

PRIVATE HOSPITALS CAPITAL EXPENDITURE

REPORT BY
ACCESS ECONOMICS PTY LIMITED

FOR

AUSTRALIAN PRIVATE HOSPITALS
ASSOCIATION (APHA)

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EXECUTIVE SUMMARY

The Australian Private Hospital Association (APHA) commissioned Access Economics to develop a survey to measure current and future capital expenditure intentions of the private hospital sector. The capital expenditure survey was distributed in January 2005 to the entire APHA membership, along with Catholic hospital groups that are not members of APHA.

For the key year of interest (2004-05), the survey responses cover some 55% of available beds in private acute/psychiatric hospitals – a healthy proportion from which to measure expected investment for the sector. For this report, estimates of capital expenditure by non-respondents have been developed (based on trend analysis) to provide a measure of total expected capital expenditure by the sector.

The latest Australian Bureau of Statistics (ABS) information showed a notable decline in investment for the sector in 2002-03. Capital expenditure in 2002-03 was some \$314 million, notably down on the average over the decade to 2002-03 of \$403 million, and the peak year of 1998-99 when there was capital expenditure of some \$549 million. A trend of declining capex is also suggested in the ABS *Building Approvals* publication, continuing into 2003-04.

Aggregate investment

For the sector as a whole, capital expenditure in 2002-03 had fallen to its lowest nominal level since 1992-93 (implying a substantial real decline in capex across that period).

The APHA capital expenditure survey suggests that the worst has passed for the sector – investment has lifted from its 2002-03 low point, but is still well short of the robust levels of investment achieved in 1998-99 and the early 2000s. However, it is likely that some of the pick up from the lows seen in 2002-03 represents a lift in prices rather than volumes, as a jump in construction materials and labour costs is doubtless affecting building costs for this sector. Investment as a share of income for private hospitals therefore remains well below its 1998-99 peak, and has been running counter to a growing investment share for the wider economy. Table 1 shows projected levels of capital expenditure.

TABLE 1: PRIVATE HOSPITALS CAPITAL EXPENDITURE PROJECTIONS, \$M NOMINAL

| | 2002-03 | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|----------------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| Capital expenditure | 315.7 | 343.7 | 385.1 | 341.0 | 318.8 | 334.8 | 329.4 | 293.1 |

Beyond 2004-05, the forward profile for capital expenditure in the private hospitals sector is one of a moderate decline over time. That said, there is an economy-wide tendency to underestimate future capex plans, and the private hospital sector may not be an exception. It is therefore possible that the future expenditure plans should be regarded as conservative.

Components of investment

In terms of components of investment, construction of new buildings, alterations and additions, and equipment purchases each accounted for nearly one-third of capital expenditure in 2004-05. Compared with 2003-04, the capital expenditure profile for the sector has changed, with a greater focus on expansion and relatively less focus on equipment purchases.



Investment in specialist areas

There was limited response to a survey question on investment in certain specialist areas: orthopaedics, ophthalmic, cardiology, scopes and other specialist areas.

Of those who did respond, the majority of their capital expenditure is still expected to be in non-specialist areas. Within specialist areas, the largest amount of investment is expected to be in orthopaedics, closely followed by scopes.

Diversification

There was limited response to a question on planned diversification. Only one respondent organisation stated that they were planning diversification into high and low care, with the high care expansion to be undertaken through both acquisition of new buildings and building new facilities.

Impediments to capital expenditure

The APHA capital expenditure survey asked respondents to comment on impediments to future capital expenditure via three questions.

- ❑ The overwhelming response to these questions was that the current contracting environment has made it significantly harder for hospitals to undertake capital expenditure. Responses suggested that growth in remuneration levels of 1-2% per annum have not kept pace with the cost of providing services.
- ❑ New guidelines in Western Australia were the most mentioned State government regulations which were seen as impeding capital expenditure. Respondents said that the guidelines have significantly increased costs of hospital redevelopment, specifically when it came to building standard requirements.
- ❑ Another stated impediment to further capital expenditure was hospital licensing requirements. It was indicated that private hospitals have to meet higher thresholds than public hospitals (where a lesser standard is imposed). There were also concerns over the way that licensing requirements are administered.

Trends in public hospital capital expenditure

In contrast to modest growth in investment in private hospital facilities expected in 2004-05, capital expenditure for health or human services in most States (dominated by investment in public hospitals) is expected to increase dramatically in 2004-05. Across all States, capital expenditure of nearly \$1.9 billion is planned in 2004-05, a 26.8% increase on 2003-04 levels.

In part, the strong growth in planned capital expenditure reflects very strong revenue growth at the State government level, as well as some growing urgency in improving the standard of service available from public hospital facilities – a catch-up following a period of under-investment in public hospital facilities.

Access Economics
9 March, 2005



1. INTRODUCTION

The Australian Private Hospital Association (APHA) commissioned Access Economics to develop a survey to measure current and future capital expenditure intentions of the private hospital sector, and to report the findings of the survey.

The need for a survey of current and future activity stemmed from the latest Australian Bureau of Statistics (ABS) information showing a notable decline in investment for the sector in 2002-03. Given the importance of capital expenditure to the future growth of the sector, APHA saw a survey of current and future spending as important in informing upcoming policy discussions.

This report provides a snapshot of both current capital investment in the private hospitals sector as well as intentions to invest in upgrading current bed stock and equipment in the near to medium future. It also touches on difficulties and barriers experienced by private hospitals which may be limiting their capital expenditure.

Survey process

The capital expenditure survey was distributed in January 2005 to the entire APHA membership along with Catholic hospital groups that are not members of APHA. Together, these groups cover the majority of private hospital operators in Australia. However, as the survey is only sent to existing operators, it will not include information on any entities currently outside the sector who are thinking of building new hospital facilities.

The survey responses have been collated and analysed by Access Economics, with the individual response information remaining confidential to Access Economics. This report only presents data in aggregate across respondents.

A key issue in analysing the survey results is to understand what proportion of the sector responded to the survey, and how to approximate the capital expenditure of non-respondents.

To gauge the rate of response, the ABS publication, *Private Hospitals 2002-03*, is used as a benchmark, with the number of beds available in private hospitals the key data item used in benchmarking. The ABS survey provides the definitive measure of the number of beds available in private hospitals in 2002-03: 24,454 for acute and psychiatric hospitals, and 1,910 for free-standing day hospitals. The APHA capital expenditure survey also asked respondents to state the number of beds available in 2002-03, and summing these across respondents provides a measure for the proportion of the sector covered.¹

Using this measure as a benchmark (and noting that not all respondents answered all questions on future capital expenditure intentions), produced response rates to questions on capital expenditure for acute/psychiatric hospitals as shown in Table 2.

¹ In those cases where respondents did not state the number of beds available in 2002-03, the number of beds available in 2003-04 has been used as a proxy.

**TABLE 2: SURVEY RESPONSE RATE FOR ACUTE/PSYCHIATRIC HOSPITALS, % OF TOTAL
AVAILABLE BEDS IN SECTOR**

| | 2002-03 | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|------------------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| Response rate (%) | 27.1% | 49.2% | 55.0% | 43.0% | 43.0% | 42.5% | 42.5% | 42.5% |

For the key year of interest (2004-05), the survey responses cover some 55% of available beds in private acute/psychiatric hospitals – a healthy proportion from which to extrapolate.

Note that Table 2 shows survey response rates as a share of beds of all private hospital operators, not just as a share of members of APHA or Catholic hospital group who were sent the survey. The method used to approximate the capital expenditure of non-respondents in the sector is described further in Chapter 3.

While the survey produced a healthy response rate from acute and psychiatric hospitals, the response rate from free standing day hospitals was much lower, approximating only around 3% of available beds.

These facilities are typically much smaller, and the ABS survey shows that this part of the sector has historically accounted for only around 6% of the sector's total capital expenditure. Given the very low survey response rate, expected capital expenditure for free standing day hospitals is projected on the basis of trend analysis rather than survey responses (discussed further in Chapter 3).

