SUBMISSION

TO THE ACT LEGISLATIVE ASSEMBLY STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

THE INQUIRY INTO CALVARY PUBLIC HOSPITAL OPTIONS

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I respectfully make the following submission to the Committee.

My submission addresses an issue that arises from all of the Ministerial Options, particularly in relation to possible new activity funding agreements.

My submission relates to a question that arises from each of the Options for Calvary Public Hospital (***Calvary***), namely, what effect would any of the options have on the funding, operations, continued public ownership and multi-faceted enhancement of the ACT community hospice, Clare Holland House (***CHH***), and the related community-based palliative care programs that are run from CHH.

The 2008/2009 plans by the current ACT Government to sell CHH to Little Company Heath Care (***LCMHC***) were widely described and criticised as a sweetener to encourage LCMHC's sale of Calvary to the Government.

That aspect of the plans provoked significant public protest and a community-based campaign which contributed to eventual abandonment of the linkage between the sale of Calvary and the reciprocal sale of CHH.

However, the Government's decision (limited to the duration of the current Legislative Assembly only) not to sell CHH should not result in the view that, 10 years after it opened, CHH can simply continue to operate as before as if a traumatising, controversial and awakening event had not occurred.

Internally and externally, CHH and its environs require attention - as you would expect after 10 years without any major Government refurbishment program.

Internally, the four bed room for terminally ill people was a design mistake rectified in 2006. But externally, the lack of a simple path around the building for patients and family to walk was and remains a deplorable design oversight.

Ten years on, the car park, the roundabout, the equipment, the family room, the limited overnight family accommodation, the furnishings, the paintwork, the garden all deserve renewed attention.

But something else is obviously much more important. In my opinion, as someone who has observed the operations of the hospice for over 10 years, hospice staff levels are not always sufficient to deliver world's best practice palliative care for those who require the sanctuary of the hospice, while preserving the commitment, excellence and wellbeing of the very staff who deliver the caring service.

Quality nursing care is sometimes the major difference between the ability, philosophically and physically, to face the end of life, and the alternative nightmare of depression, discomfort, pain and despair that prompt thoughts of assisted suicide.

World's best practice palliative care nursing is obviously an amalgam of many things, for example, compassionate and committed professionals, who are highly trained, continuously developing, under stable and effective leadership, and who themselves have emotional and moral support to cope with the challenges of the work.

But one thing that must not be overlooked even when all the others are present is sufficient numbers of nurses and related staff at critical times on each shift to cope with the demands and the needs of quality care.

And to cope in a way that does not undermine the wellbeing of those very nursing carers. Of their very nature, hospice and community palliative care nursing requires more time than is involved in dispensing medication, sophisticated though that task is.

Increased staff levels would come at a cost to Government and the whole community – just as the absence of sufficient staffing would impose a different kind of cost on a small part of that community, the patients.

LCMHC is a contractor which manages the delivery of hospice and community palliative care services at and from CHH in a kind of association with its delivery of public hospital services at Calvary.

However, the amount of money allocated by Government for those hospice and community palliative care services, and the amounts actually spent on hospice and palliative care have never been publically disclosed by the Government.

Unless Government establishes, and discloses to the public in the budget, the annual amount of money that it spends on CHH and related palliative care services, it is impossible to know what the Government regards as its funding base line for hospice and palliative care in the ACT.

It is consequentially impossible for even the Government, let alone any other interested parties, to know to what relative standard hospice and palliative care services are being delivered in the ACT, what scope exists to enhance them and at what cost.

Because of this lack of Government transparency, it is not possible to compare the ACT's financial commitment to hospice and palliative care and its outcomes, with the commitment of governments elsewhere, for example, in the rest of Australia, in North America, in the UK and Ireland, or in Europe.

As a result, it is impossible to know whether, and where, significant improvements could and should be made relative to the funding, practice and performance of comparable States, territories and countries.

It is not known why Government will not disclose the level of its expenditure on hospice and palliative care services in the ACT, both directly and contractually.

The lack of Government transparency may have to do with commercial confidentiality of its contractual relationship with LCMHC. However, if that is the case, such an approach can have no legitimacy in law or public policy.

The fact that separate hospice and palliative care services happen to be bought from a private sector corporation, as a component of a very much larger health service contract, cannot justify a Government's failure to disclose what is in practice and reality its annual budget for hospice and palliative care.

The people of Canberra have a right to know from Government how much of their money is being spent at CHH and elsewhere on hospice and community palliative care.

The current Government arrangements whereby the LCMHC receives a disclosed global contract figure (of about $116 million) for activity funding to cover both Calvary and CHH is devoid of transparency and unacceptable to the community that pays the bill.

I, therefore, respectfully make the following suggestions to the Committee:

- for the purpose of properly considering each of the Minister's options, in particular Option 1, the Committee should obtain from the Government and release details of the levels of funding allocated in this and previous years to hospice and community palliative care;

- the Committee should not allow itself to be obstructed with arguments about commercial confidentiality that can have no legitimacy in the quest to understand how effectively a community may deliver the hospice and community palliative care aspects of its health services, including those which happen to be delivered by a contracting corporation - acceptance of such an excuse would signal the end of effective financial accountability for critical components of the health dollar;

- the Committee should recommend that such data be made publicly available in the Government's annual budget estimates on an itemised basis, including expenditure on CHH.

It is, in effect, my submission to the Committee that consideration of each of the Ministerial Options for Calvary would be incomplete if it did not fully take into account what effect the Option would have on a vital aspect of public health care that is currently very much tied up with the Calvary and LCMHC, namely the funding, operations, continued public ownership and multi-faceted enhancement of the ACT community

hospice, Clare Holland House and the related community-based palliative care programs that are run from it.

I am willing to appear before the Committee, if requested.

Peter O’Keeffe

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