

STANDING COMMITTEE ON HEALTH, COMMUNITY
AND SOCIAL SERVICES

Calvary Public Hospital Options

MARCH 2011

Report 5

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Resolution of appointment

On 9 December 2008, the Legislative Assembly for the ACT resolved to establish the **Standing Committee on Health, Community and Social Services** to:

Examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability matters, drug and substance misuse, targeted health programs and community services, including services for older persons and women, families, housing, poverty, and multicultural and indigenous affairs.¹

Terms of reference

On Thursday 23 September 2010, the ACT Legislative Assembly referred to the Standing Committee on Health, Community and Social Services for inquiry and report, the proposed four new options for future ownership and management arrangements of Calvary Public Hospital, put forward by the Minister for Health on 19 August 2010, as follows:

1. The Committee evaluate the relative merits of the four options presented by the Minister for Health, including the financial and health impacts of the options;
2. As appropriate, the Committee identify and evaluate any further options available for Calvary Hospital that have not been presented by the Minister; and
3. The Committee report back to the Assembly by the last sitting day in March 2011.

¹ Legislative Assembly for the ACT, *Minutes of Proceedings No 2*, 9 December 2008, pp 12–13

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ABBREVIATIONS

ABF	Activity Based Funding
AFA	Activity Funding Agreement
ASMOF	Australian Salaried Medical Officers Federation
COAG	Council of Australian Governments
CADP	Capital Asset Development Plan
CHH	Clare Holland House
CPH	Calvary Public Hospital
LCMHC	Little Company of Mary Health Care
LHN	Local Hospital Network
QCH	Queensland Children's Hospital
QEII	Queen Elizabeth 11 Family Centre
RAH	Royal Adelaide Hospital
RCH	Royal Children's Hospital (Melbourne)
SMO	Salaried Medical Officer
TCAS	Time Coast Allocation Schedule
TCH	The Canberra Hospital
UC	University of Canberra
VMO	Visiting Medical Officer

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL
SERVICES

RECOMMENDATIONS

RECOMMENDATION 1

2.46 The Committee recommends that the ACT Government provide to the Assembly the evidence demonstrating the efficiencies to be gained by having a fully networked and specialised hospital system for ACT public hospitals.

RECOMMENDATION 2

3.31 The Committee recommends that in the event that the ACT Government and Little Company of Mary Health Care are unable to reach agreement, an independent arbitrator be appointed to assist the parties to reach a mutually beneficial contractual arrangement.

RECOMMENDATION 3

3.32 The Committee recommends that any future agreement between the ACT Government and Little Company of Mary Health Care seek to establish the requirement for Calvary Health Care to provide an annual and financial report for the Legislative Assembly and the people of Canberra.

RECOMMENDATION 4

4.19 The Committee recommends that the ACT Government report to the Assembly the steps taken to address the concerns raised by the Auditor-General in relation to cross-charging arrangements between Calvary Public Hospital and Calvary Private Hospital.

RECOMMENDATION 5

5.38 The Committee recommends that the ACT Government consider the merits of a Public Private Partnership for the construction of a new public hospital, should it proceed with this option.

RECOMMENDATION 6

7.10 The Committee recommends that the ACT Government does not proceed with Option C that would result in three acute hospitals and Option B that would result in TCH becoming a 'super hospital' as proposed in the Government discussion paper released on 25 February 2011.

RECOMMENDATION 7

7.11 The Committee recommends that the ACT Government proceed with developing a fully networked and specialised hospital system as proposed by Options D and E in the Government discussion paper released on 25 February 2011.

1 INTRODUCTION

- 1.1 Public hospital services in the ACT are provided by The Canberra Hospital (TCH) and Calvary Public Hospital (CPH). CPH is owned by the Little Company of Mary Health Care (LCMHC) and managed by Calvary Health Care ACT (CHC), a subsidiary of LCMHC. LCMHC is a Catholic organisation that provides health care, aged care and palliative care services in a number of states across Australia. LCMHC controls 30 per cent of public hospital services in the ACT.
- 1.2 The ACT Government began negotiating the transfer of ownership of CPH with the LCMHC in August 2008. In-principle agreement was reached in October 2009 for the ACT Government to purchase and operate CPH. This agreement also included the transfer of Clare Holland House (CHH) to LCMHC. However, this proposal met with opposition from the Catholic Church concerned about the loss of control of its public hospital asset. Significant concern was also raised by community members unhappy with the proposal to transfer CHH to LCMHC. In February 2010, LCMHC withdrew its support for this agreement.
- 1.3 Further negotiations ensued and a new agreement was reached, with support from the Catholic Church, for the ACT Government to purchase CPH and for CHC to continue to operate the hospital under a 'renegotiated operating agreement' (the network agreement).²
- 1.4 During this period, the Australian Accounting Standards Board released an exposure draft of ED194, an 'international public sector standard which proposed that the government apply the same principles as private operators when accounting for what is known as a service concession arrangement'.³
- 1.5 Accounting advice sought by the Government, prior to finalisation of the agreement, identified that the newly negotiated draft network agreement 'represented a service concession arrangement [under interpretation 12 of the

² Minister for Health, *Transcript of Evidence*, 1 December 2010, p 2

³ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 2

new accounting standard] and that the Territory would be able to capitalise Calvary hospital assets without legal ownership'.⁴ This prompted the Government to seek further advice on the existing arrangements with LCMHC which identified the current arrangements could also be interpreted as a service concession arrangement, and the Territory was informed CPH should now be recognised as a Territory asset.⁵ This advice was confirmed by the Auditor-General in June 2010, and the ACT Government formally withdrew its offer to purchase CPH.⁶

- 1.6 LCMHC disagree with the Government's advice that their relationship is a service concession arrangement and have contrary advice to support their view that the relationship is one of 'a joint venture'.⁷
- 1.7 LCMHC have indicated their intention to continue to provide public hospital services from the Bruce campus. The Chair of LCMHC, The Hon John Watkins told the Committee:

We have a clear intention to remain as the owner and operator of the public hospital at Bruce. We wish to expand the public services at Bruce and develop additional private healthcare services, and we want to do that in close partnership with ACT Health and the government.⁸

- 1.8 The ACT Government has indicated that its preferred option was to own and operate CPH, considering this the best way to allow for an integrated and more efficient and effective health system across the ACT.⁹ However, since the transfer of ownership is no longer an option, primarily due to the change in accounting practices, the ACT Government is reconsidering its position.
- 1.9 The Minister for Health, Ms Katy Gallagher, put forward four options on 19 August 2010. These were:

⁴ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 3

⁵ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 3

⁶ ACT Government, *Briefing Paper for community stakeholders, Public Hospital Services in the ACT*, 2010, p 2

⁷ Submission 6, Calvary Health Care ACT, p 12

⁸ The Hon John Watkins, *Transcript of Evidence*, 22 December 2010, p 62

⁹ Submission 14, ACT Government, p 6

- Little Company of Mary maintains the crown-lease on the land with the establishment of a new activity funding agreement;
 - The ACT Government proceed with the network agreement in its current form;
 - The ACT Government assists the Little Company of Mary Health Care in developing a stand-alone private hospital as a public-good investment; and
 - The ACT Government builds a new acute public hospital on Canberra's north side.¹⁰
- 1.10 The Committee was disappointed with the paucity of detail about the four options provided by the ACT Government in its submission, and received no further information apart from other publically available documents. This lack of detail was also noted by the Save Calvary Group who felt that there was insufficient information provided by the Government to inform public debate.¹¹
- 1.11 The Australian Nurses Federation (ACT Branch) felt that without greater detail of the proposal for a new hospital it was difficult to comment, other than to provide in-principle support.¹²
- 1.12 However, on 25 February 2011, the ACT Government began a public consultation and released two new documents: *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*; and *ACT Public Hospital Services: Delivery of Additional Hospital Beds Options Analysis* outlining five new options in greater detail. The new options, representing a combination of the distribution of beds between TCH, CPH and new hospitals, are based on hospital projections estimating the requirement of an additional 400 hospital beds by 2022.¹³ The options are:
- Option A - Expand TCH and CPH by 200 beds each;
 - Option B - Consolidation of 400 beds at TCH;

¹⁰ Hansard for the Legislative Assembly of the ACT, 19 August 2010, pp 3666–3669

¹¹ Submission 7, Save Calvary Group, p 3

¹² Submission 10, Australian Federation of Nurses (ACT Branch) (Other issues raised by the ANF are discussed throughout this report.)

¹³ This figure is based on Government projections and is detailed in chapter 2.

- Option C - A new 200 bed north side hospital on a greenfield site and 200 beds at TCH;
 - Option D - A new 400 bed acute hospital and CPH converted to a sub-acute hospital; and
 - Option E - A new 200 bed sub-acute hospital and 200 beds at CPH.¹⁴
- 1.13 The consultation period will run from 25 February 2011–14 April 2011 with the Government indicating a decision for the provision of expanded hospital services to be made for the 2011–12 ACT Budget.¹⁵
- 1.14 These documents were made available to the Committee on 25 February 2011. The new options are considered in this report.

Conduct of inquiry

- 1.15 On Thursday 23 September 2010, the ACT Legislative Assembly referred to the Standing Committee on Health, Community and Social Services for inquiry and report, the four options for future ownership and management arrangements of CPH as proposed by the Minister for Health on 19 August 2010.
- 1.16 The inquiry was advertised in *The Canberra Times*, *The Chronicle* and on the Legislative Assembly website. Electronic networks were also utilised to promote the inquiry.
- 1.17 Public hearings were held on 1 December, 22 December and 23 December 2010 where the committee heard from the Minister for Health and Treasurer, representatives of LCMHC and other witnesses. The Committee recalled the Minister for Health and Treasurer on 16 March 2011 to discuss the details contained in the documents released on 25 February 2011. The full list of witnesses is at Appendix B.
- 1.18 The Committee visited CPH on 15 December 2010 and was provided with a comprehensive tour of the facilities. The Committee also met with senior

¹⁴ ACT Health, *Hospital Services: Delivery of Additional Hospital Beds Options Analysis*, February 2011, p 2

¹⁵ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 3

management as well as doctors and staff and appreciated the opportunity to see the operations of CPH.

- 1.19 The Committee visited TCH on 9 February 2010 and was provided with a comprehensive tour of the facilities. This visit also gave the Committee some sense of what it is like to be operating hospital services in an environment of on-site construction.
- 1.20 The Committee thanks the management and staff of CPH and TCH who provided information and assistance during the tours.
- 1.21 The Committee received 18 submissions. The full list is at Appendix C.
- 1.22 The Committee thanks the participants to the inquiry who provided submissions and/or oral evidence.

Structure of report

- 1.23 The Committee was tasked with assessing the health and financial implications of the four options provided by the Minister on 19 August 2010. However, as noted earlier, on 25 February 2011, the ACT Government released an additional five options for public consultation. These additional options are incorporated into the body of the report and will be referred to as Option A–E.
- 1.24 Chapter two considers the need for change through an analysis of the redevelopment of CPH, the single management model and projected demands on public hospital services in the ACT. The issue of local governance is also considered, with particular regard to Local Hospital Networks (LHNs).
- 1.25 Chapter three considers the range of options that represent the current situation of the ACT Government and LCMHC working together to deliver public hospital services. This includes the different models proposed by the Government and the development of a new activity funding agreement and a new network agreement.
- 1.26 Chapter four considers the ACT Government assisting LCMHC to build a new private hospital and the implications of this on the operations of CPH. The problems associated with the private hospital located within the public

hospital building, particularly in relation to cross-charging arrangements, are also explored.

- 1.27 Chapter five examines the need and options for a new hospital in the ACT. Drawing on examples of hospital development projects currently underway across Australia, the advantages and disadvantages of building a new hospital, as opposed to redeveloping an existing hospital site are considered. This chapter also considers public private partnerships (PPPs) as they pertain to the development of public infrastructure and considers the potential for such a partnership in any future hospital development in the ACT.
- 1.28 Chapter six examines other options for the delivery of health care services in the ACT, including enhanced sub-acute facilities and greater models of care provided in the community.
- 1.29 Chapter seven provides the Committee's concluding comments and final recommendations.

