people – but these moves are now on hold. It is likely they would be made only in metropolitan areas if at all.

9.6. A Member of the Committee, Dr Kinloch MLA, directly asked the Board:

> whether our very system, that is the health system in the ACT, is actually an efficient size for the bottom line, the bottom line being the better health of people in our community?

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[92] ACT Board of Health submission, p.3.

[93] National Health Strategy, **Hospital Services in Australia: Access and Financing,** Issues Paper No. 2., 1991, pp.144–145.

9.7. The response of the Board was:

> I do not think organisationally that there is likely to be terribly much benefit for us, for example, taking over the Goulburn and the Yass hospitals and so forth... I suspect it might have the reverse effect, simply longer lines of communication...
>
> The size of our system... is also the sort of size that a number of health systems have adopted for things, like Area health boards and so forth, populations of 300,000, 400,000, 500,000[94]
>
> At the clinical interface we are, in effect, fully integrated not only into the south–east region, but into the super–specialities in Sydney and Melbourne and elsewhere...[95]
>
> I think as long as those artificial boundaries do not actually block the clinical integration and management, and I do not think we are in that situation in the ACT, then in a sense, we are probably as well placed as we can be in terms of the scale of the health services that we are operating in at the moment.[96]
>
> There is one size disadvantage we have and that is, of course, that there is the State–type functions – planning, policy, political relationships, all of those sorts of things – and all other things being equal, one would prefer to have to carry that cost burden on the basis of a much bigger system.[97]

9.8. The Committee was told that the NSW south East Region Area Health Board was presently conducting its own strategic review and 'are actually talking to us about the development of that [strategic] plan.[98]

9.9. The Committee notes that the responsibilities of the ACT and NSW health authorities were 'defined and endorsed by the responsible Federal and State Ministers' as recommended by the Commonwealth Auditor–General in a 1983 efficiency audit of the administration of public hospitals by the (then) Capital Territory Health Commission.[99] But

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[94] Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.50.

[95] Mr Woods, ibid, p.50.

[96] Dr O'Loughlin, ibid, p.54.

[97] Mr Service, ibid,p.52.

[98] Dr O'Loughlin, ibid, p.53.

[99] Commonwealth of Austrslia, Joint Committee of Public Accounts, **Review of the Auditor–General's Efficiency Audit Report: Administration of Public Hospitals by the Capital Territory Health Commission,** Report 238, 1985, p.11.

given the changes that have taken place in both the ACT and NSW health systems since that time, the Committee wonders to what extent the following comments by the Auditor–General may still be relevant:

> Audit found the liaison arrangements between the Commission and the NSW Health Department to be unsatisfactory, and recommended definition and Government endorsement, where necessary, of the respective regional responsibilities of the two authorities. Strategic planning activities were considered not to be integrated and development of an overview planning statement was recommended.[100]

9.10. The Committee has earlier commented on the desirability of ACT health statistics being made comparable to those for NSW (Chapter 3).

9.11. The desirability of going further toward some sort of formal integration of the ACT system into the present South Eastern and South West Health Areas of NSW raises complex issues. These include the question of whether it would be better to formally integrate the ACT into the NSW health system or encourage the ACT to contract to provide health services to the area. The Committee does not have a view on this matter but considers the next Legislative Assembly should look at the issues.

9.12. The Committee recommends that:

> **the next Legislative Assembly consider setting up an inquiry into the appropriate structure to meet the health needs of the ACT and adjoining regions.**

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100 Ibid, p.10.

10 NEW FACILITIES

A Medical School for the ACT

10.1. The state of medical education in the ACT in 1988 included:

the establishment of a chair in Geriatric Medicine (located in the ACT) by the University of New South Wales (UNSW):

– this has been primarily aimed at providing undergraduate and post basic medical education; however, considerable support has also been given to post–basic nursing education;

– it has had the direct effect of introducing education research into the hospital system;

arrangements with the University of Queensland to provide limited medical undergraduate clinical training at ACT hospitals (with similar benefits as the UNSW arrangements);

introduction of a clinical reserach unit by the Australian National University (ANU) into Royal Canberra and Woden Valley Hospitals; and

development of a post–graduate committee in medical education at ANU, acknowledging the need for further support and development in the hospitals and medical community.[101]

10.2. The 1988 Kearney review of health service in the ACT recommended the development and adoption of a more integrated policy of medical, undergraduate and post–graduate training[102]. Dr Kearney considered the policy should have two components:

the ANU to negotiate with a university medical school to provide formal arrangements for entry of ACT school students, and for the ANU to work with the hospitals to provide a component of clinical undergraduate medical education to that medical school; and

...establishment of a Post–graduate Medical School, concentrating on existing areas of strength in the John Curtin School of Medical Research.[103]

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101 Dr Brendon J Kearney, Independent Review of the ACT Health Services: Final Report, November 1988, pp.27–28.