The rest of the report is structured as follows:

- ❑ Chapter 2 examines historic trends in private hospital capital expenditure using ABS data where available;
- ❑ Chapter 3 examines the results of the APHA survey of current and future capital investment intentions in total;
- ❑ Chapter 4 examines survey results for components of capital expenditure, including the type of investment, investment in specialist areas, diversification and impediments to further capital expenditure;
- ❑ Chapter 5 looks at capital expenditure trends for public hospitals as a point of comparison; and
- ❑ Chapter 6 provides a glossary of key terms used in this report.

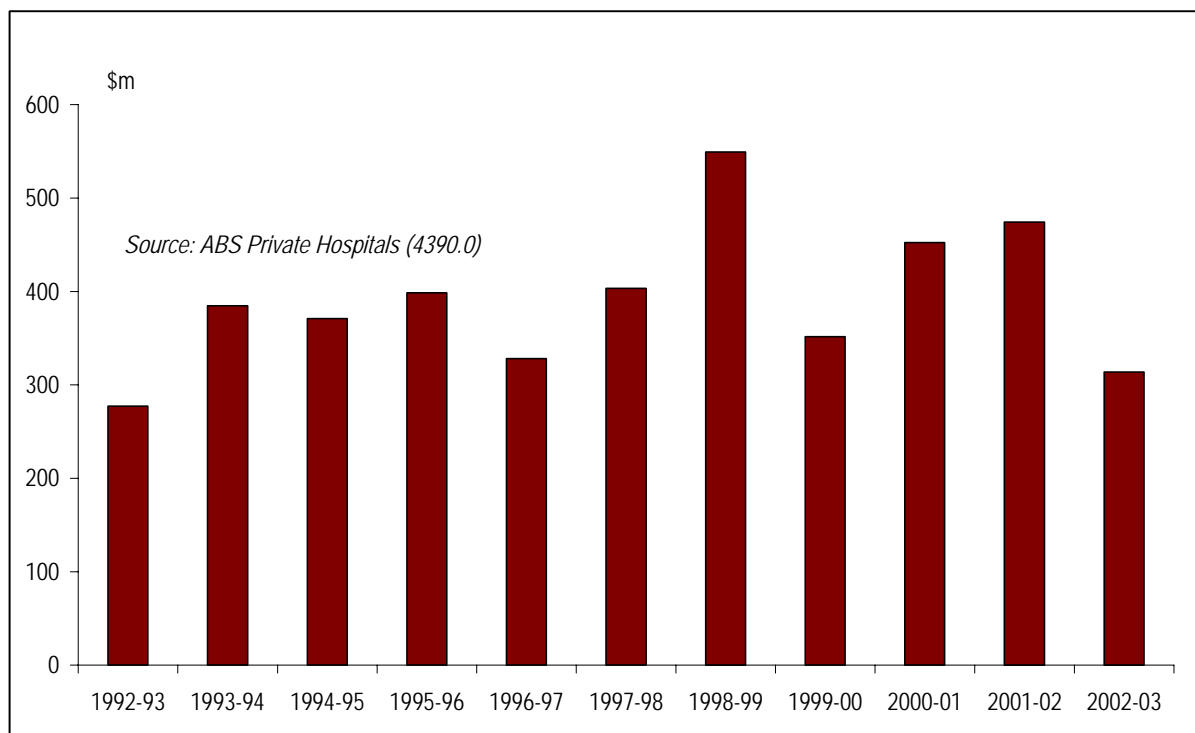
2. TRENDS IN CAPITAL EXPENDITURE

The ABS *Private Hospitals* publication provides annual data on capital expenditure for the sector. The most recent publication for 2002-03 covers 536 private hospitals (some 296 acute and psychiatric hospitals, and 240 freestanding day hospital facilities). The ABS report is comprehensive and provides the most definitive measures of activity in the sector, based on a national census of private hospitals. However, the latest results are for 2002-03, and even though only recently published, they may not reflect current activity – hence the need for the APHA survey to provide a current snapshot.

The *Private Hospitals* publication shows that the level of capital expenditure in the sector has fluctuated somewhat over the last 10 years. The average level of gross capital expenditure over the decade to 2002-03 was \$403 million per annum. Of that, only a small proportion is attributed to free standing day hospitals – on average \$22 million per year over the same time period, or around 6% of total expenditure. Expenditure by free standing day hospitals has been reasonably steady over time, compared to the much more volatile spending pattern over time for acute and psychiatric hospitals.

Chart 1 shows that, for the sector as a whole, capital expenditure in 2002-03 had fallen to its lowest nominal level since 1992-93 (implying a substantial real decline in capex).

CHART 1: PRIVATE HOSPITALS CAPITAL EXPENDITURE OVER TIME



Capital expenditure in 2002-03 was some \$314 million, notably down on the decade average of \$403 million, and the peak year of 1998-99 when there was capital expenditure of some \$549 million.

Another measure of investment in the sector comes from the ABS *Building Approvals* publication which measures the value of work associated with building approvals. It also provides a forward looking measure of investment in the health care sector, including a split



of ownership between the public sector and private sector. However, it only covers investment in building work, rather than equipment, so therefore may not cover a substantial element of investment in the private hospitals sector.

CHART 2: VALUE OF BUILDING APPROVALS, PRIVATE SECTOR HEALTH CARE FACILITIES

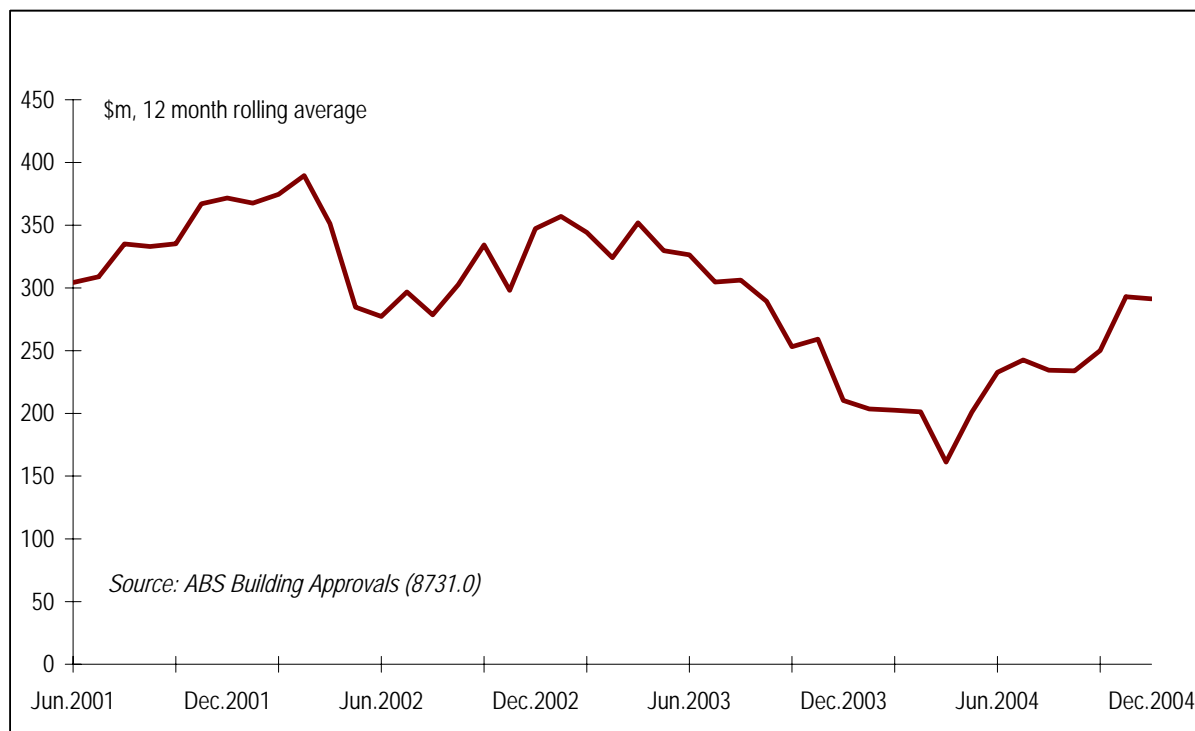


Chart 2 shows the value of building approvals in private sector health care facilities over time as a 12 month rolling sum (the total for the previous 12 months). The chart shows a clear deterioration in the value of capital expenditure building work for the sector over time. The trend continued beyond 2002-03 to reach a low point for the 12 months to April 2004. Since that time the value of building approvals has lifted somewhat.

