



LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

**REPORT OF THE
SELECT COMMITTEE ON
THE ESTABLISHMENT OF A NEW PRIVATE HOSPITAL**

NOVEMBER 1997

Members of the Committee

Mr Wayne Berry MLA (Chair)

Mr Harold Hird MLA

Ms Kerrie Tucker MLA

Secretariat

Mr John Cummins

Mrs Kim Blackburn

Terms of Reference

On 15 May 1997 the Legislative Assembly passed the following resolution:

That a Select Committee be appointed to inquire into and report on the establishment of a new private hospital at or near The Canberra Hospital with particular reference to -

(a) current provision of both public and private beds in the ACT and the appropriate ratio of public/private beds as well as the overall requirement for beds in the ACT and surrounding region;

(b) the possible inter-relationship of the proposed new private hospital with The Canberra Hospital;

(c) the impact of any new beds in the private sector on -

(i) the current public hospitals in the ACT;

(ii) the current private hospitals in the ACT;

(d) the current and projected requirements of different types/categories of beds in the ACT including different levels of acute care beds and day care bed requirements as well as other possible combinations;

(e) the financial arrangements associated with the proposed new private hospital - including land allocations and proposed working and transfer arrangements;

(f) the impact on the citizens of the ACT in the climate where the number of private beds is rising at the same time as private health insurance is falling;

(g) any economic or employment benefits of the new private hospital;

(h) any other related matters.

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Recommendations

1. the ACT Government commission an independent review of public and private bed needs with particular reference to the impact of an additional 100 bed hospital on the public and private health sectors.
2. the Legislative Assembly request the Standing Committee on Public Accounts to examine the principle of Commercial-in-Confidence.
3. the Attorney General request the Government Solicitor to examine the contract and other agreements to ensure they comply with trade practices legislation.
4. the Auditor General examine the arrangements between the Government and Health Care of Australia to ensure that the ACT taxpayer is receiving a fair return for their investment, and
the Auditor General continue to monitor those arrangements.
5. The Canberra Hospital only enter into arrangements with National Capital Private Hospital concerning access to Accident and Emergency which are effectively available to the other hospitals;
numbers of patients admitted to the three private hospitals from The Canberra Hospital Accident and Emergency be monitored and that data be reported to the Assembly after twelve months of operation of National Capital Private Hospital; and
protocols be developed and published concerning the roles and conduct of private and public staff in The Canberra Hospital Accident and Emergency, particularly as the conduct relates to the patients' choice of admission as public or private patients.

1. INTRODUCTION

Background

1.1. ACT Government officials advised the Committee that the selection process of the successful proponent to establish the private hospital was conducted by a committee appointed by the Chief Executive of the Department of Health and Community Care.¹

1.2. An open call for expression of interest to develop a private hospital on, or adjacent to, The Canberra Hospital (TCH) campus occurred over August-September 1996. Five expressions of interest were received, including two non-conforming bids. Detailed proposals were then invited from three organisations which expressed interest (October-December 1996). Detailed proposals were received from two proponents.

1.3. In developing the proposals, proponents were advised to conduct their own research on market strength and the viability of the project. Proponents were advised that they could not rely on guarantees of Government business. Proponents were advised to make their decisions based on the demography of the ACT and surrounding areas, private health insurance trends, and the provision of medical and specialist services in public and private areas. They also undertook their own financial modelling.

1.4. In December 1996, the Minister agreed that Health Care of Australia (HCoA) should be the preferred proponent. On 8 May 1997 the Agreement to Lease was signed between the Department of Health and Community Care and HCoA.

1.5. HCoA is a division of Mayne Nickless Limited and operates Australia's largest private hospital and health system. The Company has approximately thirty-six hospitals and 3500 beds. It is also plays a significant role in high technology medicine, acute emergency services, pathology and primary care. HCoA operates co-located facilities in Melbourne and Sydney and has three new co-located facilities under construction outside the ACT.²

The Proposal

1.6. The National Capital Private Hospital (NCPH) will be a facility of 110 beds located on TCH campus adjacent to its main entrance. The hospital, which is planned to be fully operational in August 1998, will include:

- four major operating theatres (including cardiac surgery)
- cardiac catheterisation laboratory
- 5 bed intensive care unit

¹ACT Government, *Submission*

²Health Care of Australia, information brochure

8 bed coronary care unit
endoscopy suit
day surgery unit
day chemotherapy unit
radiology
consulting rooms.

1.7. The new private hospital will also provide an additional scope for the training of Registrars. In addition, the private hospital will commit \$100 000 per year (indexed) for training and research.