2 THE NEED FOR CHANGE?

- 2.1 The need for change is central to the current debate on the future ownership and management arrangements of CPH. As noted earlier, the ACT Government has presented five new options for consideration and public consultation. The Government notes that the options provided 'involve substantial change to the way we [the ACT Government] currently provide hospital services'.¹⁶
- 2.2 In 2008–09, the ACT Government commenced the Capital Asset Development Plan (CADP) *Your health—our priority*, allocating \$300 million over four years as the first tranche in an overall \$1 billion health infrastructure program.¹⁷ This process also began a reassessment of all aspects of the ACT health system.¹⁸
- 2.3 In its 2009 information paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, the ACT Government stated that the separate governance of CPH in perpetuity was inconsistent with its vision of an integrated public health system. LCMHC agreed to enter into a conversation about possible changes to the existing arrangements involving CPH and CHH.¹⁹
- 2.4 The main reasons for seeking the transfer of ownership, governance and control of CPH identified in the information paper included:
- the purchase of the CPH would allow the Government to invest much needed funds to upgrade the Bruce campus facility; and

¹⁶ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 3

¹⁷ ACT Health, *Your health—our priority, Ready for the Future Stage 1*, p 3 and p 6

¹⁸ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, viewed 28 January 2011, p 9,
<<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1254360543&sid=>>

¹⁹ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, viewed 28 January 2011, p 2,
<<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1254360543&sid=>>

- efficiencies could be gained by having one operating and management system for the two ACT public hospitals.²⁰
- 2.5 The purchase would also allow LCMHC to expand its private hospital services and enhance its provision of palliative care services, an area in which it excels.²¹
- 2.6 However, the protracted debate over the transfer of ownership has raised many concerns. Opposition to change has primarily come from members of the community who have had a close association with the hospital in either a personal or professional capacity.²² For example, the Save Calvary Group, formed in 2009, consisting of community members who have had personal and family contacts with CPH were concerned that:
- ... the community would lose a much valued long-standing hospital which provides exemplary health care.²³
- 2.7 Some thought the transfer of management would result in a 'loss of the Calvary 'ethos' of care in the public health sector'.²⁴ Ms Darlene Cox, Executive Director, Health Care Consumers Associations argued that in her view the 'ethos' described was 'more of a function of the facility', i.e. the size and nature of the CPH being a Tier 2 hospital rather than a tertiary hospital, which creates a calmer environment.²⁵
- 2.8 The Committee also heard strong support for the upgrading and expansion of CPH.²⁶ For example, the Australian Medical Association ACT (AMA ACT)

²⁰ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, viewed 28 January 2011, <<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1254360543&sid=>>

²¹ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, viewed 28 January 2011, p 3<<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1254360543&sid=>>

²² See Submission 1, Dr Peter French, Submission 2, Mr Mark Rolf, Submission 4, Dr David Dickson, Submission 7, Save Calvary Group, Submission 11, Mr Peter Lawler, Submission 12, Mr Paul Monagle, Submission 17, AMA (ACT) and Submission 18, Senior Medical Officers (CPH)

²³ Submission 7, Save Calvary Group, p 1

²⁴ Submission 13, Health Care Consumers Association, p 3, See also Save Calvary Group, *Transcript of Evidence*, 22 December 2010, pp 98–99

²⁵ Ms Cox, *Transcript of Evidence*, 1 December 2010, p 58

²⁶ See submissions 1, Dr Peter French, Submission 4, Dr David Dickson, Submission 7, Save Calvary Group 17, Submission 18, Senior Medical Officers, Calvary Public Hospital

called for a dedicated day surgery facility to be built on the site.²⁷ This was supported by Dr David Dickson, an ophthalmologist and visiting medical officer (VMO) at CPH, who suggested the development of a dedicated eye surgery facility to cater for public and private elective procedures freeing up main theatre space for specialities that 'really need them'.²⁸

2.9 Senior medical officers working at CPH also raised concerns regarding the future of the teaching role. In their submission, they advised the Committee that gaining training accreditation from speciality colleges can take a number of years and required senior medical officers willing to take on the role of trainer. Their major concern was their hard won gains at CPH would be lost, and in the event of a new hospital considered it was not 'feasible that accredited programs would be in place for at least five years after the hospital opened'.²⁹

2.10 Others were less supportive of the Catholic Church having such a large stake in public hospital services in the ACT. Mr Keith Sayers, a patient of CPH, disturbed by the presence of symbolic displays, said his preference was 'to be treated in a hospital free of such symbols'.³⁰

2.11 The Committee was also concerned that certain services were not provided at CPH, particularly those relating to women's reproductive health. The Committee understands that under its current agreement:

Calvary cannot be required to perform services which are inconsistent with its medico moral principles.³¹

2.12 The Hon Mr John Watkins acknowledging that certain services are 'not delivered through any Catholic hospital in Australia, including Little Company of Mary hospitals', told the Committee that in his view it 'is well known and generally accepted by the community'. He went on to say:

In the ACT community those services are available to anyone who wants or needs them through a range of public or private providers. The fact that some of

²⁷ Submission 17, Australian Medical Association (ACT)

²⁸ Submission 4, Dr David Dickson, p 1

²⁹ Submission 18, Senior Medical Officers CPH, p 2

³⁰ Submission 5, Mr Keith Sayers

³¹ Submission 6, Calvary Health Care ACT, p 11

those services are not delivered at Calvary at Bruce does not mean that the community of Canberra does not have access to those services.³²

- 2.13 The following section examines the argument for change with specific attention to upgrading CPH and the problems associated with separate management structures. Demand for hospital services and local governance issues are also considered.

Demand for hospital services

- 2.14 The ageing population, the prevalence of chronic diseases, advances in technology and medications and consumer expectations continue to place increasing demands on the health and hospital system.
- 2.15 Population projections to 2050 would see the ACT population increase to 500,000 people and the percentage of people over 85 years of age to increase by 509 per cent, to 22,500. Based on current planning and these population projections the ACT Government has estimated the need for an additional 400 hospital beds by 2022.³³
- 2.16 NSW residents currently make up about 25 per cent of ACT public hospital admissions and this proportion is not expected to change in the future. In today's figures that translates to the ACT health system providing care to a population in excess of 500,000 people.³⁴
- 2.17 While the ACT population is evenly divided between the north and the south, new developments in Gungahlin and Molonglo are expected to increase the proportion of people living in the north to 53 per cent. To cater to the needs of the growing population in the northern suburbs the Government has estimated the requirement of an additional 272 public hospital beds by 2022.³⁵

³² The Hon John Watkins, *Transcript of Evidence*, 22 December 2010, p 75

³³ The Government notes that this is not a final figure and may need to be updated to incorporate changes in demographics, technology and treatments and as the CADP progresses over the next 10 years.

³⁴ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 4

³⁵ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 4

- 2.18 Also in this period to 2022 the ACT Government estimates public hospital admissions to increase by 77 per cent and overnight public hospital admissions to increase by 49 per cent, from 54,000 to 96,000. The greatest increases are expected in emergency departments, high dependency units, and acute care beds.³⁶
- 2.19 The demand for sub-acute beds is also increasing. Of the current 88 sub-acute beds, 35 are located at TCH with the remaining 53 located at CPH. The projected demand for specialised rehabilitation services including sub-acute and non-acute beds is estimated at an additional 164 beds by 2021–22.³⁷ Of the 400 beds being considered, the Government is anticipating 50 of those beds being allocated to sub-acute care. The Committee received evidence supporting a new sub-acute facility. This is discussed in chapter 6.

Upgrading Calvary Public Hospital

- 2.20 CPH was built in 1979 to the design features and specifications of the time. Despite the recent investment in the new Intensive Care Unit (ICU) at a cost of \$13.5 million, launched on 11 June 2010,³⁸ there has been no other significant improvement on the main building.
- 2.21 There was little dispute that the CPH is in need of significant upgrading to bring it in line with modern standards and position it to deal with future growth. The ACT Government, through its CADP, has estimated the required refurbishments to be in the vicinity of \$200,000 million over ten years. Areas identified for redevelopment include a new ICU (noted above), upgraded emergency department, new wards and outpatient services.³⁹

³⁶ ACT Health, *Your Health Our Priority Stage 2*, viewed 28 January 2011, <<http://www.health.act.gov.au/c/health?a=sp&pid=1216959407>>

³⁷ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 6

³⁸ Mr Jon Stanhope, *Stage one of Calvary Hospital's Intensive Care Unit opens*, 11 June 2010, <<http://www.chiefminister.act.gov.au/media.php?v=9629&m=51&s=12>>

³⁹ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 9

2.22 Dr Peter Collignon, President of the Australian Salaried Medical Officers Federation (ASMOF) and Dr Ian Dunlop, President of the Australian Medical Association (AMA) ACT agreed that CPH required significant redevelopment.

2.23 Dr Collignon was of the view that 'a hospital lasts 20 years before you have to do it again'⁴⁰ and in the case of CPH the acute facilities such as medical and surgical wards, recovery wards and X-ray facilities would need to be rebuilt.⁴¹ Dr Collignon, an expert in infection control, also told the Committee that:

Their rooms, even though it (CPH) was built after Canberra Hospital, are less adequate for infection control purposes.⁴²

2.24 Dr Dunlop told the Committee that it could be easier to build the extent of the renovations required at CPH into a new hospital rather than 'integrate into an existing one'.⁴³

2.25 However, despite this the AMA ACT:

... does not support any plan for the diminution of the role played by Calvary, but sees instead an opportunity for an expanded facility to provide an improved case-load service, complementing the acute care and tertiary role Canberra Hospital is moving towards.⁴⁴

2.26 The scope and size of the potential for growth of CPH is demonstrated through the CHC 2011–12 ACT Budget bid of over \$76 million. This includes:

- \$32 million for a 900 space multistorey car park;
- \$5.5 million for refurbishment of the emergency department;
- \$22 million for an Ambulatory Care Centre;
- \$3 million for a Diagnostic Cardiology Clinic;
- \$2 million for a Magnetic Resonance Imaging Service;
- \$11 million for an Ophthalmology Centre;
- \$1.05 million to upgrade Medical Imaging Equipment.

⁴⁰ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 108

⁴¹ Dr Collignon, *Transcript of Evidence*, 22 December 2010, pp 106– 107

⁴² Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 107

⁴³ Dr Dunlop, *Transcript of Evidence*, 23 December 2010, p 117

⁴⁴ Submission 17, AMA ACT, p 2

Calvary Health ACT is also seeking recurrent funding for many of these projects.⁴⁵

2.27 The location of CPH was also raised as an argument in support of its upgrading.⁴⁶ In its submission to the Committee, the AMA expressed the view:

... the current two pillars model with Calvary Hospital located centrally in north Canberra and the Canberra Hospital located in the south is [the] most appropriate foundation for health planning for the future.⁴⁷

2.28 Prior to the change in accounting standards the Government expressed reluctance to a high level of investment at CPH, explaining:

... this would result in a transfer of cash from the ACT Government's balance sheet to fixed assets on the balance sheet of a third party, namely LCMHC. That is, any capital investment hits the Government's bottom line, with the benefits accruing to a non-government provider. The assets created through capital investment are then further subject to complex cross-charging arrangements.⁴⁸

2.29 While the recent changes to the accounting standard now enable the ACT to claim the asset on its books, it has given rise to a number of other issues. As the Minister explained:

If we just refurbish Calvary, there are constraints that do not exist on a blank canvas that a new hospital would present. We have got an old building—1970s—that comes with its own issues. I imagine that the minute you start chipping into it, you will find that. Plus there is the fact that the service concession arrangement allows us to book the current asset. We would then have to negotiate each additional parcel of land that we might need to build with the Little Company of Mary Health Care, because the service concession arrangement does not deal with that. So if we wanted to go outside the existing building, that would all be subject to a different process with LCM around the

⁴⁵ Calvary Health Care ACT, Submission to the ACT Government 2011–12 Budget Consultation, viewed 31 January 2011, <<http://www.treasury.act.gov.au/budgetconsultation/submissions/45.%20Calvary%20Health%20Care%20ACT.pdf>>

⁴⁶ See Submission 1, Dr Peter French, Submission 7, Save Calvary Group, Submission 17, AMA ACT

⁴⁷ Submission 17, AMA ACT, p 1

⁴⁸ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 9

use of that land, what could be built and how new elements of a building on that site could feed into the existing infrastructure.⁴⁹

2.30 However, despite many of the problems associated with redeveloping CPH the Government notes:

... refurbishment and expansion of this scale, if properly planned, also provides opportunities to provide better access for patients to efficient, effective and higher quality services.⁵⁰

2.31 The argument to redevelop or build a new facility is explored further in chapter five.

One management model

2.32 As noted earlier, under the current arrangements LCMHC manages close to 30 per cent of ACT's total public hospital capacity. A far greater proportion of private control of public hospitals than in any other jurisdiction in Australia.⁵¹

2.33 The relationship between the ACT Government and LCMHC is currently governed by six different agreements. A performance audit into the *Management of Calvary Hospital Agreements* conducted by the ACT Auditor-General in 2008, found that the contractual arrangements between the ACT Government and LCMHC to be:

... complex, not well understood, out of date, and not fully reflective of the relationship between the parties and resulted in inefficiencies (for ACT Health and CHC) in managing the contractual relationship.⁵²

The nature of the contractual arrangements and further discussion on the findings of the 2008 Audit is discussed in chapter three.