However, it may be that some of the recent lift in building approvals in the sector is price rather than volume driven. Chart 3 shows the growth in non-residential construction prices (less CPI inflation, so as to help isolate the cost gains specific to the sector). As shown in that chart, gains in this measure are at record highs.

Similarly, and as shown in Chart 4, increases in the cost of skilled construction labour over the past two years have been considerable.

Although the measures in both these latter two charts are not sector specific, they do point to the likelihood that some of the recent increase in building approvals in nominal terms represents prices rather than volumes.

CHART 3: GROWTH IN NON-RESIDENTIAL CONSTRUCTION PRICES, LESS CPI INFLATION

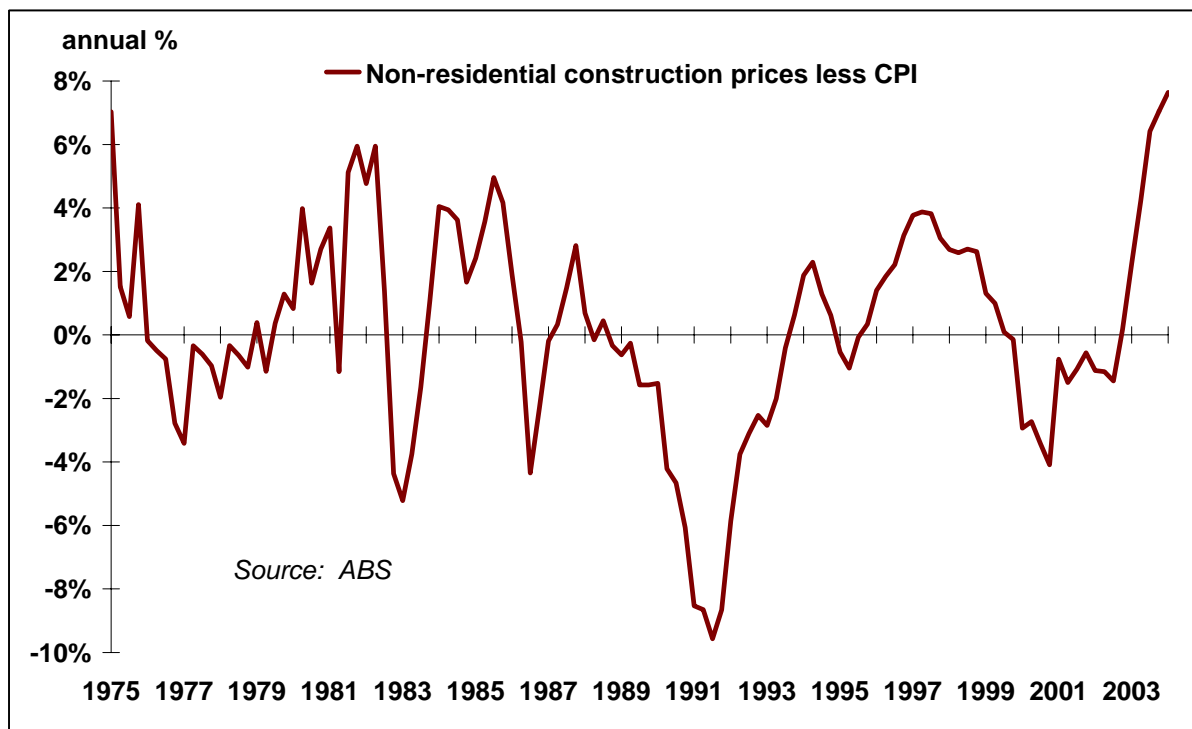
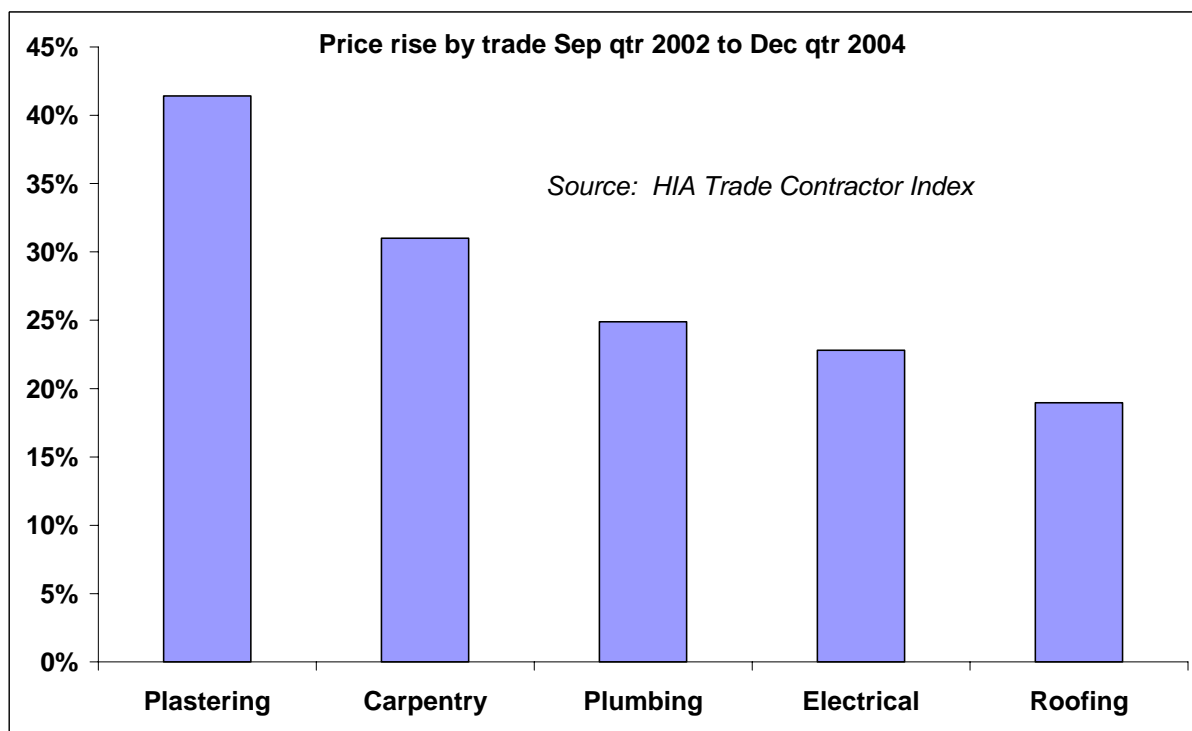


CHART 4: PRICE RISES FOR SELECTED CONSTRUCTION SERVICES, SEP 2002 TO DEC 2004



The other key ABS publication which covers future capital expenditure intentions, the *Private capital expenditure survey*, does not include health care facilities within its coverage.

The clear message from the most recent ABS *Private Hospitals* survey is that capital expenditure had fallen away in the private hospitals sector. A trend of declining capital



expenditure is also suggested from the ABS *Building Approvals* publication, continuing into 2003-04 (though building work would only cover a portion of the sector's capital expenditure).

In order to obtain a comprehensive view of current and expected future capital expenditure in private hospitals, a survey of the sector was undertaken through January 2005. The results of that survey are presented in the next two chapters.



3. SURVEY RESULTS – AGGREGATE CAPITAL EXPENDITURE

3.1 SCALING UP FOR NON-RESPONDENTS

Table 2 earlier showed that the APHA survey accounted for a good proportion of beds available in acute and psychiatric hospitals in the sector. However, to ensure comparability with the historic ABS series, some estimate of the capital expenditure of non-respondents must be calculated.

For the benchmark year of 2002-03, while the response rate for the acute and psychiatric hospitals in terms of available beds was 27.1%, the capital expenditure in 2002-03 from survey respondents was some \$160.5 million, or 55% of the total reported in the ABS survey for 2002-03 for the sector as a whole. Survey respondents accounting for a high share of capital expenditure is understandable as survey responses covered many of the larger and multi-location operators in the sector who may have greater means and incentive to invest.