1.8. The ACT Government and HCoA advised that the co-location of the hospitals will provide an opportunity for TCH and ACT Government services to provide on a commercial basis products and services to the private hospital. In principle agreement has been reached to explore the provision of services in pathology, radiology, pharmacy, biomedical engineering, ultrasound, nuclear medicine, education, catering, maintenance and engineering, fire and safety, waste removal, stores and supply and inventory and the use of the loading dock. These services are still to be negotiated and are subject to agreement on both sides on price, volume and standards. The Committee was advised that the ACT Government will be negotiating a price that includes use of capital already invested at TCH.³

The Inquiry

1.9. The Committee held two public hearings and inspected The Canberra Hospital, John James Memorial Hospital, Calvary Hospital and St George Public and Private Hospitals in Sydney.

1.10. On the day the motion was moved to establish the Select Committee, the lease agreement between the Government and HCoA was signed. The signing severely limited the extent to which the Assembly, through one of its committees, could meaningfully scrutinise decisions relating to the need, location, construction and nature of the proposal.

1.11. It is clear from the Committee's inquiry that there are many issues which, if properly examined during the planning phase, may have led to entirely different outcomes. For instance no feasibility study was undertaken by the Government on the need for a new hospital or its impact on existing hospitals. From the Committee's examination, it also appears that no serious consideration was given to alternatives, such as the up-grading of John James Memorial Hospital (JJMH), or TCH opening its own private ward.

1.12. The Committee accepts that the process by which the preferred proponent was selected was an open and public tender process. This occurred however after the decision by the Government to proceed had been

³ACT Government, *Submission*

made. On the evidence presented, it is the Committee's view that the decision to proceed with the new private hospital was an ideological one decided without open consultation with the parties who might be severely affected including the general Canberra community.

1.13. The Government did not properly consult interested persons or organisations concerning the need for, and nature, of additional beds. The Committee finds it astonishing that, in particular, neither Calvary Hospital nor JJMH were consulted.

1.14. The Government's submission to the inquiry claims that the commitment to the development of a private hospital was announced in the policy platform prior to the 1995 Election⁴. The Committee was unable to find any reference to a new private hospital in the official policy documents. Nor was anybody able to provide the Committee with any documents indicating that this was official Liberal Party policy.

1.15. This matter was further pursued with the Chief Executive Officer of the Department of Health and Community Care who stated that:

I was certainly informed by my Minister it was a policy of hers prior to the last election...⁵

⁴ ACT Government, *Submission*

⁵ ACT Government, *Transcript*

2. IMPACT ON EXISTING HOSPITALS

Current Bed Ratios

2.1. In 1997 in the ACT there are 240 private hospital beds and 784 public hospital beds. In 1995-96, 20 percent of patients treated at TCH, which is the only tertiary referral hospital in the region, had home addresses outside the ACT.

2.2. In addition in the south east region of NSW there are 557 beds located in 15 hospitals. Most of these fulfil community and regional hospital roles, that is, lower acuity care. There are no private hospitals in this region. The catchment area which TCH serves varies depending on the condition for which treatment is sought. The most serious and complex conditions are those which require interstate patients to transfer to The Canberra Hospital.

2.3. The National Health Strategy, in 1991, predicted that 3.3 beds (both public and private) per 1000 people would be a reasonable national target for 2001. The most recent figures of bed ratios indicated that nationally for both public and private hospitals, in 1994-95 there were 4.3 beds per 1000 population. In terms of public beds, the ACT, with 2.6 beds per 1000 population, was at the national metropolitan average. The current level of 0.8 private beds per 1000 population is below the national average of 1.3 private beds per 1000 population. The addition of 100 beds at the NCPH would bring the ACT close to the national average for private bed provision.¹

Projected Demand

2.4. The Committee was advised that the general factors affecting demand for acute hospital services in the ACT did not differ significantly from patterns observed and expected elsewhere in Australia. Changes in surgical and medical practices, and developments in drug therapy, permit shorter stays in hospital. It would be expected therefore that the demand for beds in Canberra would decrease in line with national trends. However, the ACT's population structure is rapidly changing to a more mature, older population structure. This will create an increased demand for beds, because those aged over 65 use hospital services at approximately 5.5 times the rate of those under 65.²

2.5. JJMH agreed that on the surface this appeared to be a justification for the increases in the number of beds. However, the ACT's population

¹ ACT Government, *Submission*

²ibid

was such that bed usage was much lower than the national average and would continue to be so, and hence the extra beds may not be needed. JJMH asserted that even though the ACT population was aging, the population makeup meant that only 86 percent of the beds at the accepted rate would be required. This would indicate that the ACT might only require 858 beds. If these predictions were accurate then, new hospital beds will not be required in the foreseeable future.³

2.6. With the opening of NCPH the numbers of beds in Canberra's private hospitals will be:

John James	174
Calvary Private	60
National Capital	110
Total	344

2.7. The Committee was advised that the current usage of private hospital beds in the ACT is between 65 and 70 percent, leaving substantial excess capacity in Canberra's private hospitals⁴. The Committee was told that the new hospital will greatly increase the already significant under-utilisation of beds. Based on a number of assumptions, including optimistic expectations of transfers of private patients who currently use TCH, it was estimated that the occupancy rate of total private beds would be about 52 percent.