⁴⁹ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 13

⁵⁰ ACT Government, *ACT Public Hospital Services: Delivery of Additional Hospital Beds Options Analysis*, February 2011, pp 3–4

⁵¹ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, viewed 28 January 2011, p 7
<<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1254360543&sid=>>

⁵² ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 6

2.34 The ACT Government has expressed the view that ownership and management of the two public hospitals in the ACT would lead to improved health services for the people of the ACT and resolve some of the issues identified by the 2008 Audit. As the Government explained:

In a small jurisdiction with only two public hospitals, the ACT Government believes this is not the most efficient and effective means of managing service delivery. This dual governance of the Territory's public hospital beds significantly complicates the planning and delivery of services, and creates inefficiencies within the system.⁵³

2.35 The Committee understands that public health services are best delivered through an integrated model. The successful networking of public hospital and health services requires a clear and manageable governance structure. According to the ACT Government:

The current ownership and management arrangements in the ACT are far from clear, are at times challenging to manage, and have made it very difficult to network hospital services across the ACT.⁵⁴

2.36 The ACT Government further argues that one operator would mean consistency in policy, planning and management.⁵⁵ This argument is highlighted in the different operating standards across the two public hospitals. For example Ms Jenny Miragaya, Branch Secretary, Australian Federation of Nurses (ACT Branch) told the Committee that inconsistencies across the two hospitals in relation to occupational health and safety issues and WorkSafe issues impacted on staff and patient well-being.⁵⁶ Ms Miragaya told the Committee that CHC as a private company:

... has its own policies and procedures which are not the same as those that are available within ACT Health. Therefore, they do not comply with those, like the

⁵³ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 7

⁵⁴ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 7

⁵⁵ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 3

⁵⁶ Ms Miragaya, *Transcript of Evidence*, 1 December 2010, p 49

reporting of occupational health and safety incidents through the injury management prevention system.⁵⁷

- 2.37 The Health Care Consumers Association (HCCA) also agreed about the importance of standard operating procedures between the two hospitals. Ms Darlene Cox, Executive Director of HCCA, told the Committee:

It is much easier if care is consistent between the two hospitals in the ACT, and that is not the case, and it is often something that we get calls in the office about.⁵⁸

- 2.38 Another concern raised by the nurses union was the different measures for nurse/patient ratios. Ms Miragaya told the Committee:

... although nursing hours per patient day have now been agreed for the surgical and medical areas of the Canberra Hospital, we are only still trying to progress that through Calvary Public Hospital, even though it was party to the project, because they had a system of work hours per patient day where they do not just look at nursing hours, they look at all hours that comprise a patient journey.⁵⁹

- 2.39 The Committee also heard that the national interest of LCMHC impacted on standardised operating procedures. Dr Collignon, an expert in infection control, was concerned that interstate protocols were used to develop operating procedures for infection control at CPH. He told the Committee that in his view this happens to some degree 'with Calvary because it is part of a national organisation of which this is a minor bit'.⁶⁰

- 2.40 The Committee also received evidence supporting greater public control for public services.⁶¹ HCCA reported that the majority consumer view supported the purchase of CPH as it would improve 'integration of services, the effective use of public money and improved conditions for staff and better health

⁵⁷ Ms Miragaya, *Transcript of Evidence*, 1 December 2010, p 50

⁵⁸ Ms Cox, *Transcript of Evidence*, 1 December 2010, pp 56–57

⁵⁹ Ms Miragaya, *Transcript of Evidence*, 1 December 2010, pp 47

⁶⁰ Dr Collignon, *Transcript of Evidence*, 22 December 2010, pp 110–111

⁶¹ See Submission 3, Community and Public Sector Union, Submission 5, Mr Keith Sayers, Submission 10 Australian Federation of Nurses (ACT Branch)

outcomes'.⁶² HCCA also reported a similar range of community sentiment with the proposal for a new acute hospital.⁶³

2.41 While the Government has argued that efficiency would be made under a one management model, the Committee was only presented with anecdotal evidence to support this. Mr Khalid Ahmed, Executive Director, Policy Coordination and Development Division, Treasury explained that due to the complexity and lack of comparative data Treasury has not 'gone about explicitly quantifying the level of inefficiency in the current structure or organisation of our hospital services'.⁶⁴

2.42 However, Mr Ian Thompson, Deputy Chief Executive, ACT Health, did advise that there are:

... general principles that the research shows around the efficiency and effectiveness of hospital systems. And one of those is the degree to which you can have hospitals specialising in particular areas. It generally equates to better efficiency and effectiveness. In other words, you get better volume, better skills and greater capacity to allocate the resources in a specialised way.⁶⁵

2.43 The Committee notes the research suggesting that the most 'effective organisation of hospital services is achieved where each hospital has a clearly delineated role, and is able to specialise in specific areas of service delivery'.⁶⁶ The Committee further notes that the Government's analysis of the new options proposing a new north side hospital and a new sub-acute hospital (Options D and E) 'demonstrates the benefits of the creating a fully networked and specialised public hospital system' as they allow for a clearer role delineation than a two hospital model.⁶⁷

2.44 While these options do not address the issue of a single management structure, greater Government control over acute services in the ACT would go some

⁶² Submission 13, Health Care Consumers Association, pp 2–3

⁶³ Submission 13, Health Care Consumers Association, pp 2–3

⁶⁴ Mr Ahmed, *Transcript of Evidence* 1 December 2010, p 35

⁶⁵ Mr Thompson, *Transcript of Evidence* 1 December 2010, p 35

⁶⁶ J Dwyer cited in ACT Government, *ACT public hospital services: delivery of additional hospital beds options analysis*, February 2011, p 13

⁶⁷ ACT Government, *ACT public hospital services: delivery of additional hospital beds options analysis*, February 2011, p 13

way to achieving the efficiencies gained through consistency of planning, policy and management, as discussed earlier.

- 2.45 The Committee accepts the anecdotal evidence pointing to efficiencies in a single management structure or a better networked public hospital system, but considers an evidence based approach essential to the development of all public policy matters, and particularly so when major change is proposed. Therefore, the Committee considers that information demonstrating the efficiencies of a fully networked hospital system would better inform the Assembly and the community when the Government makes its final decision.

RECOMMENDATION 1

- 2.46 **The Committee recommends that the ACT Government provide to the Assembly the evidence demonstrating the efficiencies to be gained by having a fully networked and specialised hospital system for ACT public hospitals.**

Local governance

- 2.47 LCMHC is one of Australia's largest not for profit organisations providing health, aged and community care services.⁶⁸ While there are benefits that come with the national experience of LCMHC it also raises a number of concerns. Submission 11, purporting to convey the views of the Catholic Church stated 'that the interests of Calvary as an ACT public hospital are best served by a representative local governing board'.⁶⁹ This view was supported by submission 12 which stated 'the particular interests of the Canberra community were being subsumed by the interests of the national company [LCMHC]'.⁷⁰

⁶⁸ Submission 6, Calvary Health Care ACT, p 1

⁶⁹ Submission 11, Mr Peter Lawler

⁷⁰ Submission 12, Mr Paul Monagle

- 2.48 Calling for a resolution of the local governance issues Mr Paul Monagle, in his submission, suggested that LCMHC introduce a local board with the Archbishop of Canberra and Goulburn represented on the board.⁷¹
- 2.49 Reforms at the national level, particularly the establishment of Local Hospital Networks (LHN) agreed by the Council of Australian Governments (COAG) on 13 February 2011 are intended to 'give local communities and clinicians a greater say in the delivery of their local health services'.⁷²
- 2.50 COAG is also of the view 'that devolving the control of hospital management to LHNs, [and the establishment of Medicare Locals⁷³], will lead to services which are more responsive to the needs of local communities' and that 'Medicare Locals and LHNs will work together to integrate services and improve the health of local communities'.⁷⁴
- 2.51 The proposed LHN for the ACT would be comprised of TCH, CPH, CHH and the Queen Elizabeth II Family Centre⁷⁵(QEII). QEII and CHH have been included in the ACT LHN to enhance clinical governance and contribute to better integration with related services.
- 2.52 Under the LHN, the ACT Government would 'continue to manage the system-wide public hospital service planning and performance, including the purchasing of public hospital services, and will be responsible for the management of the performance of the ACT LHN'.⁷⁶

⁷¹ Submission 12, Mr Paul Monagle

⁷² COAG, communiqué Attachment A - *Heads of Agreement National Health Reform*, 13 February 2011, p 5, viewed 15 February 2011, <http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/index.cfm?CFID=32091&CFTOKEN=46987299>

⁷³ Medicare Locals are localised primary health care organisations being established as part of the national reforms to ensure that health care is better integrated and responsive to local needs.

⁷⁴ COAG, Communiqué Attachment A - *Heads of Agreement National Health Reform*, 13 February 2011, p 8, viewed 15 February 2011, <http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/index.cfm?CFID=32091&CFTOKEN=46987299>

⁷⁵ QEII is a 10 bed facility run by the Mothercraft Society under a service level agreement with ACT Health. It is a gazetted public hospital. Clare Holland House is an inpatient facility but not a gazetted public hospital. ACT Government Information Paper, *A Local Hospital Network for the Australian Capital Territory, A Discussion Paper on Implementing the National Health and Hospital Network Agreement*, 2010, p 7

⁷⁶ ACT Government Information Paper, *A Local Hospital Network for the Australian Capital Territory, A Discussion Paper on Implementing the National Health and Hospital Network Agreement*, 2010, p 7

- 2.53 An ACT LHN Council is also proposed to assist the LHN by providing advice on improving patient outcomes, responding to system wide issues and local needs. The Council would also be required to 'maintain effective communication with the Territory and relevant stakeholders, including clinicians and the community'.⁷⁷

Committee comment

- 2.54 The Committee notes the need for additional hospital beds to meet the increase in demand for public hospital services in the coming decade. These beds must be accommodated in either the existing hospitals or new purpose built hospitals.
- 2.55 The extent of the upgrading required at CPH, changes in accounting standards and the protracted debate over ownership and management of CPH have given rise to a range of options for the delivery of new beds, since the inquiry began in September 2010.
- 2.56 The Committee notes the associated complications of having two separate management structures for the public hospitals and in particular the different operating procedures. The Committee considers that this issue needs to be resolved sooner rather than later to reduce delays and inconvenience to patients and staff, particularly nurses working between the two hospitals. While having one manager for the two hospitals would address this issue, the Committee considers the introduction of the LHN for the ACT has the potential to impact on the operation of the two public hospitals and may go some way to addressing the concerns raised about operating procedures between the two public hospitals, and focusing outcomes on local needs. The Committee further notes that the LHN is unlikely to impact on the concerns raised by the Catholic community of a local governance board for CPH, as this is an issue for LCMHC.
- 2.57 The Committee notes the ACT Government assessment of the five options against the planning principles (discussed in chapter three) demonstrates the

⁷⁷ ACT Government Information Paper, *A Local Hospital Network for the Australian Capital Territory, A Discussion Paper on Implementing the National Health and Hospital Network Agreement*, 2010, p 8

benefits of a fully networked and specialised public hospital system in the ACT. LCMHC is a significant player in the provision of public hospital services in the ACT and are implicated in the development of the network.

- 2.58 The Committee is concerned that the relationship between the ACT Government and LCMHC will impact on their ability to negotiate a mutually beneficial agreement, under the current circumstances.
- 2.59 While the ACT Government has been supportive about the day-to-day management of CPH⁷⁸, it is clear that things cannot stay as they are. A decision on the way forward must be reached to end the uncertainty. The following chapters consider the options in detail.

⁷⁸ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 9

3 MAINTAINING THE STATUS QUO

- 3.1 Calvary Health Care is a major provider of public hospital services in the ACT. CPH provides a range of acute and sub-acute care services and undertakes a substantial amount of elective surgery. It currently provides 222 public hospital beds with a further 90 beds in its private hospital facility, and as noted earlier, provides close to 30 per cent of public hospital services. This chapter considers all the options relating to CPH continuing to operate its public hospital services, in some form.
- 3.2 The Minister for Health, in August 2010, put forward four options for the future arrangements for CPH. On considering the options and the evidence the Committee condensed these into two main choices for the ACT Government:
- proceed with a major upgrade of CPH and continue to work with LCMHC under a revised agreement (the form of which is yet to be determined); or
 - build a new hospital, restructure CPH and continue to work with LCMHC in a reduced capacity.
- 3.3 Of those options, two pertain directly to the development of new agreements to maintain CPH as a provider of acute public hospital services. However, any option that includes CPH continuing to operate a public hospital service will require the development and negotiation of a new agreement. The introduction of five new options presented by the ACT Government, on 25 February 2011, has not changed this premise.
- 3.4 The relationship between the ACT Government and LCMHC is currently governed by six agreements 'encompassing the conduct, control and management of the public hospital and in relation to the establishment and operation of Calvary Private Hospital, entered into over a period of some 25 years commencing in 1971'.⁷⁹

⁷⁹ Australian Capital Territory, Government Solicitor, Advice to ACT Health, 30 October 2009

3.5 Based on an additional 400 hospital beds, four of the five new options, maintain the current model of acute care services being provided at CPH. Options A and E propose an expansion of the services at CPH while options B and C propose that CPH continues to operate at its current capacity. Option D proposes the transformation of CPH into a specialised sub-acute and rehabilitation centre. The options, as noted earlier can be summarised as follows:

- Option A - Additional beds placed equally between TCH and CPH. This would include refurbishment at both facilities to enable the additional bed capacity.
- Option B - All the additional beds be placed at TCH.
- Option C - Some of the additional beds placed at TCH with the remainder of the beds forming a new north side acute facility.
- Option D - A fully networked and specialised hospital system linking TCH, Calvary Hospital and a new north side facility. Under this option, CPH would become a centre of excellence focussing on sub-acute and private hospital related work and the new north side hospital would be the acute facility for northern Canberra.
- Option E - A fully networked hospital system linking TCH, CPH and a new north side facility. Under this option CPH would be the north side acute facility, and a new sub-acute facility on the north side of Canberra would be developed.⁸⁰

3.6 LCMHC currently hold the crown lease on the land where CPH is located for 99 years with an option to renew the lease at the end of that time. LCMHC may elect to surrender the crown lease at any time, on the provision of 12 months notice to the Territory. The ACT Government, on the other hand, has no contractual ability 'to terminate the Public Hospital Agreements or the Crown Lease' unless either are breached.⁸¹

⁸⁰ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 8

⁸¹ Australian Capital Territory Government Solicitor, Advice to ACT Health, 30 October 2009,

- 3.7 LCMHC have indicated that it is their preferred option to maintain the crown lease with a new agreement, and no contrary evidence was presented to suggest that LCMHC had any intention to relinquish the crown lease. Therefore, despite option 1 specifically referring to the future of the crown lease, all options would see LCMHC retaining the crown lease unless it chose otherwise.
- 3.8 All the current options will require upgrading of the public hospital building and despite what decision is made CPH will need to continue operating in its current form until new arrangements are put into place. Under a new north side hospital option, the current arrangements would need to be maintained 'for a minimum of five years with Calvary Health Care, which would require some additional capital investment in that short term'.⁸² The Committee notes that this could be longer depending on the size and design of a new hospital building.
- 3.9 The next section looks at the options for the development of a new activity funding agreement and a new network operating agreement as proposed by the Minister in the earlier options.