The result is that the capital expenditure of non-respondents in 2002-03 can be derived, including on the basis of average capital expenditure per available bed (calculated at \$7,283 per annum, compared with \$24,187 in 2002-03 for survey respondents).

This derived figure (of average capital expenditure per available bed for non-respondents) is used to project non-respondents' capital expenditure in future years (multiplied by the number of available beds for non-respondents and a price index for health services, as projected by Access Economics, to allow for price growth).

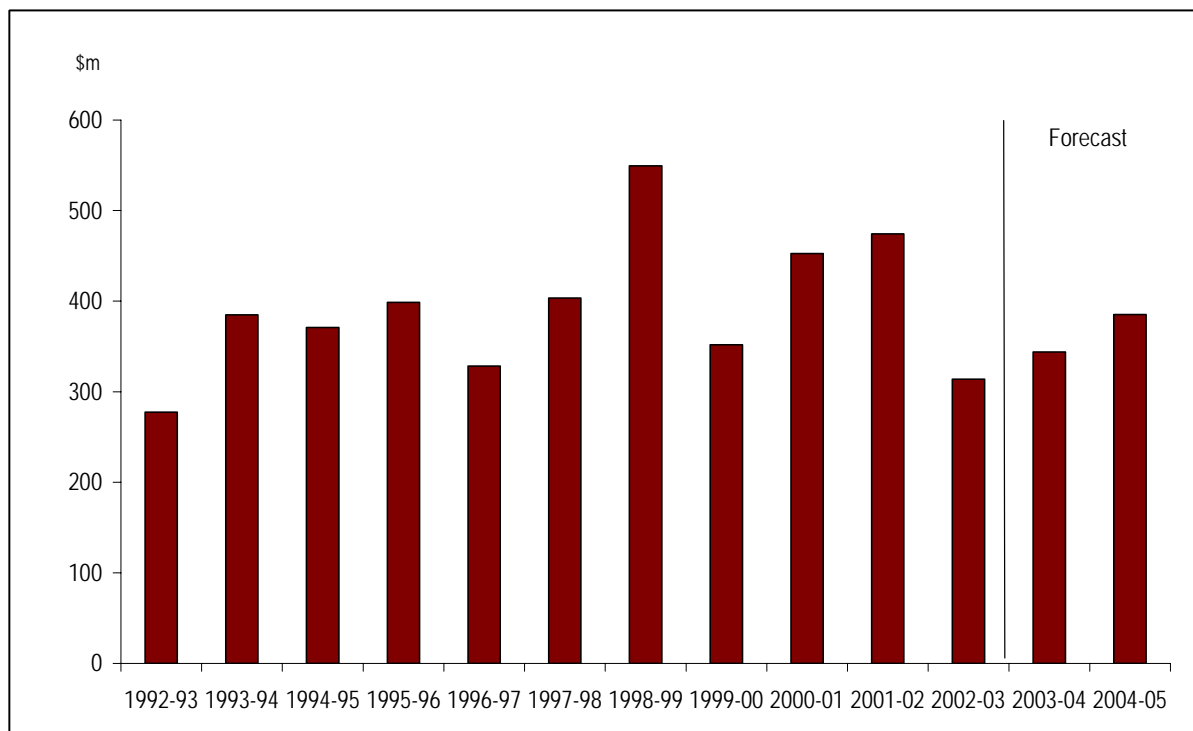
The survey response rate for free standing day hospitals was very small (at around 3%), which is not amenable to the scaling up on the basis of respondents. However, ABS data shows that capital expenditure by free standing day hospitals has maintained a relatively constant level for the past six years - despite the upwards trend in the both the number of beds and hospitals. For the projections shown in this report, the 2002-03 level of capital expenditure for free standing day hospitals has been grown by a price index for health services, as projected by Access Economics. As discussed earlier, this part of the sector has only accounted for around 6% of the sector's capital expenditure over the decade to 2002-03.

3.2 CURRENT CAPITAL EXPENDITURE

Using survey data (and the methods of scaling-up and trend projection described above), Chart 5 shows historical and expected expenditure for private hospitals over the short-term horizon (2003-04 and 2004-05).

The survey suggests that following the decade low point for capital expenditure reached in 2002-03, capital expenditure did rise in 2003-04, but not by a significant amount (some \$28 million). For 2004-05, expected capital expenditure is set to rise again, by a further \$41 million, to reach a level of \$385 million. That amounts to a reasonable lift from the 2002-03 low point (of some 22%), though it would still be below the average capital expenditure achieved over the decade to 2002-03 (of some \$403 million per annum in nominal terms).

CHART 5: PRIVATE HOSPITALS CAPITAL EXPENDITURE, SHORT TERM PROJECTIONS



From respondents to the survey, capital expenditure in 2003-04 is expected to result in 265 new patient beds, and 7 new theatres. For 2004-05, capital expenditure from survey respondents is expected to result in an additional 315 patient beds and 18 new theatres.

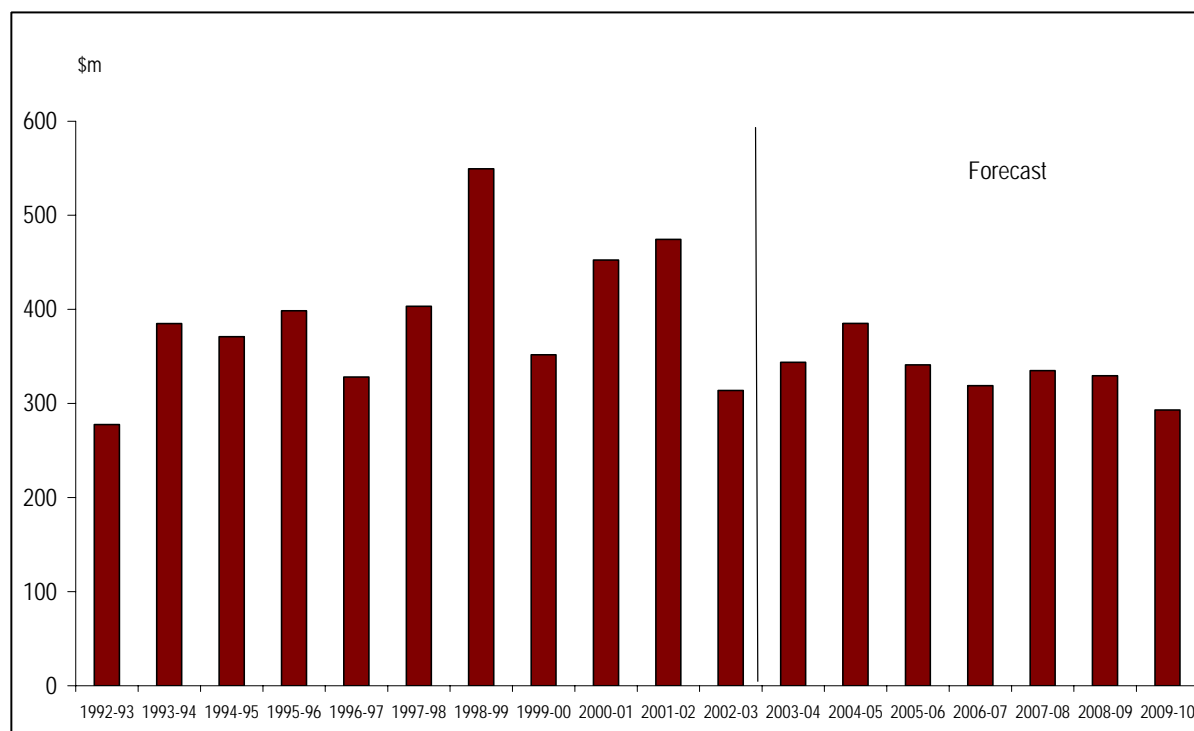
In short, the picture of current investment from the APHA capital expenditure survey is that the worst has passed – investment has lifted from its 2002-03 low point, but is still well short of the robust levels of investment achieved in 1998-99 and the early 2000s.

3.3 FUTURE CAPITAL EXPENDITURE INTENTIONS

Beyond 2004-05, the APHA capital expenditure survey also sought information on the future capital expenditure intentions of private hospitals. Survey respondents could either provide a year-by-year profile of expected expenditure, or nominate an estimate of expenditure for the next five years (from 2005-06 to 2009-10), with that amount apportioned equally over the years in this analysis.