2.8. On the other hand, the ACT Division of General Practice considered that the new hospital would enable more beds to be made available at TCH for elective admissions, as private and third party trauma cases were admitted to NCPH.⁵ The Australian Medical Association (AMA) also believed that an increase in the number of beds may be justified. The AMA advised that Canberra has some of the longest waiting times in the country for elective surgery. The AMA concluded that "... we can fill the beds so I do not see that as a problem"⁶.

2.9. The AMA questioned, however, the need to provide these beds at a new private hospital.⁷

Filling a Niche?

2.10. According to the Government submission current ACT private hospitals have tended to provide services at the medium level of acuity,

³ John James Memorial Hospital, *Submission*

⁴ Health Services Union of Australia, *Submission*

⁵ ACT Division of General Practice, *Submission*

⁶ Australian Medical Association, *Transcript*

⁷ *ibid*

while TCH provides services to a higher level. The submission states that the Government has specifically promoted the new private hospital:

... to fill the niche market of acute care not met by the current private hospitals in the ACT. The new hospital will have both an intensive care unit and a coronary care unit, and operating theatres which can meet the needs of complex surgery, which indicated a substantial investment in this niche market.⁸

2.11. The Government advised that even though there will be some patients who would choose to attend the new private hospital who might otherwise have gone to the current private hospitals, this was entirely consistent with the national competition policy reform agenda. In the case of competition in the private hospital market in the ACT, the Government believed that there should be positive improvements to consumers with additional choice, and presumably an improvement in service, standards and efficiency as existing hospitals position themselves to retain their existing market share. The Government however, offered no reason why the existing two private hospitals did not provide the desired competition.

2.12. Both Calvary Hospital and JJMH questioned the Government's assertion that the new hospital was primarily to service a niche market. Apart from the five bed intensive care unit and the eight bed coronary care unit, the other 97 beds are in direct competition with beds provided by the other ACT hospitals. There is already an under-utilisation of such beds in Canberra's private hospitals. The Chairman of the Board of Management of JJMH said:

The niche issue, yes that was fine if it was just a niche, right? ... they are not looking at just doing the niche. They are looking at broadening the whole range of service - they will look for the whole range of services. So it is not just a niche market⁹.

2.13. JJMH stated that it was false for the Government to say that JJMH meets the needs of people who only have medium level complex conditions. The Casemix index for JJMH (a reflection of the complexity of the treatment required by its patients) is 1.07. This compares favourably with the average Australian hospital at 1.00 and TCH at 1.10.¹⁰

⁸ACT Government, *Submission*

⁹ John James Memorial Hospital, *Transcript*

¹⁰ John James Memorial Hospital, *Submission*

2.14. There were very few services that the hospital could not provide. It did not provide an Accident and Emergency Centre and was limited, at present, in its ability to handle very complex neurosurgical, vascular and cardiological procedures. These limitations have remained because there has not been sufficient demand to justify the enormous capital and ongoing expenditure required. However, JJMH has recently taken the decision to upgrade its Intensive Care Unit to meet the needs of those patients requiring very intensive nursing and medical care.

2.15. Calvary Private Hospital is co-located in the public hospital building and provides its services from 60 beds in the specialities of medicine, surgery and obstetrics and gynaecology. The Hospital has recently opened a medical centre from which a range of specialists will operate. A private psychiatric unit comprising 20 inpatient beds and day-care facilities will open in 1988.¹¹ It is clear that there are many services offered by Calvary Private Hospital that NCPH will duplicate.

2.16. The Government's claim that the hospital will fill a niche market is, in the Committee's view, misleading. It is clear from the number of non-cardio and non-intensive care beds at NCPH, that the new private hospital will be attempting to attract business across a wide range of public and private services. This will be assisted by medical specialists with clinical practices in both TCH and the new private hospital.

Source of Patients

2.17. While NCPH will be providing many services which are offered by the present private hospitals, this would not present difficulties to Calvary Private Hospital or JJMH if NCPH could attract only privately insured patients who presently use public facilities.