Activity funding agreement

Little Company of Mary maintains the crown-lease on the land with the establishment of a new activity funding agreement.

- 3.10 Since the withdrawal of the offer to purchase CPH, LCMHC have indicated their intention to maintain the crown lease and support the development of a new Activity Funding Agreement (AFA).⁸³ In its submission, the ACT Government outlined the terms of the AFA as proposed by LCMHC. This included:

⁸² Minister for Health, *Transcript of Evidence*, 1 December 2010, p 12

⁸³ Submission 6, Calvary Health Care ACT, p 5

- The AFA would be for a fifteen year term. Finalisation of any negotiation for a renewal of the AFA must occur no later than two years before it expires.
- The AFA would contain an Annual Service Annexure which would provide for agreed service level targets and caps and the resultant total funding.
- Calvary Health Care would be responsible for the maintenance, repair or development of the Public Hospital assets (both external and new), and the Territory will provide Calvary Health Care funding for this purpose.
- The Agreement would contain an independent dispute resolution clause.⁸⁴

3.11 Under the proposed terms of the agreement LCHMC would sub-lease land to the Government for the construction of any new buildings for 30 years and 'the Territory would [then] lease the newly constructed buildings to Calvary Health Care under a building lease of 30 years'. At the end of this time, the buildings would belong to CHC 'for a "peppercorn" amount'.⁸⁵

3.12 In its submission, the ACT Government reported it did not consider this to be a viable option, stating:

... the short term of the AFA, at fifteen years, provided uncertainty regarding assets created by public investment and would require the Territory to transfer the assets to LCMHC before the end of their useful life without adequate compensation. Further, the option of gaining access on a sub-lease and then sub sub leasing it back to LCMHC appeared to be developed to only serve the purpose of avoiding a service concession arrangement and there was no benefit for the Territory in supporting this complex arrangement. The proposal also lacked specific details to establish the accounting treatment with a reasonable degree of certainty.⁸⁶

3.13 In light of these concerns, the Minister told the Committee that the ACT Government was no longer considering this option.⁸⁷

⁸⁴ Submission 14, ACT Government, p 4

⁸⁵ Submission 14, ACT Government, p 5

⁸⁶ Submission 14, ACT Government, pp 4-5

⁸⁷ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 11

- 3.14 The Committee notes that activity based funding (ABF) is an important component of the national health reforms and is disappointed that greater detail of the proposed AFA was not available.
- 3.15 To ensure a fair and efficient price for hospital services COAG agreed to the 'establishment of a national approach to activity based funding (ABF) and that public hospital services will be funded, wherever possible, on the basis of a national efficient price for each public hospital service provided to public patients'. It was further agreed that the system would be introduced from 1 July 2012, and would make public hospital funding 'more transparent, and help to drive efficiency in the delivery of hospital services'.⁸⁸
- 3.16 ABF, as the name suggests, is funding based on activities undertaken. ABF has been used in Australian hospitals since the early 1990s and is currently the dominant funding model in Victoria and South Australia, and an element of broader funding models in NSW. However, not all hospital activity is able to be funded in this way. As Professor Kathy Eagar from the University of Wollongong explains 'it is not possible to use ABF if you cannot define, classify, count, cost and pay for each activity in a consistent manner'.⁸⁹
- 3.17 The National Partnership on Health and Hospital Reform (2008) recognises five activities to be funded under ABF: acute inpatient admissions; emergency department services; sub-acute care; outpatient services; and hospital-auspiced community health services. However, only acute inpatient care has a 'nationally adopted classification'⁹⁰ that can be used to define the 'activity' to be counted in an ABF model'.⁹¹

⁸⁸ COAG, communiqué Attachment A - *Heads of Agreement National Health Reform*, 13 February 2011, p 5, viewed 15 February 2011, <http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/index.cfm?CFID=32091&CFTOKEN=46987299>

⁸⁹ Professor K Eagar, ABF Information Series No. 1, *What is activity-based funding?* Centre for Health Service Development, University of Wollongong, March 2010, viewed 10 February 2011, <<http://chsd.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082633.pdf>>

⁹⁰ This classification is the Australian-Refined Diagnosis Related Group (AR-DRG)

⁹¹ Professor K Eagar, ABF Information Series No. 1, *What is activity-based funding?* Centre for Health Service Development, University of Wollongong, March 2010, p 2, viewed 10 February 2011, <<http://chsd.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082633.pdf>>

3.18 While COAG has agreed to introduce a national ABF system by July 2012, according to Professor Eagar it will only be possible to begin with acute inpatient services. She goes on to say:

Adopting or developing nationally agreed classification for these [other] types of care will not be a trivial exercise and, even after a national classification is agreed, it will take several years to implement the required information systems and design the ABF model'.⁹²

3.19 The Committee understands that ABF covers the funding model and that other aspects of the governing agreement need to be considered between the ACT Government and LCMHC. As noted in the following section, LCMHC have suggested ABF as part of the broader network agreement.

Network agreement

The ACT Government proceeds with the network agreement in its current form.

3.20 Like the previous option, this would maintain the current arrangements with CHC owning and managing CPH under the existing agreements.

3.21 However, the dispute over the interpretation of the new accounting standard and problems with the current agreements, as identified by the Auditor-General make this option unsustainable. The Minister considered this option problematic as it would 'continue to create tension between the territory and Little Company of Mary around the accounting issues'.⁹³

3.22 In their submission to the Committee, CHC stated they 'would not be party to the network agreement in its current form'. In their view:

Proceeding with the network agreement in its current form would be inconsistent with the existing Government-Calvary agreements dating back to 1971 that underpin Calvary's tenure as a long term leaseholder and mostly

⁹² Professor K Eagar, ABF Information Series No. 1, *What is activity-based funding?* Centre for Health Service Development, University of Wollongong, March 2010, p 3, viewed 10 February 2011, <<http://chsd.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082633.pdf>>

⁹³ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 4

autonomous owner and operator of public and private health services on the Bruce Campus.⁹⁴

- 3.23 CHC have however, proposed the following options be included in a new network agreement which they consider would be mutually beneficial:
- introduction of a mechanism by which capital development can take place on the current crown lease;
 - negotiation of an activity based funding agreement;
 - clarification of the roles and responsibilities, including clinical role delineation;⁹⁵ and
 - processes for relationship management, reflecting the fact that Calvary is an essential part of the ACT health system.⁹⁶
- 3.24 Acknowledging that agreements would need to be updated⁹⁷, the Minister advised of the Government's interim decision that the:
- ... best way forward at this stage is to continue to operate Calvary Public Hospital in accordance with the current agreements. Indeed, that is the status at this point in time.⁹⁸
- 3.25 Further to the problems with the existing agreements the 2008 performance audit into the *Management of Calvary Hospital Agreements* noted that:
- [To date] The parties to these agreements have been unable to agree on the terms of a single, improved, replacement.⁹⁹
- 3.26 The Audit concluded that consolidation of the current agreements would make management easier and that replacing the set of agreements with a new, single agreement 'is necessary in the longer-term'.¹⁰⁰

⁹⁴ Submission 6, Calvary Health Care ACT, p 2

⁹⁵ The Committee notes that the ACT Clinical Services Plan 2005–2011 is currently being reviewed

⁹⁶ Submission 6, Calvary Health Care ACT, p 13

⁹⁷ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 10

⁹⁸ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 4

⁹⁹ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 5

¹⁰⁰ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 7

- 3.27 The Audit also noted the efforts of the Government stating 'there have been significant efforts over the years, mostly by the Government, to improve the contractual arrangements, largely without success'.¹⁰¹
- 3.28 Despite CHC and the ACT Government both agreeing to the Auditor-General's recommendation to 'replace the current set of agreements as soon as possible with a single agreement that incorporates better practice'¹⁰² the Committee understands this has yet to take place.
- 3.29 The Committee is concerned about the ongoing tension between the parties over the governing agreements, more so now with the disagreement over the accounting standard, and the difficulty for achieving a mutually beneficial arrangement. It is imperative that the issue is resolved and a newly negotiated agreement is finalised as soon as possible.
- 3.30 Further to this, the Committee notes that reporting of the activities of CPH is limited and considers greater accountability of the expenditure of publically funded hospital services through annual reporting on the expenditure and activities of CPH, separate to that of ACT Health, would serve the interests of the ACT community.

RECOMMENDATION 2

- 3.31 **The Committee recommends that in the event that the ACT Government and Little Company of Mary Health Care are unable to reach agreement, an independent arbitrator be appointed to assist the parties to reach a mutually beneficial contractual arrangement.**

RECOMMENDATION 3

- 3.32 **The Committee recommends that any future agreement between the ACT Government and Little Company of Mary Health Care seek to establish the requirement for Calvary Health Care to provide an**

¹⁰¹ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 7

¹⁰² ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, Recommendation 1, p 14

annual and financial report for the Legislative Assembly and the people of Canberra.

For and against

- 3.33 Maintaining CPH under the ownership and management of LCMHC will require a renegotiated contractual arrangement between the ACT Government and LCMHC be it an activity funding agreement or a network agreement. The current situation provides an ideal opportunity for the development of an improved single agreement.
- 3.34 With CHC clearly indicating their preference for expanded public hospital services on the Bruce campus site, in their submission to the inquiry, they provided the following benefits:
- the opportunity to build on the current services provided at CPH;
 - previous experience in managing major public infrastructure development;
 - benefits from the national experience and network of LCMHC (however, this also has some disadvantages to local service delivery);
 - opportunity to foster the long term health planning partnership between LCMHC and ACT Health;
 - national experience of different funding systems in other states informing moves to ABF payments;
 - current role delineation as described in the Clinical Service Plan suits ABF; and
 - changes in accounting practices allowing the ACT Government to recognise CPH as an asset paving the way for investment into the Bruce campus.¹⁰³
- 3.35 In the discussion paper released on 25 February 2011, the ACT Government outlined five planning principles against which to assess the relative merits of each option. These principles are described in the table below.

¹⁰³ Submission 6, Calvary Health Care ACT, pp 6–10

Principle	Core Descriptive Element
Patient Centred	<ul style="list-style-type: none"> • Care is delivered in the right place at the right time • Have consideration of the needs of families and carers • Respect and promote patient and carer choice
Intra-disciplinary and Collaborative	<ul style="list-style-type: none"> • Involve a systems approach to services facilitating linkages and coordination • The workforce will be configured to deliver integrated care • Organisation of services will support funding and accountability arrangements
Accessible to all ACT Residents Safe and High Quality	<ul style="list-style-type: none"> • Service delivery will be timely, equitable and appropriate • Services will be evidence based • Services will be provided in the ACT where there is an appropriate level of demand to ensure ongoing clinical competence, or will be referred elsewhere as necessary
Efficiency and Cost	<ul style="list-style-type: none"> • Capital construction cost impacts should be minimised • Recurrent cost savings should be sought

Source: ACT Government, ACT Public Hospital Services: Delivery of Additional Hospital Beds

3.36 Providing additional beds at CPH (option A) would mean the ACT continues to operate with two public hospitals, both providing a mix of acute and sub-acute care. The ACT Government analysis against the planning principles found that this would enable some streamlining of services that could lead to improvements in the quality of services.¹⁰⁴

3.37 The down side to this is that any option to expand the services at CPH would mean both public hospitals in the ACT would be operating around on-site construction. The ACT Government notes:

... experience from construction currently under way at TCH indicates that construction has significant impacts on the planning and construction processes as well as on the cost of maintaining the hospital services at the same time.¹⁰⁵

3.38 The Minister also told the Committee that continuing to provide 24 hours care seven days per week on a construction site:

¹⁰⁴ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 9

¹⁰⁵ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 13

... is a huge stress to staff... both to the people that are working on the site but also staff in the hospital that are having to deal with that. It is very much at the forefront of my mind in terms of having both of our public hospitals under significant construction for the next five to eight years. I think will be a very big challenge.¹⁰⁶

- 3.39 The Treasury analysis for the two options for expanding bed capacity at CPH found these to be the second and third most expensive for construction costs.¹⁰⁷

Committee comment

- 3.40 Maintaining CPH under the ownership and management of LCMHC, regardless of which option is pursued, will require a renegotiated contractual arrangement between the ACT Government and LCMHC. The Government does not agree with the terms of the proposed AFA and LCMHC does not agree with the current network agreement.
- 3.41 The Committee agrees that the contractual arrangements between the parties must be resolved and supports the incorporation of ABF into any new agreement, consistent with the national reforms, if the option to expand bed capacity at CPH was to proceed. As noted however, it may be some time before a nationally consistent basis for ABF is developed and the parties will need to establish their own efficient price for hospital services delivered by CPH in the interim.
- 3.42 The Committee is of the view that the level of upgrading required on the Calvary site comes with its own set of problems. The Committee notes the argument for building a new hospital, incorporating modern design features, compared to extensive redevelopment of an existing building. This is discussed further in chapter 5.
- 3.43 The Government has made it clear that it is their desire to have operational control over the two acute public hospitals to improve efficiencies and provide an integrated health care system. Expanding the bed capacity at CPH does not

¹⁰⁶ Minister for Health, *Transcript of Evidence*, 16 March 2011, p 152

¹⁰⁷ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 15

address this concern, but could be better managed through the development of an appropriate contractual arrangement, as suggested by the Auditor-General in the 2008 Audit.