Chart 6 shows that capital expenditure is expected to fall away over the five years to 2009-10, from the point achieved in 2004-05. The decline in expenditure is relatively moderate – until the last survey year of 2009-10, expected expenditure remains above that recorded for 2002-03.

CHART 6: PRIVATE HOSPITALS CAPITAL EXPENDITURE OVER TIME



From respondents to the survey, capital expenditure over the five years to 2009-10 is expected to result in a total additional 553 patient beds.

It should be kept in mind that the reporting of estimated expenditure beyond the current year of 2004-05 would be sensitive to typical ‘realisation ratios’ in capital expenditure plans (the ratio of actual capital expenditure during a period of time relative to that which was expected prior to the period). The further one is reporting in advance, the less certain one is of the capital expenditure which will typically take place in that year. In general, estimates of future capital expenditure tend to be *under-stated*.

The ABS *Private Capital Expenditure* survey reports typical realisation ratios for mining, manufacturing and other selected industries (comprising construction, wholesale and retail trade, transport and a range of business service industries). For the broad group of ‘other selected industries’ realisation ratios of 140% have been typical in that survey’s earliest estimates (which are some six months prior to the commencement of a year). That is, for a typical year (say, 2005-06), estimates reported six months prior to the year (at December 2004) would typically understate actual expenditure by some 40%. The time periods examined here also go out much further (five years ahead) than does the ABS survey.

Whether such realisation ratios should apply equally to the private hospitals sector is open to question. Given the falls in the average length of stay in hospitals, there has been a significant overall decline in beds per thousand of population. Offsetting that, the private hospital sector has gained market share, particularly since the resurgence of private health insurance covering following the introduction of the 30% tax rebate and Lifetime Health Cover. Also, capital expenditure is not simply a function of capacity expansion. Health facilities need to be updated regularly as health technologies change.

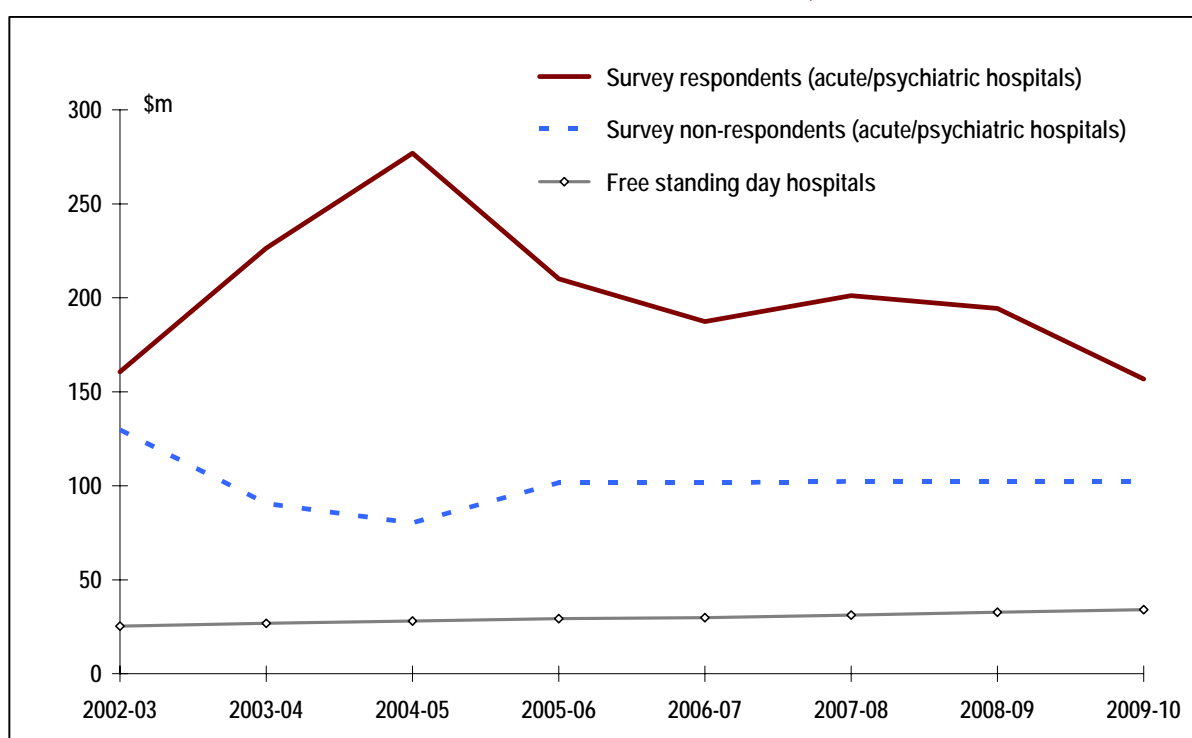
The APHA capital expenditure survey, if repeated over time, would be able to estimate typical realisation ratios for the sector. For this analysis, we have not applied any realisation

ratio to future estimates of capital expenditure, which may tend to underestimate investment plans.

In summary, the forward profile for capital expenditure in the private hospitals sector is one of a moderate decline over time, though noting that this may be conservative given a tendency in other sectors to under-estimate future capital expenditure plans.

Chart 7 shows a split of estimated capital expenditure for the period covered by the APHA capital expenditure survey, with expenditure shown for survey respondents (acute and psychiatric hospitals), as well as for the two derived components: survey non-respondents (acute and psychiatric hospitals), and free standing day hospitals. The latter two categories have been calculated, as described in section 3.1.

CHART 7: PRIVATE HOSPITALS CAPITAL EXPENDITURE, MAJOR CATEGORIES



Within total capital expenditure, free standing day hospitals capital expenditure is growing on average by 4.3% per year, in line with expected growth in the price index for health services.

Capital expenditure for survey respondents rises up to 2004-05 and then moderates. The decline in estimated capital expenditure for non-respondents from 2002-03 to 2004-05 reflects the fact that there are fewer non-respondents in 2004-05 (a smaller proportion of the sector did not answer the question in that year). Other than variance in the response rate, expected expenditure growth in this sector is also driven by expected growth in the price index for health services.

Investment from outside the sector

The APHA capital expenditure survey only reports on capital expenditure intentions by current operators in the sector. Those currently not within the sector who may be looking to build private hospital facilities would not be included. We have examined Delta Electricity



and Access Economics *Investment Monitor* database for any such proposals, with only one proposal of note:

- ❑ A proposed 130 bed private hospital, along with a medical centre and aged care facility in Wollongong proposed by Jempac Developments (development cost of \$110 million).

It would appear therefore that the bulk of investment in the private hospitals sector is being undertaken by those already within the sector.

3.4 IMPLICATIONS OF CAPITAL EXPENDITURE PROFILE

The results of the APHA capital expenditure survey suggest that recent and current capital expenditure by private hospitals is relatively modest. The future expenditure profile is also moderate, though noting that expenditure plans which are further out in time are likely to be understated at present.

ABS data and the survey suggest that capital expenditure for 2002-03, 2003-04 and 2004-05 are all expected to have been below the average capital expenditure achieved over the decade to 2002-03 in nominal terms.

While that information would suggest the sector is 'under-investing', it is difficult to say exactly how what amount of capital expenditure private hospitals would typically require on an ongoing basis (such an estimate would ideally require information on the asset base of the sector, depreciation rates to apply and the average age of assets).

One can perform a broad assessment of capital expenditure relative to income over time. Chart 8 shows capital expenditure relative to income for private hospitals (using estimates of income for 2003-04 and 2004-05) compared with an equivalent measure for the economy as a whole (business investment as a share of GDP).