2.18. In the ACT at present, if people have private health insurance, for many of the more acute health problems, their only choice for treatment is TCH. Often, and in an increasing trend, particularly in the ACT, people with private health insurance are choosing not to declare it when they go into a public hospital. Nationally, health insurance rates have fallen from 50 percent in 1984 to 33.6 percent in June 1996. The ACT, with 38 percent, has the highest level of privately insured residents in Australia. However available data indicates that only about 21 percent of those insured use their insurance. This indicates that there is a large pool of insured people choosing not to use their insurance.¹²

¹¹ Calvary Hospital, *Submission*

¹² ACT Government, *Submission*

2.19. HCoA believe that most of their patients would come from privately insured patients who currently use the public system but do not declare their insurance, third party insurance trauma cases and Veteran's Affairs patients. HCoA stated that their experience in operating hospitals elsewhere in Australia indicated that privately insured patients take the opportunity to be treated privately in a co-located private hospital. Furthermore, the Company argues that many of the services which they will offer, are not provided in any other private hospital in Canberra, which results in a significant outflow of privately insured patients to Sydney and Melbourne¹³.

2.20. Private patients occupy over 30 000 days at TCH. JJMH finds it hard to imagine that the majority of these admissions to TCH were because of the lack of service provision in the private sector. TCH data shows the most common private admissions (except those related to cardiovascular disease) to be limb fractures, normal delivery, medical back problems, gastroenteritis, and respiratory infections. These conditions can be effectively treated in the existing private hospitals. JJMH considers it highly unlikely that these patients will be treated in NCPH and will continue to be treated at TCH.¹⁴

2.21. A percentage of patients with private insurance elect to use TCH as a public patient so as to avoid the potential of having to pay out of pocket expenses as a private patient (usually a doctor's bill). These are often people who feel that if they have to be treated in TCH they will receive no benefit from their insurance. There are no figures available to determine exactly how many of these people there are, although the perception is that there are significant numbers. JJMH estimates that there might be 21 000 bed days which one could expect to be private but are in fact public. It is optimistic to believe that insured persons will automatically elect to be treated as a private patient. JJMH asserts that the majority will not want to incur potentially large out of pocket expenses, unless they are coerced into doing so.¹⁵

2.22. The Committee questions the view put by HCoA that a major source of its patients will be those privately insured patients at present using the public system. While the Committee was told that there was evidence that this has occurred elsewhere, none was provided to the Committee. It is, in the Committee's view, questionable that significant numbers of patients, who do not now declare themselves as private patients in a public hospital, might change their longstanding habits in

¹³ Health Care of Australia, *Transcript*

¹⁴ John James Memorial Hospital, *Submission*

¹⁵ *ibid*

order to enter the more expensive private hospital treatment regime of NCPH.

2.23. The Committee accepts however that there will be patients who elect to be treated in a modern co-located hospital, rather than travel to Sydney and Melbourne, as some patients now do. The Committee notes however that the attraction of Sydney or Melbourne is often the surgeon, rather than the hospital.

2.24. The Committee is concerned that the co-location of the new private hospital could lead to patients being encouraged by both direct as well as more subtle means into agreeing to treatment in the new private hospital where it will be in the treating medical specialist's business interests to do so.

Private Hospital Viability

2.25. The ACT Government contends that the viability of the private hospital has been carefully assessed by the private sector which will invest well over \$20 million initially. The two proponents who submitted detailed proposals undertook their own research and consider the new private hospital to be a viable business prospect based on no guarantee of government business. The ACT Government considers that the establishment and operation of the National Capital Private Hospital will be a positive, much needed addition to the health system in the ACT.¹⁶

2.26. According to JJMH, the building and operation of the NCPH will have a drastic effect on the viability of private hospitals in the ACT. Because of the favoured treatment that the NCPH will receive together with its ownership by one of Australia's largest companies, it is likely that it will be able to withstand low occupancies and, thus, losses for a long period of time. This may be long enough to see the demise of one or both of the current not for profit institutions.

2.27. If as stated earlier in the report, occupancy rates in the three private hospitals were to be as low as 50 percent, and if all three private hospitals were to maintain this level of occupancy, they would all find it difficult to survive. Given the advantages of co-location, the NCPH is likely to be able to maintain a higher occupancy rate. With this being the case, according to JJMH, the only option for the current operators would be to close beds and downsize. This means fewer patient beds, probably reducing to the same number that existed when only two private hospitals operated. Over time the number of private beds will not have changed - they will simply have been reallocated to the new hospital. Because of the small size of one of the current operators it is

¹⁶ ACT Government, *Submission*

likely that it would have to close but it is possible that both will be at significant risk of closure¹⁷

2.28. Calvary Hospital considered that a third hospital would have an impact but had not had the opportunity to assess the magnitude of that impact. However, in contrast to the views of John James Hospital, Calvary stated that:

...we do see that it will create an opportunity for us, in the future, to perhaps even further extend our services. There will be new visiting medical staff, perhaps available to us. If, in the future, there is a thought that public services might be tendered, then we have - we see ourselves with a golden opportunity to bid for those services. We believe we are well positioned¹⁸.