- 3.44 Despite what decision is made, the ACT Government and LCMHC will need to continue to work together to provide hospital services, until any new arrangements are established, and therefore must reach an agreement to end the uncertainty of the future operations of CPH.

4 A NEW PRIVATE HOSPITAL

The ACT Government assists the Little Company of Mary Health Care in developing a stand-alone private hospital as a public-good investment.

- 4.1 Under this option proposed in August 2010 the ACT Government would assist LCMHC to develop a stand-alone private hospital on the Bruce campus site. The detail of how the public hospital would operate is not explicitly stated, other than an understanding that a public hospital would continue to operate on the Bruce campus site. Despite this option not being considered in the Government's new options, as an option in the referral from the Legislative Assembly, the Committee has the following comments to make.
- 4.2 CHC have stated they would welcome Government support to build a stand-alone private hospital and expand not-for-profit private health services on the Bruce campus. However, this is contingent on a public acute hospital operating from the same site.¹⁰⁸
- 4.3 Under the agreements governing the operation and maintenance of CPH LCMHC can cease operating the private hospital at any time by providing 12 months notice, but unlike the public hospital agreement, 'the Territory may [also] terminate the Calvary Private Agreement by giving Calvary 3 years notice'.¹⁰⁹
- 4.4 The ACT Government reported that LCMHC had expressed concerns that their private hospital was not viable imbedded within the CPH building.¹¹⁰ This view was supported by Mr Tom Brennan, the then Chair of LCMHC who told doctors and staff of Calvary Health Care services:

In July 2008 our then Acting Chief Executive, Peter Hedge, met with the ACT's Health Minister and informed her that our hospitals in Canberra had not been

¹⁰⁸ Submission 6, Calvary Health Care ACT, p 14

¹⁰⁹ Australian Capital Territory Government Solicitor, *Advice to ACT Health*, 30 October 2009, p 2

¹¹⁰ Submission 14, ACT Government, p 5

performing to the level that we expected and that we proposed to change that. The Minister responded by offering to buy the public hospital off us.¹¹¹

- 4.5 It was considered that the capital from the transfer of CPH to the ACT Government would allow LCMHC to enhance its palliative care services and invest in a 'proposed new not-for-profit private hospital facility at Bruce'.¹¹²
- 4.6 There is considerable support to maintain and enhance the private hospital on the Bruce site as it offers a range of valuable services and provides greater choice of hospital services for north side residents.¹¹³
- 4.7 The loss of a private hospital on the north side would place greater demand on the public hospital, and ultimately the ACT health budget. CHC estimates the costs of their private hospital services to be in the vicinity of \$37 million annually.¹¹⁴
- 4.8 Without Government assistance to enhance the private hospital CHC have noted in their submission that 'it is extremely unlikely that a business case could be made to fully privately fund expanded private services at Bruce'.¹¹⁵
- 4.9 The separation of acute services from the Bruce campus site, as suggested in Option D, would further impact on the viability of Calvary Private Hospital.
- 4.10 In evidence to the Committee, the Minister noted that this option involved the Government 'taking over the [public] hospital' and assisting LCMHC to build a private hospital'.¹¹⁶ The ACT Government submission sheds little light on its intention for the operation of CPH under this option. The Government is clear that pursuing this option would require significant evidence demonstrating the public good before any investment could be made.

¹¹¹ Mr Tom Brennan, *Remarks To Doctors And Staff of Calvary Home Care, Calvary Aged Care and Calvary Health Care Services in Canberra*, 28 September 2009, p 3, viewed 1 February 2011, <http://www.calvary-act.com.au/assets/uploads/news/14/speech_by_lcmhc_chair.pdf>

¹¹² ACT Government Information Paper, *A Local Hospital Network for the Australian Capital Territory, A Discussion Paper on Implementing the National Health and Hospital Network Agreement*, 2010, p 5

¹¹³ ACT Government Information Paper, *A Local Hospital Network for the Australian Capital Territory, A Discussion Paper on Implementing the National Health and Hospital Network Agreement*, 2010, p 5

¹¹⁴ Submission 6, Calvary Health Care ACT, , p 15

¹¹⁵ Submission 6, Calvary Health Care ACT, p 14

¹¹⁶ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 11

4.11 LCMHC has indicated its aspiration to expand its private hospital operations but has indicated no intention of relinquishing control over CPH. As The Hon John Watkins told the Committee:

... it is not an either/or. It is about delivering the best quality health care for Canberra. We think we can do that, certainly through the public hospital, through expanded private hospital services. They are going to be needed as Canberra grows. We are good at delivering that as well. We see that as bringing an extra benefit to Canberra citizens.¹¹⁷

4.12 The location of the private hospital in the public hospital building has been raised as a concern. While it is not unusual to have public and private hospitals co-located in one building, it is unusual when both hospitals are owned and managed by the same organisation, particularly so 'for cross-charging arrangements being critical to the proper allocation of costs between the public and private hospitals'.¹¹⁸

4.13 The Auditor-General in the 2008 performance audit found a number problems with the cross-charging arrangements, including:

- the CHC reimbursement systems involving complex calculations;
- lack of documented policies or procedures;
- no evidence of review of the correctness and completeness of reimbursements to CPH by any relevant staff working solely for the public hospital;
- CHC not using the Time Cost Allocation Schedule (TCAS) survey result prepared by an independent auditor in July 2007 to allocate costs of the Executives; and
- discrepancies in patient records, where the Patient Administration System identified patients as being in the PR (private recovery) Ward and the Medical Record identified these patients as being in the public hospital's ICU.¹¹⁹

¹¹⁷ The Hon John Watkins, *Transcript of Evidence*, 22 December 2010, pp 69–70

¹¹⁸ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 4

¹¹⁹ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, pp 49–50

4.14 The Audit noted that as a result of the deficiencies identified CHC was:

... developing new protocols, policies and procedures to improve the control environment and advised that it has reimbursed amounts underpaid due to errors or omissions in calculations.¹²⁰

4.15 CHC reported that recommendations made by the Auditor-General to address cross-charging issues have been implemented. Mr Walter Kmet, National Director—Public Hospitals, LCMHC told the Committee that CHC:

... have adopted all of the recommendations of the Auditor-General's review. We [CHC] have agreed on a cross-charging protocol with ACT Health and all of those agreed have been in operation for some considerable time, since last year.¹²¹

4.16 Responding to the findings of the Audit, Mr Kmet was of the view that 'there was no material loss and not a major issue'.¹²² The Auditor-General agreed the amount was 'not material' but identified a range of errors and omissions in the sample tested. The Audit also considered:

...the error rate [to be] relatively significant when considered against the small sample size examined (only three months during 2005-06 and 2006-07) and was concerned that deficiencies of policies and operating procedures in the current reimbursement system, if continued, could lead to potential loss of public revenue.¹²³

4.17 Accurate cross-charging arrangements are critical for the proper allocation of costs between the public and private hospitals, to ensure that public funds are not subsidising the private hospital. The Audit noted the cross-charging arrangements has prompted a range of reviews, audits and arbitration and that many of the recommendations made by these consultants have not been implemented by ACT Health or CHC in a timely manner.¹²⁴

¹²⁰ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 51

¹²¹ Mr Kmet, *Transcript of Evidence*, 22 December 2010, p 68

¹²² Mr Kmet, *Transcript of Evidence*, 22 December 2010, p 68

¹²³ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 60

¹²⁴ ACT Auditor-General's Office, Performance Audit Report, *Management of Calvary Hospital Agreements*, May 2008, p 50

- 4.18 The Committee notes the significant concerns raised by the Audit in relation to cross-charging arrangements and would like reassurance from the ACT Government and LCMHC that these issues have been resolved and accurate systems are in place to ensure that public money is not being used to subsidise the operations of the private hospital.

RECOMMENDATION 4

- 4.19 **The Committee recommends that the ACT Government report to the Assembly the steps taken to address the concerns raised by the Auditor-General in relation to cross-charging arrangements between Calvary Public Hospital and Calvary Private Hospital.**
- 4.20 Mr Peter Lawler also recognised the challenges of the private hospital co-located in the public hospital building stating 'it has given rise to demarcation issues in administration and accounting' and goes on to say 'there is general agreement that Calvary Private ought to be removed to a separate location as soon as practicable'.¹²⁵
- 4.21 While the Committee would support the separation of the private hospital from the public hospital it is not convinced that an investment of public money would be warranted or accepted without robust evidence of the benefit to the public. The Minister herself has noted that the public benefit would need to be well established before the community would support financial assistance from the Government to assist LCMHC to build a new private hospital.

For and against

- 4.22 A stand-alone private hospital on the Bruce campus site would have the following advantages:
- increased bed capacity at the Bruce campus by private beds converting to public beds when the private hospital was completed;

¹²⁵ Submission 11, Mr Peter Lawler, p 4

- would maintain a private hospital on the north side, something that 'is highly desirable';¹²⁶
- separate the private from the public hospital ensuring accurate cross-charging estimates;¹²⁷ and
- the cost of building a private hospital is much cheaper than building an acute public hospital due to the number of beds and the types of services offered.

4.23 Disadvantages include the following:

- would still require investment on the Bruce campus site;
- does not accommodate the additional public hospital beds required;
- does not provide any details of the operations of the public hospital;
- does not resolve 'the issue of the jeopardy around the operation of the public hospital and the recognition of the asset';¹²⁸ and
- possible community opposition to private company receiving public funds unless the public benefit was justified.¹²⁹

Committee Comment

4.24 The Committee was asked to assess this option. However, in the later options released it would appear that the Government is no longer considering the future of Calvary Private Hospital as one of its options. While CPH continues to operate in its current form, or indeed in an expanded form, the Committee anticipates that the Calvary Private Hospital would also continue to operate.

4.25 However, there is no guarantee and in the event that LCMHC chose to no longer operate a private hospital on the north side it is likely this would have a considerable impact on public hospital services and would reduce the hospital choices available to north side residents.

¹²⁶ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 4

¹²⁷ Calvary Health Care does note some advantages of having the hospitals co-located. Submission 6, Calvary Health Care ACT, p 15

¹²⁸ Submission 14, ACT Government, p 5

¹²⁹ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 4

4.26 While the Committee supports enhanced private hospital facilities on Canberra's north side it is not convinced that this should be at the expense of the public purse. However, the Committee understands that if LCMHC were to relinquish the crown lease they would be entitled to compensation for the 'unexpired portion of its Crown lease and its rights to occupy and use the land, building[s] and assets over that time'.¹³⁰ As the ACT Government Solicitor explains:

If the Territory wishes Calvary to surrender its rights, then the surrender or acquisition of those rights—the right to use the Public Hospital and its assets—is a right that can be valued and for which a payment may be required'.¹³¹

¹³⁰ Australian Capital Territory Government Solicitor, Advice to ACT Health, 30 October 2009, p 4

¹³¹ Australian Capital Territory Government Solicitor, Advice to ACT Health, 30 October 2009, p 4

5 A NEW PUBLIC HOSPITAL

The ACT Government builds a new acute public hospital on Canberra's north side.