CHART 8: CAPITAL EXPENDITURE SHARE OF INCOME, PRIVATE HOSPITALS AND WHOLE ECONOMY

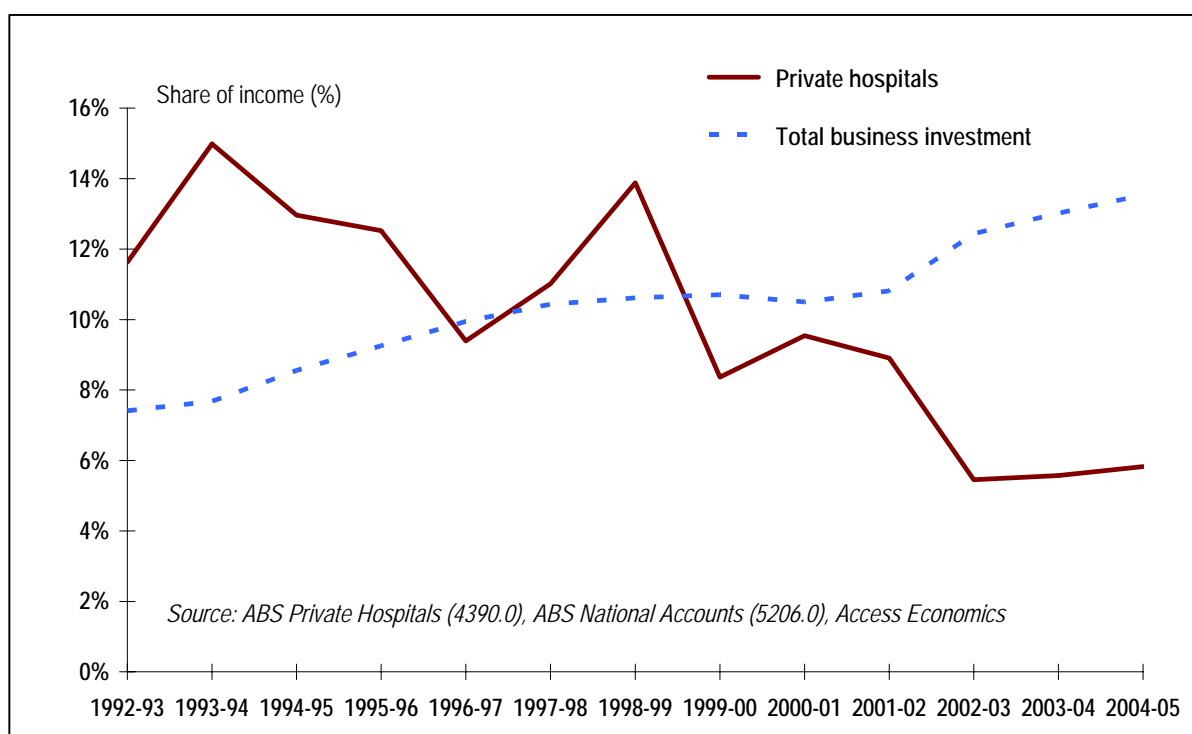




Chart 8 shows that business investment as a share of income has been rising steadily for many years. For private hospitals on the other hand, there has been a notable decline in investment as a share of income since 1998-99, and the rate of investment is now well below the economy-wide average, despite the rapid rate of demand growth in the sector.

The implications of an extended period of under-investment in the private hospitals sector could include:

- ❑ A developing lack of available beds, or within total available beds, a greater proportion of shared rooms rather than private rooms;
- ❑ Slower adoption of new medical technology, and so some deterioration in the quality of health service provided relative to best practice; and
- ❑ Some deterioration in the physical work environment for staff, which could lead to problems in recruiting or retaining staff.

A period of under-investment however, would also sow the seeds for the sector to go through a period of stronger (or 'above normal') investment at a later stage. As capacity constraints are reached, returns on new investment are pushed higher (either through prices being pushed up, or a greater likelihood that the additional beds or equipment will be used to capacity rather than sitting idle).

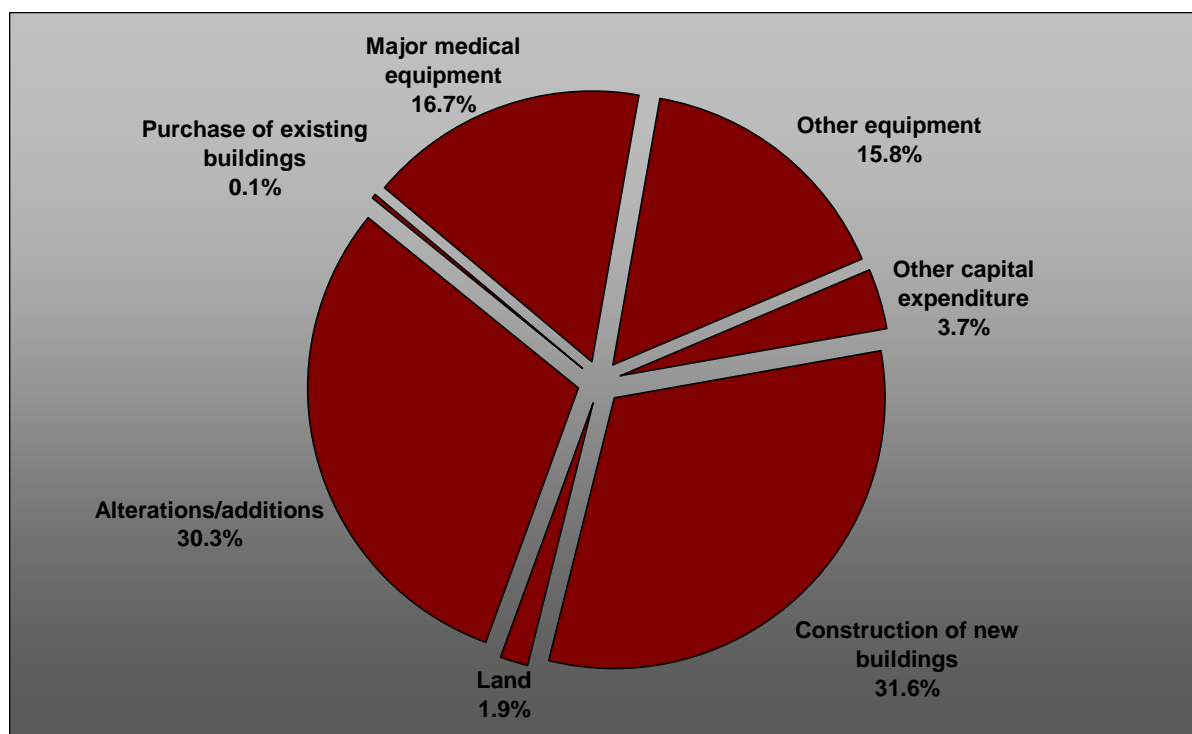
A volatile capital expenditure profile over time is not a good thing for the private hospital sector (as at times it may affect access and the standard of service delivered), but it is a phenomenon often seen in many sectors of the economy. Indeed, the strong growth in State government capital expenditure for public hospitals seen currently (and discussed in Chapter 5), can be seen in part as a catch-up for several years of under-investment in those facilities.

4. SURVEY RESULTS – COMPONENTS OF CAPITAL EXPENDITURE

4.1 TYPE OF INVESTMENT

The APHA capital expenditure survey asked respondents to provide a breakdown of their total capital expenditure into various components, including equipment and building investment. Chart 9 shows the share of capital expenditure for each component for 2004-05. It shows that construction of new buildings accounts for nearly a third of capital expenditure, with alterations and additions also over 30%. Adding in purchases of land and existing facilities means that some 64% of planned investment is for expansion or alterations of buildings. The remainder is largely accounted for by equipment purchases, with a fairly close split between major medical equipment and other equipment.

CHART 9: COMPONENTS OF CAPITAL EXPENDITURE 2004-05



Capital expenditure is not split into these components in the ABS *Private Hospitals* publication, so it is not possible to compare the survey profile with historic trends for the sector.

Table 3 shows the same data (capital expenditure by component) in terms of total dollars expected to be spent by the sector.²

² Total expenditure is the scaled-up estimate for the whole sector as discussed in Chapter 3, which means that survey non-respondents are assumed to have the same expenditure profile as survey respondents.