102 Ibid, p29

103 ditto

10.3. Dr Kearney provided the following justification for these recommendations:

> The benefits of similar affiliation arrangements in other hospitals for health care services, and for recruitment have been significant. For the ACT, it is my view that the benefits of the proposed arrangements for the long term recruitment of medical staff committed to the Service are likely to be as significant, if not more so, than the recent concentration on parity cliams for pay and conditions[104]

10.4. The Committee is aware that Sydney University recently proposed that a clinical school be established in the ACT. The clinical school would be

> simply for the final three years of undergraduate training...[which is] really different to a teaching hospital in the traditional sense that we are all accustomed to...
>
> When it was fully up and running...there would be a maximum of 90 students...30 in each intake [for the fourth, fifth and sixth years of a doctor's training]. This would involve seven or eight professors, and it is the number of professors, in a sense, which determines which specialities will be further developed within a system to respond to the clinical school.[105]

10.5. The Board's response to the proposal is that it:

> likes what it sees in terms of principles. I think we are thoroughly convinced that having a clinical school...would help us to increase the quality of health care delivered in the Territory and that, of course, is what we are all on about. The issue with which it is much more difficult to grapple is the long–term costs.[106]

10.6. In its discussions with health authorities in Sydney the Committee was informed of the pluses and minuses of establishing a medical school. The pluses include increased questioning and sophistication of the medical fraternity together with increased specialisations being introduced. The minuses include the increased costs associated with supporting the university staff and the tensions introduced into the health system as these staff exercise influence on the existing management structure.

10.7. The Illawarra Area Health Service – which is linked to the medical school of the University of NSW – has found an increase of 5–10 percent in the total operating cost of a facility with medical students. It compares this to a 5 percent increase in Canadian hospitals.

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[104] Ibid,p.28

[105] Mr Service, Transcripts of Proceedings, Friday 29 November 1991, p 55 and 56

[106] Mr Service, Transcript of Proceedings, Friday 29 November 1991, p.54.

10.8. The Illawarra Area Health Service also advises that the link to undergraduate medical training was not useful in itself but – in line with Dr Kearney's view noted above – reaped benefits in attracting good–quality graduates into the Area: graduates who knew what the Area offered and hence, were enthusiastic.

10.9. Overall, the Committee considers the establishment of a clinical school in the ACT would increase the quality and prestige of the ACT health system and assist in reassuring people that the hospital redevelopment project was worthwhile.

10.10. The Committee therefore recommends that:

the Government, as a matter of priority, pursue negotiations leading to the establishment of a clinical school in the principal hospital.

A Hospice for the ACT

10.11. The Committee is aware that the issue of a hospice in the ACT is currently being considered in the Acton Peninsula Review. The present ACT Government states that it:

> has decided in principle to locate non–acute public health facilities on the site [of Acton Peninsula]. This will include rehabilitation and aged care, convalescent and hospice care services as well as the Queen Elizabeth Home for Mothers and Babies.
>
> Forward planning for a hospice on the site will begin this year with a view to starting construction in 1992.[107]

10.12. Although the impact of a hospice upon demand for hospital beds may be 'marginal'[108], the Committee commends the Government for its in–principle decision.

10.13. The Committee recommends that:

the building of a hospice proceed as a matter of urgency.

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[107] Ms Follett, Chief Minister, **Budget Speech 1991–92,** Budget Paper No.1, p.19.

[108] Mr Service, transcipt of proceedings, Friday 29 November 1991, p.71.

11 STRUCTURAL CONCERNS

Ambiguity About the Roles and Responsibilities of the Board of Health and the Board of Health's Senior Management

11.1. The Committee notes that the Board of Health in its initial response to the call for submissions on the Inquiry's terms of reference drew a sharp distinction between persons able 'to express the management policies of the Board' and 'more junior officers'. The letter from the Board suggested that only the Chairman and the Chief Executive Officer could state the Board's management policies.

11.2. The Committee is also conscious of the evident deep involvement of the Chairman of the Board (and presumably other Board members) in detailed management issues. The Committee did not observe such deep involvement of Area Health Boards in the regions visited in NSW.

11.3. On these issues, the Committee's attention has been drawn to the following article in the July 1991 issue of **Boardtalk**, a monthly newsletter to staff from the ACT Board of Health. The article was headed 'Confusion about use of title "ACT Board of Health' and is reproduced in full. The article is a report of a meeting of the Board.