- 5.1 The final proposal is the building of a new hospital on the north side of Canberra. The current options under consideration, released by the ACT Government on 25 February 2011, include building a new:
- 200 bed hospital and expanding bed capacity at CPH, resulting in three acute hospitals (Option C);
 - 400 bed hospital and transforming CPH into a sub-acute facility (Option D); and
 - 200 bed sub-acute facility and increasing bed capacity at CPH (Option E).
- 5.2 While there was significant in-principle support for a new hospital, it was difficult for submitters to comment in the absence of any detail of the proposed development. In response to further clarification sought by the Australian Nursing Federation the Government advised 'that as no decision has yet been made as to the future of Calvary Public Hospital' clarification was not possible.¹³²
- 5.3 There was little argument that Canberra needed or could sustain three acute hospitals, as proposed by Option C. According to HCCA the Government's clinical services plan or the CADP supports the need for a third hospital.¹³³
- 5.4 In 2009, the ACT Government recognised that the additional capacity requirements for projected demand 'could be met by utilising the existing hospital campuses...(and) the decision was taken that major investment, involving rebuilding and refurbishing all existing health infrastructure, was required'.¹³⁴

¹³² Submission 10, Australian Federation of Nurses, p 2

¹³³ Submission 13, Health Care Consumers Association, p 2

¹³⁴ ACT Government, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House, An ACT Government Information Paper*, 2009, p 9

5.5 The Minister for Health, Ms Katy Gallagher also agreed, and in evidence to the Committee stated:

We cannot run three acute public hospitals. We could not staff them. There would be issues about patient safety. However, if you moved your acute hospital to another site and still ran two public hospitals, the issues facing the workforce and the service delivery would be the same as they are now.¹³⁵

5.6 Under Option C, the development of a new hospital would constitute a third acute hospital for the ACT. The Minister acknowledged the impact this would have on CPH, but noted any changes would 'require agreement from LCM'. Noting LCMHC's preference was to remain functioning, at this stage, as an acute hospital the Minister explained that she did not want CPH to cease functioning as a hospital but to:

... examine the opportunity for that to become a rehabilitation or sub-acute centre of excellence. I have had that discussion with LCM. They have not ruled it out. They have not embraced it either. They have sort of noted it.¹³⁶

5.7 The ACT Government is of the view 'that a network of three clearly delineated public hospitals could exist'. This would include:

- TCH remaining as the central tertiary referral facility for the ACT and region with a capacity of around 860 beds;
- a new third hospital situated on the north side of Canberra; and
- CPH operating sub/non acute beds for public patients.¹³⁷

5.8 However, LCMHC have clearly indicated their intention to 'remain as the owner and operator of the public hospital at Bruce'. Furthermore, the Committee was advised of their wish to expand the public services at Bruce and develop additional private healthcare services ... in close partnership with ACT Health and the Government'.¹³⁸

5.9 As noted earlier, under the terms of the agreement between the ACT Government and LCMHC the Territory has no contractual ability to terminate

¹³⁵ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 16

¹³⁶ Minister for Health, *Transcript of Evidence*, 1 December 2010, pp 8–7

¹³⁷ Submission 14, ACT Government, pp 5–6

¹³⁸ The Hon John Watkins, *Transcript of Evidence*, 22 December 2010, p 62

either the lease or the agreement, and delineation of services is reached by negotiation between CHC and the ACT Government.

- 5.10 The Committee notes that one of the latest options under consideration by the Government is the development of a third acute hospital (Option C). The bed configuration of this proposal would add 200 beds to TCH, build a new 200 bed hospital on the north side and CPH would continue to operate as usual. This proposal also includes three emergency departments.¹³⁹
- 5.11 This option did not rate favourably in the Government analysis, despite having the second lowest construction costs. This option presents no clear role delineation, would be difficult to staff¹⁴⁰ and is rated as being less efficient than other options.¹⁴¹ This assessment concurs with the evidence received by the Committee, particularly in relation to staffing difficulties, that clearly does not support a third acute hospital in the ACT.

Building versus redevelopment

- 5.12 Design principles of modern buildings and advances in the delivery of health care impact significantly on the development of new hospitals. Design features of new hospital buildings include;
- managing infection control through a higher-percentage of single-bed rooms,
 - environmentally sustainable features; and
 - technological capacity incorporated into new designs.
- 5.13 While there is capacity to redevelop older buildings to bring them in line with modern standards, the benefits of building a new hospital must also be considered against the time, cost and disruption to existing services.

¹³⁹ ACT Health, *ACT Public Hospital Services: Delivery of Additional Hospital Beds, Options Analysis*, February 2011, p 8

¹⁴⁰ Submission 1, Dr Peter French and Submission 4, Dr David Dickson

¹⁴¹ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds HEALHT Service Delivery Public Consultation & Discussion Paper*, February 2011, pp 10–11

- 5.14 The Committee heard conflicting evidence on the benefits and costs of building a new hospital as opposed to developing an existing site. For example, Mr Mark Doran, Chief Executive Officer, LCMHC, told the Committee 'most of the investment is in brownfields, not in greenfields. In other words, do not build a new hospital; build on what you have got. It is much more effective.'¹⁴²
- 5.15 Dr Collignon on the other hand, told the Committee 'there are advantages for a new greenfields site in that you can usually build the hospital better and cheaper'.¹⁴³ Commenting on the extent of redevelopment required at CPH, Dr Dunlop told the Committee:
- All of these things can be built into the first sketch of a new hospital but they are more difficult to integrate into an existing one.¹⁴⁴
- 5.16 The Minister also noted the benefits of building a new hospital, stating:
- A north side hospital under option 4 provides a blank canvas about how we design the hospital services, how we design a building and what services go in there—as I say, a blank canvas which provides more opportunity than refurbishing Calvary.¹⁴⁵
- 5.17 According to the Capital Projects and Service Planning Unit of the Victorian Government Department of Health, which provides comprehensive information regarding the costing and planning for new hospital projects:
- Redevelopment of an existing hospital will typically cost 30-90% of an equivalent new hospital, dependent on age and quality of the building stock, services and other infrastructure. In exceptional circumstances where the building requires extensive upgrade to meet current regulations, it may be cheaper to demolish and build from new.¹⁴⁶

¹⁴² Mr Doran, *Transcript of Evidence*, 22 December 2010, p 91

¹⁴³ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 108

¹⁴⁴ Dr Dunlop, *Transcript of Evidence*, 23 December 2010, p 117

¹⁴⁵ Minister for Health, *Transcript of Evidence*, 1 December 2011, p 7

¹⁴⁶ Victorian Government Health Information, Capital Development Guidelines, *Hospital Capital Planning Module*, viewed 1 February 2011, <http://www.capital.dhs.vic.gov.au/capdev/ProjectProposals/Benchmarking/HospitalCapitalModule/>

5.18 The Committee considered a number of new hospitals developments under construction around Australia for comparative purposes.¹⁴⁷ The Committee notes that the decision to build rather than redevelop the Melbourne Royal Children's Hospital (RCH), due for completion in 2011, was 'to better support modern approaches to the provision of high quality medical care and leading research'.¹⁴⁸ A number of the new hospitals boast many of the modern design features. For example:

- The inclusion of a high percentage of single-bed rooms to reduce the risk of infection, decrease noise levels and increase privacy and comfort for patients and their families;¹⁴⁹
- The Royal Children's Hospital in Melbourne, anticipating its place as Australia's 'greenest hospital', is boasting a 45 per cent reduction in green house gas emissions and a 20 per cent reduction in water usage.¹⁵⁰
- The new Royal Adelaide Hospital will be maximising the use of natural light, embracing the latest environmentally sustainable practices and developing its own capability to generate renewable energy to help meet part of the site's energy consumption requirements.¹⁵¹
- The new Queensland Children's Hospital will also be incorporating 'environmentally sustainable design principles to reduce energy use and greenhouse gasses, to save water, reduce emissions and manage waste efficiently'. Other features of QCH will include access to 'daylight and

¹⁴⁷ These include: Royal Adelaide Hospital (RAH); Royal Children's Hospital Melbourne (RCH); Queensland Children's Hospital; WA Midland Health Campus (307 bed) PPP; and the Princess Margaret Hospital for children (PMH)
<http://www.newchildrenshospitalproject.health.wa.gov.au/TheNewHospital.aspx>

¹⁴⁸ State Government of Victoria, Department of Health, *The new Royal Children's Hospital project*, viewed 23 February 2011, <http://www.newrch.vic.gov.au/Buildingthenewhospital>

¹⁴⁹ 75 per cent single rooms at the Princess Margaret Hospital and 85 per cent at the Melbourne Royal Children's Hospital.

¹⁵⁰ State Government of Victoria, Department of Health, *The new Royal Children's Hospital project, A green hospital*, viewed 20 February 2011, <<http://www.newrch.vic.gov.au/Agreenhospital>>

¹⁵¹ SA Health, *The new Royal Adelaide Hospital, Sustainable Development*, viewed 20 February 2011, <<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/the+new+royal+adelaide+hospital/sustainable+development>>

views, therapeutic gardens and open spaces, a family-centred design and an appealing internal appearance'.¹⁵²

5.19 Another important aspect of building a new hospital is the capacity to incorporate the infrastructure required to accommodate the use of modern technology such as modern medical equipment and information technology. The ACT Government notes:

New technology has a direct impact on the construction of hospitals, with, for example, modern operating theatres being larger than older theatres to accommodate equipment, bigger medical imaging departments, and with higher levels of floor strength to accommodate heavier imaging equipment, and patient rooms and corridors larger and wider to fit larger patient monitoring and life support equipment.¹⁵³

5.20 The ACT Government also notes the following advantages and cost savings of building on a new site:

- building a new hospital means that the hospital can be designed in way to make the most efficient use of space in line with modern models of service delivery;
- building on the existing hospital campuses would require demolition of some buildings to make space for the new buildings;
- redeveloping the existing hospitals will require relocation of some services, with costs associated with establishing temporary facilities for these services, and with moving the services into and out of the temporary facilities;
- building a new hospital from the start is quicker because demolition and service relocation is not required, and as a result there are reduced costs associated with inflation and project management and administration.¹⁵⁴

¹⁵² Queensland Government, New Qld Children's Hospital, viewed 20 February 2011, <<http://www.health.qld.gov.au/childrenshospital/content/building.asp>>

¹⁵³ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 7

¹⁵⁴ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 13

- 5.21 Another consideration is the potential improved health benefits that come with a new building. In the view of Clinical Nurse, Ms Rachel Panzarino:
- ... patients can expect a more comfortable environment. The facilities will be state of the art and purpose built, so the health care that patients receive will make their outcomes better, and perhaps reduce the length of time they need to stay in hospital.¹⁵⁵

The cost of building

- 5.22 Estimating the total cost of a new hospital development is not possible without detailed planning of the overall size, design and types of services to be provided. Until a firm decision is made to build a new hospital, an accurate budget estimate for a new hospital in the ACT, cannot be made.
- 5.23 The latest construction cost estimate¹⁵⁶ of building a 400 bed hospital in the ACT is \$687,650,000 or \$1.7 million per bed. Based on this estimation the construction of a new 400 bed hospital (Option D) is the most cost effective. The Government options analysis explains that greenfield developments are more cost effective than brownfield developments due to costs associated with 'staging and decanting, increased complexity necessitating a larger contingency, and higher escalation allowances due to longer construction times'.¹⁵⁷ The Committee notes however, that this figure does not include the cost of land acquisition. The Government options analysis also notes that:
- Land would need to be acquired before bed numbers could be increased at the Calvary campus. Any purchase decision concerning land at that campus

¹⁵⁵ SA Health, The new Royal Adelaide Hospital, viewed 10 February 2011, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/the+new+royal+adelaide+hospital>

¹⁵⁶ These estimates, developed for the ACT Government, are based on floor area and facility planning by Thinc Health (an international management consultancy specialising in projects <http://www.thincprojects.com/>) and construction costs by Rider Levitt Bucknall (a global property and construction practice) <http://www.rlb.com/about.html>).

¹⁵⁷ ACT Health, *ACT Public Hospital Services: Delivery of Additional Hospital Beds, Options Analysis*, February 2011, p 17

[because LCMHC hold the crown lease] would require negotiations with Little Company of Mary Health Care.¹⁵⁸

5.24 The Committee considers the construction estimate modest in comparison to other specialised hospital developments, but more so aligned with the development of a general purpose hospital. The Committee notes the following examples:

- Melbourne Royal Children's Hospital, \$1 billion, 357 beds;
- Princess Margaret Hospital (Perth), \$1.17 billion, 274 beds (incorporating a children's trauma centre); and
- Queensland Children's Hospital, \$1.1 billion, 359 beds; and
- Midland Health Campus, \$360 million, 307 bed general hospital.

5.25 The cost of Royal Adelaide Hospital (RAH), due for completion in 2016, is not stated on its website but the SA Australian Government has estimated that in 'comparison, redeveloping the existing RAH would be more expensive, [and] cost approximately \$300 million more and would take almost a decade longer'.¹⁵⁹

5.26 The Capital Projects and Service Planning Unit of the Victorian Government Department of Health notes that the cost per bed will vary significantly depending on the level of service being provided. Factors impacting on hospital development costs can include:

- hospital role delineation (i.e. the complexity of services provided);
- functional make-up (i.e. more expensive departments such as operating theatres, laboratories or less expensive departments such as clinics, engineering and stores;
- building configuration (i.e. single storey, low rise or medium rise);
- site locality and factors (i.e. ground conditions); and

¹⁵⁸ ACT Health, *ACT Public Hospital Services: Delivery of Additional Hospital Beds, Options Analysis*, February 2011, p 12

¹⁵⁹ SA Government, *The new Royal Adelaide Hospital, Frequently asked questions*, viewed 22 February 2011, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/the+new+royal+adelaide+hospital/frequently+asked+questions>

- car parking (i.e. on-grade, low rise, multi-level or basement).¹⁶⁰

5.27 While the cost of building is a major consideration, the Committee considers that it is also important to consider the benefits that come with a new building.

Public private partnerships

5.28 Public private partnerships (PPP) aim to 'deliver improved services and better value for money primarily through appropriate risk transfer, encouraging innovation, greater asset utilisation and an integrated whole-of-life management, underpinned by private financing. PPPs as a procurement method are part of a broader spectrum of contractual relationships between the public and private sectors to produce an asset and/or deliver a service'.¹⁶¹

5.29 The guidelines and national best practice policy endorsed by COAG in 2008, adopted by the ACT Government, state that projects exceeding \$50 million are the ones likely to have potential to provide value for money using a PPP model.¹⁶²

5.30 The Committee was interested to note that the RCH, The Royal Adelaide Hospital and the Midlands Hospital (WA) were all being delivered through a PPP.