2.29. The AMA considered that the dilution of the private patients into three private hospitals would severely impair economies of scale and comprehensiveness.¹⁹

Impact on The Canberra Hospital

2.30. The ACT Government claims that it has made a firm commitment to maintaining the public health system through its three year budget projections and investment in the public health and hospital infrastructure in the ACT. The establishment of the new private hospital will enhance the opportunity for the ACT Government to focus its resources and development in the public health area, rather than continue the current situation of people with private health insurance either unnecessarily using scarce public health resources or having to travel interstate to benefit from their insurance cover.

2.31. Health Care of Australia anticipates that most of their patients will come from those currently using the public hospital system and not declaring their private health insurance, from third party insurance and Department of Veteran's Affairs patients, or those ACT residents who currently travel interstate to private hospitals. According to the ACT Government, if this occurs as anticipated, it will free resources in the public hospital to treat additional numbers of public patients. It will allow scarce public dollars to be better targeted.²⁰

2.32. The ACT Division of General Practice saw one potential benefit would be the possibility of transferring trauma patients to NCPH,

¹⁷ John James Memorial Hospital, *Submission*

¹⁸ Calvary Hospital, *Transcript*

¹⁹ Australian Medical Association, *Submission*

²⁰ ACT Government, *Submission*

thus allowing more elective surgery for those unable to access private facilities.²¹

2.33. JJMH stated that there will be some people who will take out private health insurance because they will now be able to access virtually all the hospital services they need in the private sector. This will be aided by the Federal Government's taxation rebate initiatives. This will reduce the demand on the public hospital system. If privately insured patients move from the public hospital system, a bed will be freed up for the treatment of another public patient enabling a reduction in waiting lists or a change in service provision.²²

2.34. On the other hand if the privately insured patient was being treated as a private patient, the Government will lose revenue from private insurers if another public patient fills the bed but waiting lists may be reduced or service provision changed. If the Government wishes to save money by removing private patients from the public hospital, they must close the bed that was occupied.

2.35. The Committee was told that when private maternity beds were opened at JJMH, within 12-18 months a public obstetrics ward was closed. Both the hospitals will be competing for the same private patients. The Health Services Union believe that the loss of private patients will result in a reduction in income to TCH. The replacement of private patients with public patients will only occur if the Government makes additional funds available, a proposition which the union doubts will occur.²³

Conclusions

2.36. The Committee notes that there are differing views as to the need for additional capacity in the Canberra health system, and whether these beds should be public or private. Questions such as these would have been addressed if the Government had undertaken a proper feasibility study prior to seeking expressions of interest. While HCoA has undertaken an extensive study on the viability of a new private hospital in the ACT, this information is not available to the Committee. The Committee also considers that the study undertaken by HCoA would have a heavy commercial emphasis and may not give overall community health needs the necessary priority.

2.37. On balance the Committee concludes that some additional beds may be justified, but it is not convinced that these beds need to be

²¹ ACT Division of General Practice, *Submission*

²² John James Memorial Hospital, *Submission*

²³ Health Services Union, *Submission*

provided in a new hospital. Nor is it convinced that Canberra requires the numbers of additional private beds which are proposed. The decision by the Government to proceed with the proposal was taken without proper consideration of its impact on the existing two private hospitals and flies in the face of the proper process of consultation which should have occurred given the likely dramatic effect on existing private hospital business.

2.38. In the Committee's opinion a major flaw in the Government's position relates to the effect of the move of non public patients into the private hospital. The Canberra Hospital Information Bulletin of June 1997 quantifies this at 11 percent who in turn contribute revenue to the public system. As this is the most likely group of patients who will depart the public system a considerable source of revenue will be lost, resulting in significantly increased costs to the taxpayer.

2.39. The Government and public health authorities need adequate data to ensure that limited health resources are allocated effectively. The Committee is convinced that there is only inadequate data available to ACT health authorities on bed needs, and in particular the effect of an additional 100 private beds.

Recommendation 1

2.40. The Committee recommends that the ACT Government commission an independent review of public and private bed needs with particular reference to the impact of an additional 100 bed hospital on the public and private health sectors.

2.41. The Committee notes that one justification for the provision of additional private beds was to attract private patients away from the public sector. The extra capacity so created in the public sector will enable a reduction in waiting times for elective surgery. This however will only occur if the number of beds are maintained. In the past, the transfer of beds into the private sector has led to the closure of public beds. The Committee believes that it is probable that this will occur again. The Committee questions whether or not this is the intended consequence of the co-located private hospital.