> The meeting discussed the importance of distinguishing between the Board of Health as the appointed directors, and the organisation or any of its officers. It was agreed there was some confusion about the use of the title "Board of Health".
>
> [The then] Chief Executive John Turner stressed that care was needed to ensure that the policies, decisions or views attributed to the Board of Health, were, in fact, those of the Board of Directors itself.
>
> In situations were it was intended to express the views of the health organisation or particular persons in it, as distinct from the Board of Directors, the distinction should be made clear.
>
> The Board agreed to a proposal that when the views of the health organisation were being expressed, the term "ACT Health" be used to distinguish the organisation from the Board of Directors.

11.4. The Committee has not had time to clarify the legal status of the term 'ACT Health' but considers it an undesirable situation when a distinct term needs to be 'invented' to separate the Board's responsibility from that of its management.

11.5. **The Committee recommends that:**

> **the Government and the Board of Health clarify the role and responsibility of the Board and senior management of the Board; and also clarify the status of the term 'ACT Health'.**

Ambiguity About the Accountability of the Board of Health and the Minister for Health

11.6. In a letter responding to the Committee's invitation to make a submission on the terms of reference of this Inquiry, the Minister for Health, Mr Berry MLA, commented:

> I note that the Select Committee's Terms of Reference relate almost exclusively to the management of health and hospital services within the ACT. Such matters are the responsibility of the Board of Health.

11.7. The Minister's reference to the 'management' of health is in accord with the provisions of Part 6 of the **ACT Health Services Act 1990** which provides that the Board 'manage the health services and health facilities under its control'.

11.8. The Minister's letter drew a distinction between these 'management' issues and 'issues relating to the Government's health policy'. In a sensitive area like the number of hospital beds available within the ACT community, the Committee has been unable to determine where 'management' responsibility ends and 'policy' issues begin. It seems to the Committee that the Board of Health has been placed in the situation of carrying responsibility for significant bed reductions perhaps because bed closures are not seen by the Government as a 'policy' issue.

11.9. This ambiguity in the relationship between the Board of Health and the Minister for Health was not anticipated by, among others, Dr Kearney in his review of ACT health services. Dr Kearney considered that self–government:

> should lead...to direct lines of communication and responsibility, as well as direct accountability to a local community.[109]

11.10. The Committee believes that the current area of ambiguity needs clarification, especially in such sensitive 'policy' matters as bed numbers.

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[109] Dr BJ Kearney, **Independent Review of ACT Health Services: Final Report**, November 1988, p.17.

The Dominance of Hospitals in Community Health

11.11. A submission to the Inquiry by the ACT Community Health Association expressed concern:

> that if hospital bed numbers are seen as the overriding indicator of health service adequacy for the ACT, primary health care services will suffer further constraints as funding and resources are diverted to the 'illness system'.[110]

11.12. Attachments to the Community Health Association submission stated that:

> The situation in the ACT is no different to that in most parts of the world – most resources are eaten up by the hospital and the medical system – community–based, non–medical health services receive much less resourcing.
>
> This situation is the product of many things – the power of the medical lobby, the capital costs of medical technology, hospital buildings and staffing, and of running an institution. This contrasts with the low level of resources, the competing interests of the community and consumer lobby, as well as the inaccesibility of many health system structures to consumer input, which together restricts the capacity of consumers to respond.[111]

11.13. The Association states this situation has led to:

> decreasing level of resources available for community health services, leading to poor staffing levels, cutbacks in services, lack of continuity, long waiting lists, all resulting in pressure on staff. The promotion for community health services was poor; and community health suffered because there was a lack of media interest in good news about the ACT health system.[112]

11.14. The Committee is aware that future trends in health expenditure may see attempts to 'cap' overall expenditure which – if occurring in conjunction with a rising trend in hospital costs – will of necessity squeeze that portion of health expenditure not directed into hospitals. Such trends would have serious implications for community health programs.

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[110] ACT Community Health Association submission, p.1.

[111] D Matrice, Consumers Health Forum of Australia Inc., **There's More to Health than Hospitals.**

[112] Report of the proceedings of a public forum organised by the ACT Community Health Association on 18 July 1991, contained in the submission by the ACT Community Health Association.

11.15. A particular point of concern raised by the ACT Community Health Association is that 'currently there is no consumer voice on the ACT Board of Health, or its sub–committees'.[113]

11.16. In the short time frame available, the Committee was unable to discuss these types of concerns with the Board. While the Committee understands that the demands of the hospital redevelopment project might preoccupy the Board, the Committee considers the Board should recognise that a complete health–care system for the ACT must involve the integration and mutual involvement, through close liaison, of hospital and community health services.