TABLE 3: COMPONENTS OF CAPITAL EXPENDITURE, \$M NOMINAL

| Investment type (\$m) | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|--------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Construction of new buildings | 22.69 | 121.54 | 92.54 | 70.95 | 92.36 | 88.98 | 18.70 |
| Land | 0.17 | 7.37 | 0.00 | 0.85 | 3.33 | 0.00 | 4.67 |
| Alterations/additions | 111.81 | 116.52 | 126.74 | 126.15 | 115.77 | 121.64 | 129.26 |
| Purchase of existing buildings | 0.00 | 0.28 | 0.00 | 0.51 | 3.33 | 0.00 | 4.67 |
| Major medical equipment | 30.46 | 64.32 | 49.72 | 41.17 | 46.09 | 40.16 | 47.96 |
| Other equipment | 133.49 | 60.86 | 36.47 | 41.72 | 38.04 | 42.60 | 47.88 |
| Other capital expenditure | 45.12 | 14.26 | 35.50 | 37.48 | 35.90 | 35.97 | 39.97 |
| Total | 343.74 | 385.15 | 340.98 | 318.83 | 334.81 | 329.36 | 293.13 |

Table 3 shows that the expenditure profile by components is quite variable, particularly between 2003-04 and 2004-05:

- ❑ Construction of new buildings accounted for just \$23 million in 2003-04 (or 6.6% of expenditure), with this jumping to \$122 million in 2004-05 (or 31.6% of expenditure) and thereafter dropping back.
- ❑ Purchases of other (non major medical) equipment were significant in 2003-04 at \$133 million (or 38.8% of expenditure), with this dropping to \$61 million in 2004-05 (or 15.8% of expenditure) and moderating further thereafter. Purchases of major medical equipment are expected to lift in 2004-05, before also dropping back a little.
- ❑ The profile of alterations and additions spending is relatively steady over time.

In short, the capital expenditure profile for the sector has changed between 2003-04 and 2004-05, with a greater focus on expansion and relatively less focus on equipment purchases.

The above reflects gross capital expenditure, which is the same concept reported in the ABS *Private Hospitals* survey. The APHA capital expenditure survey also asked respondents to nominate the value of any expected **disposal of assets**. For 2003-04, respondents disposed of nearly \$20 million in assets, while disposals in 2004-05 were expected to drop markedly to just \$2.1 million. Disposals of assets were then constant at \$1.2 million for the remainder of the period covered by the survey.

4.2 INVESTMENT WITHIN SPECIALIST AREAS

The APHA capital expenditure survey asked respondents to nominate their level of capital investment in certain specialist areas: orthopaedics, ophthalmic, cardiology, scopes and other specialist areas.

The total response rate for these questions was around 10% of the total sector (in terms of available beds), which is not significant enough to scale up for the sector as a whole. However, for those who responded to the survey, Chart 10 shows the share of their capital expenditure for each specialist area, along with the share of those respondent's capital expenditure which is not in specialist areas.

CHART 10: SHARE OF INVESTMENT IN SPECIALIST AREAS, 2004-05

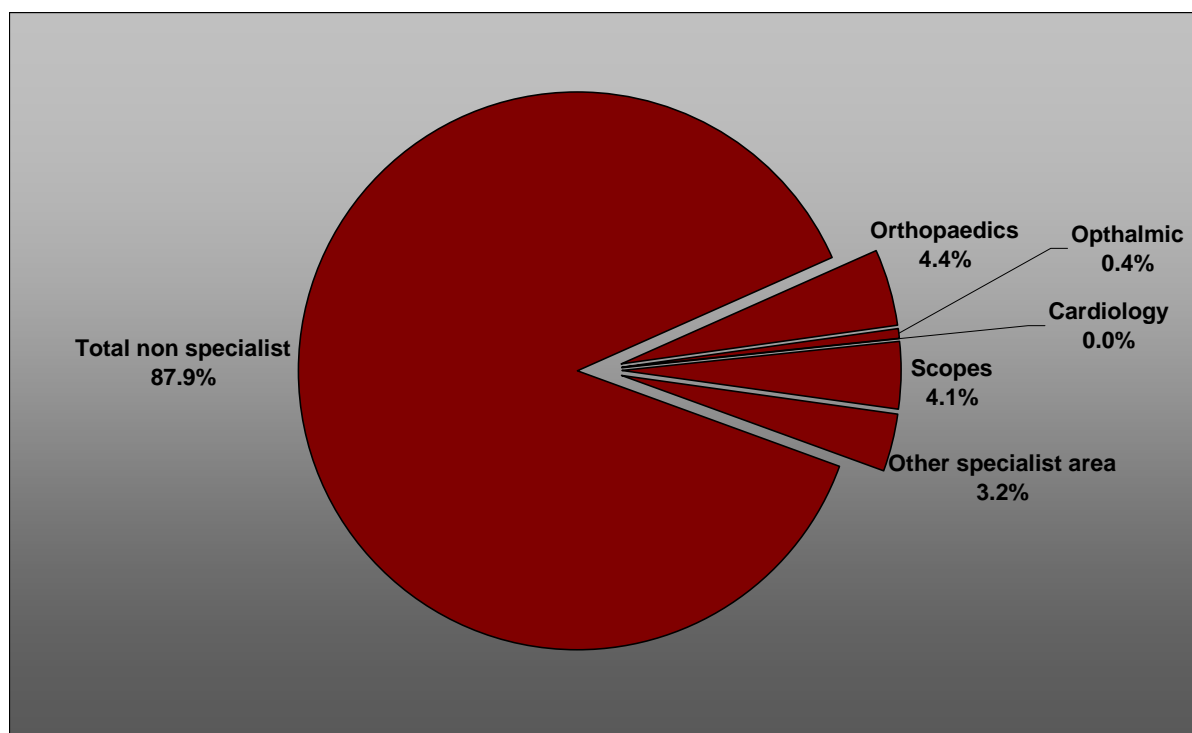


Chart 10 suggests that even for those who are investing in specialist areas, the majority of their capital expenditure is expected to be in non-specialist areas. Within specialist areas, the largest amount of investment is expected to be in orthopaedics, closely followed by scopes.

4.3 DIVERSIFICATION

The APHA capital expenditure survey asked:

If your hospital is planning to diversify, please indicate the nature of this eg. aged care, step down care, other

There were relatively few responses to this question. Only one respondent organisation stated that they were planning diversification into high and low care, with the high care expansion to be undertaken through both acquisition of new buildings and building new facilities.

Other respondents to this question noted planned diversifications into hospital activities their organisation currently wasn't involved in, such as addition of overnight admissions units for some day surgeries, and diversification into oncology, rehabilitation, plastics and reconstruction, as well as renal dialysis for some hospitals.

4.4 IMPEDIMENTS TO CAPITAL EXPENDITURE

The APHA capital expenditure survey asked respondents to comment on impediments to capital expenditure via three questions.

Impediments due to remuneration levels within the contracting (Hospital Purchaser Provider Agreement) environment

Have the current or future capital expenditure plans of your hospital/organisation been affected by remuneration levels within the contracting (HPPA) environment? Please comment

The overwhelming response to this question was that the current contracting environment has made it significantly harder for hospitals to undertake capital expenditure. Responses suggested that growth in remuneration levels of 1-2% per annum have not kept pace with the cost of providing services. In some cases that has led to cash flow difficulties and a lack of internal funding for further investment.

Some respondents suggested the result is that they do not have the confidence or the money to undertake renovations, or to purchase new equipment. This concern also extends to the development of new facilities, with some hospitals having had to drop plans for new developments, and instead extend or update existing facilities.

Impediments due to changes to State government regulations

Have the current or future capital expenditure patterns of your hospital/organisation been affected by changes to State government regulations (for example on room sizes)? Please comment

New guidelines in Western Australia were the most mentioned State government regulations which were seen as impeding capital expenditure. Respondents said that the guidelines have significantly increased costs of hospital redevelopment, specifically when it came to building standard requirements.

Another stated impediment to further capital expenditure was hospital licensing requirements. It was indicated that private hospitals have to meet higher thresholds than public hospitals (where a lesser standard is imposed). There were also concerns over the way that licensing requirements are administered.

Changes to the Central Sterilising Supply Department (CSSD) regulations were also mentioned as an impediment, with some respondents saying that the new sterilisation standards have resulted in the need of new CSSD equipment, thus leaving less capacity for other capital expenditure.

At a local government level some respondents stated that Local Council planning regulations posed many obstacles, and varied from Council to Council, depending on the attitude to development and planning issues.