3. FINANCIAL AND EMPLOYMENT ASPECTS

Financial Implications

3.1. The ACT Government advised that it had received the best market price for the development of the hospital and long term lease of the site. The direct financial benefits to the ACT include:

\$0.5 million mandatory up front payment to reimburse the Government for the costs incurred in the process of establishing the private hospital;

\$2.1 million up front payment for a 40 year lease of site to be made in late 1997-98;

an annual indexed grant of \$100,000 for research and training purposes to TCH, and

a rental premium to 5 percent to ensure the ACT Government shares in any excess profits from the hospital.¹

3.2. In addition HCoA and Government officials advised that NCPH will purchase at commercial rates a range of hotel and diagnostic services. HCoA has entered into a \$15 million contract with Totalcare for laundry services for the new private hospital and for hospitals in NSW.

3.3. While the Committee was told that all services would be provided on a full cost recovery basis, a number of organisations doubted that this would be the case. The Royal College of Nursing, for instance, was concerned, for instance, that TCH might provide services without recovering the full cost of those services. This was primarily due to the difficulty in apportioning the overheads of large teaching hospitals such as education, research and capital costs to units of service.² The Health Services Union argued that under no circumstances should any of the services provided to NCPH be subsidised by the public sector.³

3.4. . One witness was moved to say:

... [TCH] want to do the laundry and x-ray and pathology and catering and - I do not know what - if there is going to be a fee for the medical records too and bio-medical engineering and - so you wonder at the end of the day why does the public sector not just put up the hospital and run a

¹ ACT Government, *Submission*

² Royal College of Nursing, *Submission*

³ Health Services Union, *Submission*

private hospital themselves because they are just about doing most of it now.⁴

Employment

3.5. The ACT Government stated that the construction of the private hospital will be a major stimulus to the construction sector in the ACT with an estimated 230 jobs being provided. This figure comprises 30 jobs in the first four months of construction, 80 during erection of the building (five months) and 120 during the fitout and completion stage (seven months). The Committee welcomes the jobs provided during the construction phase. The ACT Government stated that when operating, the hospital would provide up to 200 jobs either directly or through its contract arrangement. HCoA told the Committee it was more likely to be 150 jobs.

3.6. HCoA did not envisage any difficulties in recruiting suitable staff. The company expected that a number of people from outside of Canberra would be attracted to come to the city and work in the new hospital. It was thought however, that most of the staff would be recruited locally. HCoA told the Committee that:

... we have had discussions with a number of people, including specialist interested doctors and their advice is that there are not significant shortages of speciality nurses, which is really the group you are talking about, in Canberra. So, we will certainly be testing the market on that and I am quite confident that we will recruit the specialist nurses that we require to man these acute facilities.⁵

3.7. This view of the availability of nursing staff contradicts the information provided by others. JJMH told the Committee that around Australia, hospitals are finding it extremely difficult to find competent, current nursing staff. This was particularly so for the specialised areas of operating theatres and intensive/coronary care units. In JJMH's view those staff can only be acquired by enticing nurses to leave other hospitals including TCH. This has the potential to undermine the high standards of care at not only Canberra Hospital but also all other hospitals.

3.8. Calvary Hospital state that:

... we already see a market place in which it is difficult to attract nurses with particular expertise in terms of intensive

⁴ Australian Medical Association, *Transcript*

⁵ Health Care of Australia, *Transcript*

care, in terms of theatre, even sometimes obstetric services and so on ... and the expansion of services in theatres and obstetrics and intensive care and the like does pose a threat for us, not just in terms of the private hospital but also in terms of the public hospital.⁶

3.9. The Royal College of Nursing believed that unless there was an ability to recruit from interstate, there would need to be a reasonable lead in time and a real financial commitment by the new hospital to educate and train new staff.⁷

Conclusions

3.10. On two occasions the Committee requested a copy of the contract between the Government and HCoA and details of any agreements relating to the provision of services by TCH. The Government initially refused the Committee's request on the grounds that the documents were Commercial-in-Confidence.

3.11. In response to the Committee's second request the Government advised that HCoA was willing to cooperate with the Committee provided that it gave an assurance that if the contract was provided it would remain confidential. While it was expected that the contract would remain confidential to the Committee, it was not willing to give an assurance that it would not be released if its release would serve the interests of the people of the ACT.⁸

3.12. Even in these days of the national competition reform agenda, the interests of the public are not served when their elected representatives are refused access to full details of the sale of public assets and the provision of public services.

3.13. The issue is wider than the agreement with HCoA, and brings into question the fundamental right of the Assembly to scrutinise the activities of the Executive. It is unacceptable that the powers of legislatures, such as the Assembly, are reduced because of the secrecy which Commercial-in-Confidence implies. As governments increasingly move to be purchasers of services and programs rather than providers, the principles of Executive accountability will diminish unless contracts specify that the agreements may be subject to parliamentary examination. The Committee considers that this is a matter which must be addressed by the Assembly.