11.17. **The Committee recommends that:**

the Board liaise with the Community Health Association about the resources able to be made available to meet community health needs.

Gary Humphries
Presiding Member
11 December 1991

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113 D Matrice, ibid.

APPENDIX 1

LIST OF SUBMISSIONS RECEIVED

1	Dr James RG Butler	
2	Michael Keats	Aged Services Association of NSW and ACT Inc
3	Mr JG Service	ACT Board of Health
4	Dr MM Herring	Australian Private Hospitals' Association Limited
5	Paul F Cross	Health Economics and Technology Assessment Corporation Limited
6	Dr J Eather	Australian Medical Association. ACT Branch
7	Mrs W Tate	Canberra Pensioners Social and Recreation Club
8	Erica Fisher	ACT Community Health Association
9	MJ Avery	Calvary Hospital ACT Incorporated
10	Daryl W Menzies	Minister for Community Services and Health, Northern Territory
11	Don Hopgood	Minister of Health, South Australia
12	Dr Graham Bates	Australian Medical Association, ACT

APPENDIX 2

LIST OF WITNESSES AT PUBLIC HEARINGS

Friday, 29 November 1991

ACT Board of Health	Dr J O'Donnel Dr V O'Loughlin Mr JG Service Mr MC Woods
Australian Private Hospitals Association	Dr MM Herring Dr J Butler Ms AL Neil Mr JR Coates
Canberra Pensioners Social and Recreation Club	Mrs W Tate
ACT Community Health Association	Ms E Fisher

Wednesday 4 December 1991

Aged Services Association of NSW and ACT Incorporated	Mr M Keats

Friday 6 December 1991

Calvary Hospital ACT Incorporated	Mr P Brazil Mr M Avery

STATEMENT BY DR KINLOCH MLA

The following personal views are not in dissent from but in addition to the report. They are conclusions drawn from exposure to the range of evidence related to hospital beds. That evidence necessarily stretched beyond the question of the numbers of beds to include discussions of the overall efficiency of our health–care system.

As a result of visits to two health–care areas in New South Wales, and in the light of some of the evidence given at our public hearings, I am now of the view that one of the basic faults in our own ACT health–care system is that it is too small to be efficient.

It would be difficult to give an exact optimum size of population, but it is certainly larger than either the 300,000 or so in the ACT, or the 400–450,000 or so in our immediate catchment area. Even in the latter case of the surrounding area, the circumstances are such that there are two or three competing administrations of health–care.

It is clear that we have a top–heavy administration not only of our hospital system, but also of our entire health–care system[73] NSW health–care systems which cater for populations of 500,000 appear to be far more efficient in terms of administration and bureaucracy.[74] A health–care area of 1m. might be more appropriate. Whatever the number, I am in little doubt that we should try to negotiate with New South Wales to create a much larger health–care administration which would include not only the ACT and the South East Region but also the health–care facilities of towns and country areas, including adjacent shires, and such towns and their peripheries as Bateman's Bay, Braidwood, Bungendore, Cooma, Goulburn, Queanbeyan and Yass. Bateman's Bay, in particular, should be considered for health–care purposes, as almost an extension of the ACT. Might Moruya and Narooma also be considered in the same light? Should this proposed area go even so far as Cootamundra and Wagga Wagga?

In welcoming the recommendation of the Committee to conduct an inquiry into this matter, I would like to see an exploration of the possibility of some kind of joint ACT and NSW Board of Health for the proposed area or areas. Already there are co–operative discussions in the South East Region related to the needs of the frail aged, but these negotiations now need to be much wider in scope.

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[73] Consider the written and oral evidence of Dr J Butler of the ANU

[74] Consider the informal advice given to us by both of the NSW health–care centres we visited.

In considering the ways in which numbers of beds and bed–days in major hospitals can be reduced, I wish to stress that the building of a convalescent and/or rehabilitation hospital should be urgently considered. The existing buildings of the Royal Canberra Hospital could be re–conditioned for such a purpose. The benefits of such a convalescent hospital would be considerable, including a favourable impact on the question of bed numbers. Patients who have already undergone major surgical or medical procedures in the two major hospitals could conclude their hospital stay in such a convalescent hospital, thus releasing needed high–acuity beds; and diminishing overall health costs.