Other impediments

Are there any other obstacles to further capital investment in hospitals or related facilities by your organisation? Please comment

Respondents referred to some potential investments not proceeding due to expected returns being too low. Impediments noted in generating low returns included the cost of building new facilities (as building costs have risen significantly), and the cost of introducing certain procedures, such as Nasendoscopy, which are costly to set up, and to maintain.

Other general impediments to investment which were mentioned were contract risk, the inability to close down areas of the hospital for any length of time, and costs associated with changing multiple bed wards to single or double bed wards.

5. COMPARISON WITH PUBLIC HOSPITAL CAPITAL EXPENDITURE

The key message from the APHA capital expenditure survey is that investment in the private hospitals sector is slowly lifting from its 2002-03 low point, but remains relatively modest (at a level which is below the average of the past decade, in nominal dollars). Capital expenditure in the sector in 2004-05 is expected to be \$385 million, a 12.0% rise on estimated capital expenditure in 2003-04.

How does that compare with public hospital capital expenditure?

Table 4 shows the budgeted capital expenditure for health or human services by each State for 2004-05, along with the percentage increase over the amount spent in 2003-04. The bulk of this capital expenditure is for public hospitals, although it would include some other health care facilities, while in South Australia and Tasmania the figures include some capital expenditure on housing.

The message from Table 4 is stark. Capital expenditure for health or human services in most States is expected to increase dramatically in 2004-05. Across all States, capital expenditure of nearly \$1.9 billion is planned in 2004-05, a 26.8% increase on 2003-04 levels.

TABLE 4: STATE GOVERNMENT CAPITAL EXPENDITURE FOR HEALTH / HUMAN SERVICES

| State | 2003-04 (\$m) | 2004-05 (\$m) | % change |
|----------------------|----------------|----------------|--------------|
| New South Wales | 456.7 | 600.0 | 31.4% |
| Victoria | 305.0 | 355.0 | 16.4% |
| Queensland | 276.7 | 406.0 | 46.7% |
| South Australia | 258.8 | 270.0 | 4.3% |
| Western Australia | 105.1 | 162.1 | 54.2% |
| Tasmania | 44.7 | 25.3 | -43.5% |
| Northern Territory | 17.8 | 32.3 | 80.9% |
| ACT | 16.2 | 27.5 | 69.5% |
| Sum of States | 1,481.1 | 1,878.1 | 26.8% |

In part, the strong growth in planned capital expenditure reflects very strong revenue growth at the State government level, with 2004-05 Budgets delivered at the peak of the residential property cycle (which delivered State governments a particular windfall via stamp duty revenues). It also reflects some growing urgency in improving the standard of service available from public hospital facilities – a catch-up following a period of under-investment in public hospital facilities.

State by State, the dollar increases in capital expenditure are most significant from New South Wales (\$143 million), and Queensland (\$129 million). In the case of New South Wales however, spending in 2003-04 had been a notable decrease on the previous two years. While most States are budgeting for strong spending growth, Tasmania's capital expenditure program is declining after many projects were completed in 2003-04. Recent years have shown that State government spending on public hospitals can vary dramatically from year to year.



State government budgets generally only report specific expenditure plans for the Budget year. While longer term plans for some specific projects are mentioned, State budgets don't present year by year planned expenditure profiles, or generally even a planned budget covering a number of years. Therefore, analysis of likely public sector capital expenditure beyond 2004-05 is not possible.

The following lists some of the major investment projects which are leading capital works programs State by State.

New South Wales

The New South Wales capital expenditure program included 27 major new works in 2004-05. Major projects underway include:

- ❑ The Royal North Shore Hospital redevelopment (Stage 2), \$414.7m from 2002 until 2010
- ❑ The Central Coast health access plan, \$212.4m from 2002 until 2006
- ❑ The Malabar Forensic Hospital, \$64.6m from 2003 until 2007

Victoria

Major allocations of funding in Victoria in 2004-05 include:

- ❑ The Alfred Centre – New purpose built Centre for Elective Surgery at the Alfred Hospital (\$60m in 2004-05)
- ❑ Medical Equipment – Upgrade and replacement of medical equipment allocated across acute health, aged care, public health and dental services (\$25m in 2004-05)
- ❑ Geelong Hospital Radiotherapy Services – Expansion and refurbishment of existing Andrew Love Cancer Centre facility (\$18m in 2004-05)
- ❑ Dandenong Hospital Redevelopment Stage 2 (\$15m in 2004-05)

Queensland

Major projects outlined for the coming years in Queensland include:

- ❑ \$200m from 2004-05 until 2007-08 to fund the integration of community and hospital based health services. Included in this investment are the Cairns Central Community Health Centre, Sunshine Coast Ambulatory and Community Centre and the Gin Gin Health Service.
- ❑ \$107m from 2004-05 until 2008-09 will be invested into the redevelopment of the Prince Charles Hospital emergency department, enhancing the Queensland Cancer Registry and the purchase of specialised health technology for cancer care.
- ❑ \$339m from 2004-05 until 2008-09 will fund information and communication technologies to improve access to client information and to continue the development and replacement of technical infrastructure.

South Australia

Major projects being undertaken in South Australia include:

- ❑ The Queen Elizabeth Hospital Redevelopment Stage 2, \$120m from 2005 until 2009.
- ❑ The Royal Adelaide Hospital Redevelopment Stage 4, \$118m from 2004 until 2011



- ❑ Lyell McEwin Health Service Redevelopment Stage B, \$32m from 2005 until 2007.

Western Australia

The Western Australian government has announced it will provide \$2.7 billion in capital expenditure for health over the next 13 years. Major projects outlined by cost include:

- ❑ \$260m for equipment replacement from 2004-05 until 2013-14
- ❑ \$347m allocated to the Northern Tertiary Hospital Redevelopment, ongoing from 2006-07
- ❑ \$420m to build the Southern Tertiary Hospital from 2004-05 until 2011-12

Tasmania

New projects commencing in 2004-05 in Tasmania include:

- ❑ Redevelopment of the Department of Emergency Medicine at the Royal Hobart Hospital
- ❑ Construction of the new hospital at Queenstown to be developed over four years from 2004-05
- ❑ Development of North East Soldiers' Memorial Hospital (Scottsdale).

Northern Territory

Ongoing major works in the Northern Territory include:

- ❑ Upgrading and modifying the existing health centre at Yuendumu (\$2m in 2004-05)
- ❑ Constructing a hospice at Royal Darwin Hospital (\$3.6m in 2004-05)
- ❑ Constructing a new health centre at Milikapiti (\$1.5m in 2004-05)

ACT

Capital works in progress in the ACT include:

- ❑ Construction of the ANU Medical School (\$5.7m in 2004-05)
- ❑ Redevelopment of Kerralika Drug and Alcohol Therapy Facilities (\$5.1m in 2004-05)
- ❑ Refurbishment of Paediatric Wards (\$3.9m in 2004-05)

6. GLOSSARY

| Term | Definition |
|-----------------------------|---|
| Acute hospital | These hospitals provide at least minimal medical, surgical or obstetrical services for admitted patient treatment and/or care and provide round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health authority. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short. |
| Available beds | The number of available beds are those immediately available (occupied and unoccupied) for the care of admitted patients if required. They include beds and chairs for same day patients. |
| Capital expenditure | Expenditure in a period on the acquisition or enhancement of an asset (excluding financial assets). |
| Free standing day hospitals | These hospitals provide investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits. |
| Major medical equipment | Expenditure on major items of medical equipment such as CT scanners, MRI equipment, X-ray equipment, ICU monitors and transplant equipment. |
| Other equipment | Machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers. |
| Patient | A patient is a person for whom a hospital accepts responsibility for treatment and/or care. Boarders are not to be counted as patients. |
| Patient days | The total number of days of hospital stay (i.e. separation date minus admission date) for admitted patients who underwent separation during a financial year. Exclude all leave periods (the day a patient returns from leave is not counted as a leave day). Same day patients are to be counted as having a stay of one day. |
| Psychiatric hospital | Psychiatric hospitals are licensed/approved by each state or territory health authority and cater primarily for admitted patients with psychiatric, mental or behavioural disorders. |