5.31 The RCH, funded by the Victorian State Government, is being delivered under the Partnerships Victoria policy. Under this model, the Department of Health, through RCH, will continue to operate all health services including operating the hospital and core medical services, staffing, teaching, training

¹⁶⁰ Victorian Government Health Information, Capital Development Guidelines, *Hospital Capital Planning Module*, viewed 1 February 2011, <<http://www.capital.dhs.vic.gov.au/capdev/ProjectProposals/Benchmarking/HospitalCapitalModule/>>

¹⁶¹ Australian Government, Infrastructure Australia, *National Public Private Partnerships Policy Framework*, December 2008, viewed 9 February 2011, p 3, <http://www.infrastructureaustralia.gov.au/files/National_PPP_Policy_Framework_Dec_08.pdf>

¹⁶² Australian Government, Infrastructure Australia, *National Public Private Partnerships Policy Framework*, December 2008, viewed 9 February 2011, p 6, <http://www.infrastructureaustralia.gov.au/files/National_PPP_Policy_Framework_Dec_08.pdf>

and research. The private partners will be responsible for design, construction, finance, and maintenance of the buildings.¹⁶³

5.32 The SA State Government will work in partnership with the private sector to deliver the new RAH on 'budget and on time'. This partnership will see the public sector (SA Health) continue to operate the hospital and provide all core clinical services, staffing, teaching, training and research, while the private sector will finance, design, construct and maintain the new hospital facility under a 35-year contract.¹⁶⁴

5.33 The Midland campus is also being developed under a PPP, however, unlike the examples of RCH and RAH, the WA Government will partner with an experienced health care provider to build, maintain and provide health care services to the community. This is a jointly funded project between the Australian and WA Governments and will operate as a private hospital for public patients.¹⁶⁵

5.34 Noting the success of PPP procurement in other Australian jurisdictions in the delivery of 'large and complex projects', the ACT Government stated:

While no new projects in the 2010-11 Budget exceed the \$50 million threshold, in accordance with this policy, the Territory will be exploring opportunities to enter into partnerships with the private sector to deliver several substantial projects that are progressing into the planning and design phase, including: the Government Office Accommodation Building Project; Enhancing Data Storage Capacity; and Student Accommodation at the Reid Campus of the Canberra Institute of Technology.¹⁶⁶

5.35 To date, the primary considerations driving PPP procurement are:

- value for money;

¹⁶³ State Government of Victoria, Department of Health, *The new Royal Children's Hospital project*, Public Private Partnerships, viewed 23 February 2011, <<http://www.newrch.vic.gov.au/PublicPrivatePartnerships>>

¹⁶⁴ SA Health, *The new Royal Adelaide Hospital, Public Private Partnership*, viewed 23 February 2011, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/the+new+royal+adelaide+hospital/construction+and+timeline/public+private+partnership>

¹⁶⁵ Government of Western Australia, Department of Health, North Metropolitan Area Health Service, *Frequently Asked Questions*, viewed 24 February 2011, <<http://www.nmahs.health.wa.gov.au/BuildingProgram/Midland/NewHospital.html>>

¹⁶⁶ ACT Government, 2010–11 Budget Paper No. 3, p 109

- significant design innovation;
- appropriate risk transfer; and
- superior whole of life outcomes.

- 5.36 The Committee notes the Territory will use similar criteria when considering the opportunities available through partnering opportunities.¹⁶⁷
- 5.37 The Committee considers that the benefits of the two different models of PPPs, noted above, should be explored if the ACT Government does decide to build a new public hospital.

RECOMMENDATION 5

- 5.38 **The Committee recommends that the ACT Government consider the merits of a Public Private Partnership for the construction of a new public hospital, should it proceed with this option.**

Hospital staff

- 5.39 Hospital staff include administrative officers, executive and officers, health assistants, health professional officers, medical officers, nursing staff and technical officers. Nurses are the single largest group of hospital staff, comprising 41 per cent of the total staffing profile.¹⁶⁸
- 5.40 CPH staff are currently employed under the *Public Sector Management Act 1994* and their collective agreements are the same as those that apply to all ACT Health staff. Staff currently working at the public hospital would not be disadvantaged as a result of any transfer of ownership to the ACT Government. They would continue to work under the same terms and conditions and would not lose service continuity, conditions or remuneration.¹⁶⁹

¹⁶⁷ ACT Government, 2010–11 Budget Paper No. 3, p 109

¹⁶⁸ ACT Health, Annual Report 2009–10, p 238 (This figure does not include staff employed by CPH)

¹⁶⁹ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 5

- 5.41 ACT public hospitals also engage salaried medical officers (SMOs) and visiting medical officers (VMOs). CPH relies heavily on VMOs who are contracted to the Territory to provide services at CPH in accordance with the legislation regulating public hospital VMO services.¹⁷⁰ VMOs generally are not confined to one hospital and spread their services between public and private hospitals.
- 5.42 Dr Collignon pointed out that one of differences between VMOs and salaried doctors are that VMOs pay for their rooms. Dr Collignon noted that the real estate value of Calvary Clinic could be devalued if CPH was to move away from acute service provision.¹⁷¹
- 5.43 As noted by Dr Dunlop, planning a new hospital is more than just infrastructure 'it is how the elements of human resources would fit together'.¹⁷²
- 5.44 The Minister told the Committee that while a significant amount of work was occurring, particularly through Health Workforce Australia and other national initiatives aimed at increasing the health workforce she was confident that the ACT had to capacity to staff a new hospital, stating:
- When you look at what we have done over the past six years or so, we have brought on about 240 beds. So it is achievable. Those beds are staffed. Those beds are open. You know, so, 400 beds over a five to eight-year period is what we are going to have to do, and, you know, staffing will remain a challenge, but we have been doing it every year, and we will continue to do it incrementally.¹⁷³
- 5.45 The Committee notes that staffing considerations are an important component of any decision the Government makes.

Committee comment

- 5.46 The Committee notes the merits of a new hospital building including:
- state of the art facility incorporating latest design principles and modern technologies;

¹⁷⁰ ACT Government Information Paper, *Future Ownership and Governance of Calvary Public Hospital and Clare Holland House*, 2009, p 5

¹⁷¹ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 110

¹⁷² Dr Dunlop, *Transcript of Evidence*, 23 December 2010, p 120

¹⁷³ Minister for Health, *Transcript of Evidence*, 16 March 2011, p 134

- enhanced sub-acute facility (if LCMHC agreed to operating CPH as a sub-acute facility)
 - standardised operating procedures across acute hospitals;
 - efficiencies gained by having single management structure for acute hospitals; and
 - better financial option than upgrading CPH.
- 5.47 The Committee notes the impact a new acute hospital would have on CPH and LCMHC and in particular, the impact on Calvary Private Hospital if the acute care hospital was moved to another site.
- 5.48 The Committee is also concerned about the current dispute over the Government's obligation to fund a 300 bed public hospital on the Bruce campus site.¹⁷⁴ The Government argues that this is not what is being operated now and this view is based on the original 1971 agreement.¹⁷⁵ However, that argument could be challenged, if LCMHC chose to do so.
- 5.49 The Committee has noted the problems associated with upgrading the Bruce site, in relation to the crown lease and service concession arrangement, despite the opportunity for the ACT Government to claim CPH as an asset for accounting purposes.
- 5.50 The options pertaining to building a new hospital, acute or sub-acute, offer the best option for the Government to having a streamlined integrated system. While a new hospital does not resolve the single management structure sought by the Government, it may afford the Government a greater level of control and networking ability. Whatever the outcome the ACT Government will need to continue to work with LCMHC as they will be operating in some form.
- 5.51 As noted earlier, LCMHC are autonomous in their decisions regarding the operations of CPH. Therefore, delineation of services for the three hospitals would need to be negotiated and agreed with LCMHC.

¹⁷⁴ Submission 6, Calvary Health Care ACT, p 19

¹⁷⁵ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 15

6 OTHER OPTIONS

- 6.1 The increasing demand on health care services is not limited to public hospitals and meeting the growing needs of the Canberra community is an increasing challenge for the Government.
- 6.2 HCCA was of the view that meeting health care needs did not need to happen in a hospital setting and strongly supported focusing care needs in a sub-acute facility and enhanced primary health care centres.¹⁷⁶
- 6.3 The Committee was told that ACT Health had been examining options to enhance service capacity at community health centres with a view to reducing the demand for acute hospital beds. Mr Ian Thompson, Deputy Chief Executive, ACT Health, told the Committee this work includes:

...various home-based care models, whether it is the hospital in the home or what we call a CAPAC program, which is a community acute/post-acute care program, and other models that are being developed elsewhere which give the capacity to either discharge people early from hospitals, therefore reducing overall demand, or even avoid a hospital admission in the first place. That has been included within our overall planning.¹⁷⁷

Sub-acute facility

- 6.4 ACT Health describes sub-acute care as 'intermediate care provided between acute care and community-based care'.¹⁷⁸ Sub-acute services include rehabilitation, psycho-geriatric care and palliative care.
- 6.5 Increasing sub-acute capacity has the potential to increase bed capacity in the acute hospital stream as many beds are currently taken up with people in recovery. Lack of sub-acute beds in both a hospital and community setting place greater pressure on the hospital system. Increasing the number of sub-

¹⁷⁶ Submission 13, Health Care Consumers Association

¹⁷⁷ Mr Thompson, *Transcript of Evidence*, 16 March 2011, p 156

¹⁷⁸ ACT Health, Annual Report 2009–10, p xi

acute beds has been identified as a priority by the Australian Government through the National Health and Hospitals Network in recognition that many people, mainly older people, are unnecessarily admitted to hospital due to lack of appropriate sub-acute services particularly in the community.¹⁷⁹

- 6.6 TCH and CPH have a range of sub-acute beds. The Committee heard that there are problems associated with the co-location of acute and sub-acute services, mainly due to different levels of infection control. As Dr Collignon explained:

... when you have acute and sub-acute close together, people are always trying to break the rules because there is a bed in sub-acute and they try to turn that into an acute care area, which has been a recent problem.¹⁸⁰

- 6.7 The ACT Government provides the following example demonstrating the need to separate the different levels of care:

Where a hospital delivers both acute and subacute care, the urgency associated with acute care delivery will frequently result in priority given to acute care ahead of subacute care, and in resources being diverted from subacute care to respond to increased in acute service demand. This in turn impacts on the efficiency and effectiveness of subacute service delivery.¹⁸¹

- 6.8 Options D and E, put forward by the Minister on 25 February 2011, propose a separate purpose build sub-acute hospital. Option D proposes transforming CPH into a specialised rehabilitation centre and sub-acute hospital to compliment a new 400 bed hospital, while option E proposes a new 200 bed sub-acute and rehabilitation hospital to compliment an additional 200 beds at CPH.¹⁸²

- 6.9 Both of these options would result in a fully networked and specialised hospital system and rate the highest in the Treasury analysis. The main features of this model is that it would provide clear role delineation for the

¹⁷⁹ Australian Government, *A National Health and Hospitals Network for Australia's Future, Delivering Better Health and Better Hospitals*, 2010, p 17

¹⁸⁰ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 109

¹⁸¹ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 6

¹⁸² ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 12

three hospitals with each specialising in particular areas leading to improvements in safety and quality of care. This would also provide greater scope for providing patient-centred care and improve accessibility on the north side.¹⁸³

- 6.10 However, the Government does point out that if Option E was to proceed, it would involve both public hospitals operating around on-site construction, as enhancing the bed capacity at CPH would require significant redevelopment, as previously discussed.¹⁸⁴
- 6.11 The Committee heard strong support for a stand-alone sub-acute hospital. While HCCA expressed in-principle support for a new hospital, their preference was for a purpose built sub-acute teaching facility on the grounds of the University of Canberra (UC) considering this would benefit the community through the provision of clinical placements for students in the nursing and allied health stream.¹⁸⁵ HCCA also suggested the facility could house a second secular hospice for the ACT and considered UC a suitable site as it was conveniently located to arterial roads and public transport and accessible to people on the north side of Canberra.¹⁸⁶
- 6.12 The Australian Nurses Federation (ACT Branch) also supported a teaching hospital on or near the grounds of UC.¹⁸⁷
- 6.13 HACC was also of the view the health dollar would be better spent by utilising the resources already available at CPH, such as the newly opened ICU and existing operating theatres, rather than building a new acute hospital. Ms Cox told the Committee, that in her view, it would be better to:

... put the energy into building a sub-acute facility that is tailor made to the community needs and that is fostering that primary healthcare base rather than getting caught up in building another hospital.¹⁸⁸

¹⁸³ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, pp 12–13

¹⁸⁴ ACT Health, *Expanding hospital services in the ACT: an additional 400 Hospital Beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 13

¹⁸⁵ Submission 13, Health Care Consumers Association, p 3

¹⁸⁶ Submission 13, Health Care Consumers Association, p 3

¹⁸⁷ Submission 10, Australian Nurses Federation (ACT Branch), p 4

- 6.14 Dr Collignon was of the view that the recent investment of \$13.5 million in the new ICU would be wasted if CPH was to become a sub-acute facility, but recognised that the new ICU would get at least five years use out of an estimated lifespan of approximately 20 years, before it would need to be upgraded.¹⁸⁹
- 6.15 The Minister advised the Committee that the ACT is currently short 160 sub-acute beds and consideration had been given to transforming CPH into a sub-acute facility of excellence.¹⁹⁰ Noting LCMHC's preference to remain functioning, at this stage, as an acute hospital the Minister told the Committee that she did not want CPH to cease operating as a hospital but to:
- ... examine the opportunity for that [CPH] to become a rehabilitation or sub-acute centre of excellence. I have had that discussion with LCM. They have not ruled it out. They have not embraced it either. They have sort of noted it.¹⁹¹
- 6.16 The Committee supports the development of specialised rehabilitation sub-acute hospital but understands that any decision to transform CPH into such a facility would require the agreement of LCMHC.