Hector Kinloch
11 December 1991

DISSENT by ELLNOR GRASSBY
INQUIRY INTO HOSPITAL BED NUMBERS

I believe that the comments by the majority of members about private hospital facilities must be seen as somewhat political in nature. The committee received advice that there is little interest in constructing new private facilities in New South Wales at this time, however, St George Hospital informed the Committee that they were considering contracting out to a large American firm a private hospital of 200 beds plus a medical centre at some future date as circumstances require.

It was also advised that there is no shortage of private beds in the ACT at this time. In spite of the fact that approved private bed levels are now at the national average of 22.4%, the committee's recommendation to re–open tenders for an additional private hospital is internally inconsistent and ill–considered.

This is borne out in the body of the report which states that institutions run by 'not for profit' bodies are coping better with current circumstances than the 'for profit' organisations. It could not be expected that a 'not for profit' organisation would enter into a competitive private market in the harsh economic times we are in and if a licence were to be given to a commercial organisation to build another private hospital it could be seen in the future as requiring additional government grants to maintain its viability.

Furthermore, the Board of Health states that there is a downward trend in the number of private patients admitted to ACT public hospitals.

A further point to consider in the body of evidence is that John James and Calvary Private Hospitals have not fully utilised their <u>approved</u> private hospital beds. This indicates that the demand is not there in the private sector in the ACT and that the ACT community is more attracted to the excellent services provided by the public hospitals' facilities. We were told that on the whole doctors prefer to admit their privately insured patients into public hospitals, one of the reasons being for their superior equipment and treatment in emergencies.

Evidence from health professionals in Sydney indicate that private hospitals are viable only when located adjacent to major public hospitals. It could not be expected to locate a new large hospital (greater than 100 beds) adjacent to either Woden Valley or Calvary hospitals whose private bed admittances are already under–utilised.

The Chairman of the Board of Health also advised that the number of beds planned could be considered 'conservative', namely that the ACT may need less than 1,000 beds.

The committee notes that the new estimates which suggest the ACT future needs may go as low as 818 beds (both public and private) are for acute care beds. It fails, however, to note that patients suffering conditions such as chronic renal failure, psychoses and some of our nursing home patients occupy these acute care beds.

The report recommended that the Board reassess its long term strategy for bed numbers. I understand that this strategy is, in fact, under constant monitoring and is already being assessed in light of modern trends in medicine and health planning, however, it became

evident early in the inquiry that counting bed numbers alone is not the way to evaluate the efficiency of a hospital.

I cannot agree with Dr Herring who suggested that 'it is going to take probably another 10 years before day surgery develops.....'. There is no evidence to support Dr Herring's observation. From my visit to several Sydney hospitals I believe that day surgery has not only become a way of life but is well on the way to becoming possibly one of the largest departments in any major hospital.

As identified, the ACT is only running at half the national average and it is heartening to see the Board of Health addressing this problem and moving to bring ACT day-surgery levels in line with the national average. Coming from a health background, I believe that the committee does not fully understand the complexity of the Board's approach to day surgery and the report is under-estimating the benefits.

The Committee's statement that there is confusion over the role of the Board of Health cannot be supported. The Board of Health's evidence to the Committee confirms this is not a matter of contention. Moreover the term 'ACT Health' was instituted to overcome the confusion created by the Alliance Government in describing components of the health organisation.

Although the report makes reference to the Board's reticence to supply information, I cannot fully support this statement because any information I requested was always forthcoming and I applaud the advice and cooperation that the Board of Health gave to this inquiry process. No where in the report has it been shown that not only is the ACT Board of Health running a hospital system and a community health system, but it is also performing the function of a department of health and credit should be given to the work done in this area.

I would also like to remark on the excellent work performed by the staff at the Woden Valley hospital, particularly in the Accident and Emergency Section, who through fast tracking of the closure of the Royal Canberra Hospital have put up with conditions far worse than any medical team working in a war zone.

I wish to address the statement regarding the ACT's integration into the New South Wales network. The Chairman of the Board of Health stated 'at the clinical interface we are, in effect, fully integrated not only into the south-east region, but into the super-specialities in Sydney and Melbourne .....'. I believe it is prudent to weigh the very real benefits accruing to the ACT from tapping into these super-specialities in Sydney and Melbourne against the unknown effects of plunging the ACT health system into complicated cross-border arrangements.

Finally, I would like to say that the one point which became very evident during the inquiry was the need for a convalescent hospital and geriatric care facilities. The evidence given by Mr Michael Keats, the Executive Director of Aged Services Association of NSW and ACT Inc, was particularly interesting and valuable and I would like to see this issue examined further.

Ellnor Grassby