Palliative care

- 6.17 With much of the earlier debate focussed on the sale of Clare Holland House (CHH) linked to the sale of CPH, a number of submitters to this inquiry again expressed concern about the future of CHH.¹⁹² Mr Peter O'Keeffe sought clarification on implications of the options on the future 'funding, operation, continued public ownership and multifaceted enhancement' of CHH.¹⁹³
- 6.18 The Australian Nurses Federation also raised concerns regarding the ongoing management and utilisation of CHH if a new hospital was to be built.¹⁹⁴

¹⁸⁸ Ms Cox, *Transcript of Evidence*, 1 December 2010, p 55

¹⁸⁹ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 108

¹⁹⁰ Minister for Health, *Transcript of Evidence*, 1 December 2010, p 8

¹⁹¹ Minister for Health, *Transcript of Evidence*, 1 December 2010, pp 8–7

¹⁹² See Submission 8, Mr Peter O'Keeffe, Submission 10 Australian Federation of Nurses (ACT Branch), Submission 13, Health Care Consumers Association

¹⁹³ Submission 8, Mr Peter O'Keeffe

¹⁹⁴ Submission 10, Australian Nurses Federation (ACT Branch), p 4

6.19 Dr Collignon told the Committee members of ASMOF:

... had a strong view that the hospice needs to stay under the ownership of ACT Health or government but could be run by whomever on a contractual basis. We think Little Company of Mary does a good job at the hospice but we did not think ownership should revert to them, which was all part of the deal.¹⁹⁵

6.20 HCCA reported a strong community view for a second secular hospice in the ACT to enable greater choice for consumers and suggested that the new sub-acute facility would be an ideal location for enhanced palliative care.¹⁹⁶

6.21 While the issue of palliative care and CHH is not directly within the terms of reference of this inquiry, the Committee understands community concerns raised and the need for certainty about the future of CHH.

A 'super hospital'

6.22 The discussion paper released by the Minister on 25 February proposes developing TCH into a 'super hospital' with the additional 400 beds being accommodated there while CPH continued to operate in its current form as an acute hospital (option B). The Treasury analysis shows this option has the highest construction costs and would provide the least opportunity to improve the operating efficiency of the two public hospitals. The concentration of services at TCH would also limit the scope to reorganise services to provide patient centred care and would reduce access to north side residents.¹⁹⁷

6.23 This option rates the least favourable of the new options presented by the Minister who has indicated this option was included for comparative reasons and it is unlikely to be pursued by the Government.¹⁹⁸

¹⁹⁵ Dr Collignon, *Transcript of Evidence*, 22 December 2010, p 106

¹⁹⁶ Submission 13, Health Care Consumers Association, p 3

¹⁹⁷ ACT Health, *Expanding hospital services in the ACT: an additional 400 beds Health Service Delivery Public Consultation & Discussion Paper*, February 2011, p 10

¹⁹⁸ Peter Jean, "'Super' hospital an unlikely option, says Gallagher', *The Canberra Times*, 2 February 2011
Comments made by the Minister on ABC Radio 666, 9.15 am, 2 February 2011

- 6.24 Based on comments by the Minister, the Committee is of the view that the ACT will continue to operate with two acute hospitals. The Committee does not support this option.

Other models of care

- 6.25 HCCA noted the \$15 million commitment from the Australian Government for the establishment of an ACT GP super clinic and the resulting increased access to primary health care services for Canberrans. HCCA provided the example of the Melton Super Clinic in Victoria to illustrate the range of ambulatory care services that can complement general practice and the acute health care system such as specialist clinics, pathology and radiology. Of particular note however, is the:

- ambulatory care stream that operates like an outpatient clinic except with a multidisciplinary approach; and
- urgent care stream that operates as a walk-in service. HCCA reported that this model is nurse-practitioner and GP led and has reduced the number of emergency department presentations.¹⁹⁹

- 6.26 While the Government supports expanded health care in the community setting it noted that despite investments in the community health sector such as the enhanced community health centres and the nurse led walk-in centre the demand for public hospital services continues to grow.²⁰⁰

- 6.27 The Minister noted the benefits of having a dedicated sub-acute rehabilitation facility pointing to the evidence that specialised services deliver a higher quality and safer service. She went on to say that a specialised facility would provide:

...integration between inpatient and outpatient services as well, so that from a patient journey point of view, you know, your experience in that sub-acute

¹⁹⁹ Submission 13, Health Care Consumers Association, pp 4-5

²⁰⁰ ACT Public Hospital Services: Delivery of Additional Hospital Beds Options Analysis, February 2011, p 3

setting should be seamless, whether you are stepping down from the acute into sub-acute or from sub-acute to the community.²⁰¹

6.28 The Committee considers that there is potential to increase the bed capacity at both hospitals through better use of current beds, particularly where operating theatres are being used for surgery that could be performed in a day surgery facility. The Committee was presented with a number of examples to illustrate this point. For example:

- a dedicated eye surgery facility that could also cater for public and private elective procedures freeing up main theatre space for specialities that require them;²⁰²
- more- sub-acute beds as previously discussed; and
- a dedicated day surgery facility that also leads to efficiencies around infection control.²⁰³

6.29 The ACT Government has already recognised the need for increased day surgery facilities stating:

... extended day surgery units will be established at Canberra Hospital (TCH) and Calvary Hospital to provide up to 80 per cent of elective surgery by 2022.²⁰⁴

6.30 Given the uncertainty of the future of CPH it is unclear whether the Government will continue with this. The Committee notes a dedicated day surgery facility at the Bruce campus should be considered if the Government decides to upgrade CPH.

²⁰¹ Minister for Health, *Transcript of Evidence*, 16 March 2011, p 153

²⁰² Submission no 4, Dr Dickson

²⁰³ Submission 17, AMA ACT

²⁰⁴ ACT Health, *Your Health Our Priority Stage 2*, viewed 28 January 2011, <<http://www.health.act.gov.au/c/health?a=sp&pid=1216959407>>

7 CONCLUDING COMMENTS & FINAL RECOMMENDATIONS

- 7.1 The Committee was asked by the Legislative Assembly to assess four options put forward by the ACT Government in August 2010 on the future ownership and management arrangement for CPH. The Committee was disappointed with the paucity of the initial information provided through the Government submission on the options and other publically available documents at that time. The Committee sought further information, but it was not until 25 February 2011, that the Government publically released a comprehensive discussion paper and options analysis for five new options. The Committee received this information at the same time.
- 7.2 The Committee understands that a public consultation is currently underway and that the Government intends to make its final decision before the 2011–12 budget is handed down on 3 May 2011.
- 7.3 While the new options came with a greater level of detail, including a cost benefit analysis and an options analysis assessed against a set of planning principles, the choices for the Government remained the same. All options retain the services of LCMHC and CPH to some degree. The Government must decide whether to upgrade the facilities at CPH or build a new acute or sub-acute hospital to accommodate the additional beds required to meet growing demand in hospital services in the coming decade.
- 7.4 The decision before the Government is not an easy one. It is clear from the evidence that Canberra cannot support three acute public hospitals. It is also clear that consolidating TCH into a 'super hospital' is not the preferred option. The evidence provided by the Government clearly favours a fully networked and specialised hospital system and that this would be best achieved through the development of a new 400 bed hospital or a new 200 bed sub-acute hospital on the north side of Canberra.
- 7.5 The Committee considers that the future of Calvary Private Hospital will be dependent on the future role of CPH and supports efforts to retain a private hospital on the north side of Canberra.

- 7.6 The Committee notes that this has been a long process of negotiation and the previous impasse added a degree of complexity to reaching a mutually beneficial solution for both parties.
- 7.7 With the current options under consideration, the Committee welcomes an early resolution to the uncertainty of the future of CPH and offers this report to the public debate and to the Government for its full consideration to ensure residents on the north side of Canberra, and indeed all Canberrans have access to the best available health care.
- 7.8 Having reviewed the available evidence and analysis, the Committee recommends against Option C which would result in three acute hospitals and Option B which would result in a 'super hospital' at TCH. Both of these options would create complications that are clearly explained in the report and show a clear balance in their relative merits assessed by the Committee towards the negative.
- 7.9 However, based on the information received through its inquiry, and notwithstanding the ongoing public consultation, the majority of the Committee is of the view that the people of the ACT would be best served through a fully networked and specialised hospital system, as proposed by options D and E. Both these options would retain the services of LCMHC and the Calvary Public Hospital as a significant stakeholder in the delivery of health care services to the people of the ACT.²⁰⁵

RECOMMENDATION 6

- 7.10 **The Committee recommends that the ACT Government does not proceed with Option C that would result in three acute hospitals and Option B that would result in TCH becoming a 'super hospital' as proposed in the Government discussion paper released on 25 February 2011.**

²⁰⁵ The Chair of the Committee, Mr Steve Doszpot dissents from paragraph 7.9 and recommendation 7. See Appendix A for his dissenting comments.

RECOMMENDATION 7

- 7.11 **The Committee recommends that the ACT Government proceed with developing a fully networked and specialised hospital system as proposed by Options D and E in the Government discussion paper released on 25 February 2011.**

Steve Doszpot MLA

Chair

28 March 2011

APPENDIX A: Dissenting Comment – Steve Doszpot

I dissent from the committee decision re paragraph 7.9 and recommendation 7 which prescribe the Government proceed with developing a fully networked and specialised hospital system as proposed by Options D and E as the committee's preferred options. Having reviewed the available evidence and analysis, I consider that it is appropriate that the committee recommends against Option C which would result in three acute hospitals and Option B which would result in a "super hospital" at TCH. Both of these options would create complications that are clearly explained in the report and show a clear balance in their relative merits assessed by the committee towards the negative.

However, as I have stated in committee meetings, I have not been satisfied that the committee has been presented with all the evidence from the Government or with sufficient evidence that would justify the committee from discounting or recommending in favour of any of the remaining options. Without clarity on the issue of where a third public hospital would be built, evidence of the ability to staff all of the options, evidence of any cost efficiencies of a "networked system" and without some of the evidence and analysis that the Government has refused to provide to the committee, I believe that all of the three remaining Government options A, D, E, have a balance of relative strengths and weaknesses that have been articulated in the report and at this stage, with the Government still conducting community consultations, should not be discounted.

Steve Doszpot MLA

28 March 2011

APPENDIX B: Public Hearings

1 December 2010

Minister for Health and Treasurer, Ms Katy Gallagher

Mr Ian Thompson, Acting Chief Executive, ACT Health

Mr Khalid Ahmed, Executive Director, Policy Coordination and
Development Division, Treasury

Ms Lisa Holmes, Executive Director, Finance and Budget Division, Treasury

Ms Jenny Miragaya, Branch Secretary, Australian Nursing Federation (ACT Branch)

Mr Tom Cullen, Industrial Officer, Australian Nursing Federation (ACT Branch)

Dr Adele Stevens, President, Health Care Consumers Association

Ms Darlene Cox, Executive Director, Health Care Consumers Association

22 December 2010

The Hon John Watkins, Chair, Little Company of Mary Health Care,

Mr Mark Doran, CEO, Little Company of Mary Health Care,

Mr Walter Kmet, National Director Public Hospitals, Little Company of Mary
Health Care,

Mr Robert Gunning President, Save Calvary Group,

Ms Rachel Horne Publicity Officer, Save Calvary Group,

Dr Peter Collignon, Australian Salaried Medical Officers Federation

23 December 2010

Dr Iain Dunlop, President, Australian Medical Association (ACT)

16 March 2011

Minister for Health and Treasurer, Ms Katy Gallagher

Mr Ian Thompson, Acting Chief Executive, ACT Health

Mr Khalid Ahmed, Executive Director, Policy Coordination and
Development Division, Treasury

APPENDIX C: Submissions

- 1 Dr Peter French
- 2 Mr Mark Rolfe
- 3 Community and Public Sector Union
- 4 Dr David Dickson
- 5 Mr Keith Sayers
- 6 Calvary Health Care ACT
- 7 Save Calvary Group
- 8 Mr Peter O'Keeffe
- 9 LCMHC, Archdiocese Canberra and Goulburn and Catholic Health Australia
- 10 Australian Federation of Nurses (ACT Branch)
- 11 Mr Peter Lawler
- 12 Mr Paul Monagle
- 13 Health Care Consumers Association
- 14 ACT Government
- 15 Dr Andrew Gordon
- 16 ACTCOSS
- 17 Australian Medical Association (ACT)
- 18 Dr Roger Lee and Dr James Riddell Calvary Public Hospital