⁶ Calvary Hospital, *Transcript*

⁷ Royal College of Nursing, *Submission*

⁸ Minister for Health and Community Care, *Correspondence*

Recommendation 2

3.14. The Committee recommends that the Legislative Assembly request the Standing Committee on Public Accounts to examine the principle of Commercial-in-Confidence.

3.15. Notwithstanding the wider question of Commercial-in-Confidence, the Committee believes that the current arrangements between the Government and HCoA need to be examined.

Recommendation 3

3.16. The Committee recommends that the Attorney General request the Government Solicitor to examine the contract and other agreements to ensure they comply with trade practices legislation.

3.17. The Committee notes the concerns of many that the provision of services of TCH may not be on a full cost recovery basis. A substantial investment of taxpayers' money has been made in the ACT Public Hospital Redevelopment, a significant amount of which is to be made available to HCoA. In addition, a major Government revenue commitment has been made to the Canberra Clinical School which will also enhance the opportunities for HCoA.

Recommendation 4

3.18. The Committee recommends that the Auditor General examine the arrangements between the Government and Health Care of Australia to ensure that the ACT taxpayer is receiving a fair return for their investment, and

the Auditor General continue to monitor those arrangements.

3.19. The Committee accepts the views of Calvary Hospital, JJMH and the Royal College of Nursing that there are shortages of nursing staff in Canberra. The fact that HCoA holds a contrary view implies that staff will be recruited either from inter-state or from the existing hospitals. In the short term, there is a likelihood that the existing hospitals will experience difficulties in providing services because of reduced staffing levels. In terms of creating additional employment, the Committee considers that employment levels are unlikely to change as occupancy levels at Calvary Hospital and JJMH decline and staff levels are reduced, because of the competition from the new hospital.

4. EFFECTS OF CO-LOCATION

Benefits of Co-location

4.1. Experience interstate and in the ACT where public and private hospitals have been co-located, point to significant efficiencies in capital expenditure, and the benefits of economies of scale where the hospitals have contracted services from each other. The co-location of Calvary Private Hospital, for instance, allows a number of benefits to accrue in the operation of both facilities. Both hospitals share a significant range of infrastructure and management services, the cost of which is shared by each organisation.¹

4.2. In principle agreement has been reached between the ACT Government and HCoA to explore the provision of services in pathology, radiology, pharmacy, biomedical engineering, ultrasound, nuclear medicine, education, catering, maintenance and engineering, fire and safety, waste removal, stores and supply and inventory and the use of the loading dock. These services are still to be negotiated and are subject to agreement on both sides on price, volume and standards. The Committee was advised that the ACT Government will be negotiating a price that includes use of capital already invested at TCH.²

4.3. Co-location will also allow doctors to remain on campus. This will reduce doctor "down time" due to travelling and allow more patient contact. It will also mean quicker response times in case of emergencies. Having co-located public and private hospitals which both operate at tertiary or high acuity levels will also make the ACT a more attractive employment prospect to high quality health professionals who in some specialties are currently difficult to attract to the ACT. For example, the establishment of a Cardiothoracic surgical unit at TCH in the latter part of 1997 has meant that high quality surgeons and support staff will be available in this specialty in the ACT. There will also be a benefit in the area of staff training with the new private hospital providing an additional scope for the training of Registrars.³

Effect on Competition

4.5. JJMH noted that there have been a number of co-locations established already in Australia, some of which have involved HCoA. JJMH believed that the proposed Canberra co-location was different to all others currently in existence. St. George Private, Royal Melbourne Private, Royal North Shore etc were all located in major capital cities. Even where the co-located private hospital does receive some "favourable" treatment, the many other private hospitals have the benefits of a very large market available to overcome the

¹ Calvary Hospital, *Submission*

² ACT Government, *Submission*

³ *ibid*

advantages of the co-located hospital. In Canberra, there is no other market and JJMH is virtually the only competitor to the co-located hospital.⁴

4.6. JJMH believes that the advantages that have been, or are to be provided by the ACT Government to the NCPH, are unfair and unjust. They are such that competition would not be enhanced, but would be effectively destroyed. Even if the advantages are such as to raise revenue for the ACT Government that will only occur at the expense of JJMH, “a valuable contributor to the health care of the Canberra community over more than twenty seven years” and whose surpluses are reinvested in the hospital for the benefit of patients. The Hospital believed that it was:

a price that most Canberrans would feel is too high particularly when the recipient of the favours is an extremely large for profit company, which ploughs its profits back to share holders.⁵

4.7. The Committee was advised by officials that there were recognised advantages in co-location. They did not agree that that amounted to an unfair competitive advantage. They argued that the Government was quite careful to ensure that there would be no unfair competitive advantage. One official stated that in any case:

There was nothing stopping any of the private hospitals in town tendering for what was put out by government in a fair and open process as a future project that would have definite advantages both for the co-located private hospital and for the public hospital there. That is why the Government made the decision to go out to tender for a co-located private hospital.⁶

4.8. The Committee believes that this comment shows a lack of understanding of the attitudes of the existing hospitals and their assessment of the need for an additional hospital in Canberra. It suggests that consultation prior to the Government decision to seek expressions of interest was inadequate. The Government seems to have taken little account of the impact of additional competition on the existing hospitals. The Committee questions the Government’s appreciation of the commercial realities in the existing private hospitals. An examination of the business arrangements in the existing hospitals suggests that neither would be in a position to establish a new hospital at TCH site.

4.9. The Committee is also concerned with the decision to offer a building at TCH to HCoA as temporary consulting suites until the completion of suites to be located in the NCPH building. The Committee understands that the

⁴ John James Memorial Hospital, *Submission*

⁵ *ibid*

⁶ ACT Government, *Transcript*

knowledge of a new hospital housing private consulting suites may have influenced the Calvary Hospital's decision to proceed with its recently completed \$7 million facility. The Committee questions the principle of offering the temporary facilities to HCoA at a time when Calvary Hospital is seeking tenants for its suites.

4.10. JJMH's detailed concerns are shown at Appendix 3. Some of the matters which were specifically raised with the Committee are briefly discussed below.

NCPH staff in Accident and Emergency (A&E)

4.11. A member of the NCPH staff will be present in the public A&E to 'suggest' to privately insured patients that if they require admission, they be admitted to the private hospital. JJMH considers that this was potentially the grossest breach of a patient's right to elect to be treated as a public patient. It would also provide the NCPH with an advantage, which would be so enormous that it would dwarf all the other advantages of co-location.

4.12. JJMH advised that private hospitals generally accept the fact that they would lose more than a million dollars a year on establishing and running an A&E. The reason they run an A&E was because it generates somewhere between 15 and 25 percent of the admissions to the hospital:

...so what you lose on the actual running of the A&E you make up on the admissions that you get from the A&E. The problem that John James has is that there is a big line down the middle. They get the benefit from getting the admissions but do not have to pay to establish the A&E and we just think that is absolutely outrageous.⁷

4.13. Government officials agreed that there was an advantage, but access was not something denied to other hospitals. They advised that the patient would always retain the right to be moved to a private hospital if they choose to do so. TCH agreed in principle to the presence in A&E of the other hospitals, but:

It depends on how it was actually given effect ... but I think the analogy was made between the hire car companies at the airports and I would not like to think that we ended up with something of that sort.⁸

4.14. The AMA thought that one area "where things seem a bit too close" was in the accident emergency area. The AMA told the Committee that on

⁷John James Memorial Hospital, *Transcript*

⁸ACT Government, *Transcript*

one day of a recent weekend, the accident and emergency centre dealt with nearly 200 cases with people waiting for five hours. The AMA said that:

If they are being strictly honest about all this [HCoA] should have their own accident emergency ... It is not as though there is not another need for a Private Accident Emergency Centre, there is a big need for it which would take some of the load off.⁹

4.15. While visiting St George Private Hospital in Sydney, the Committee was told that transfers from Accident and Emergency at the co-located St George Public Hospital were negligible at about one per week. HCoA no longer has staff in Accident and Emergency at the public hospital. This confirms the Committee's view that the majority of patients admitted to NCPH will come from patients who would have previously been admitted to the existing private hospitals. The Committee, however, is concerned that the location of NCPH on TCH campus provides it with a distinct advantage over the other hospitals. The Committee emphasises that under no circumstances should TCH enter into arrangements concerning access to A&E which are not effectively available to the other hospitals.

4.16. A further concern is that in this new competitive environment patients may be pressured to enter a particular hospital. The Committee considers it essential that protocols be developed and published concerning the roles and conduct of private and public hospital staff in A&E.

Cardiac Surgery

4.17. It is estimated that there will be approximately 260 cardiac operations performed on public patients in TCH in the first year. This is considered by JJMH to be the absolute minimum number needed to be performed to maintain competence but will almost certainly not meet the public demand for surgery.

4.18. According to JJMH the numbers of privately insured coronary artery bypass grafts patients living in Canberra or the surrounding regions is about 165. This would indicate that the demand was insufficient to justify the private cardiac surgery facility at NCPH nor would it be sufficient to attract a private cardiac surgeon. This indicated that NCPH would have their surgery done in facilities within the public system and then their post operative recovery in the private.

4.19. JJMH believes that if this information is true, the advantages to the NCPH will be substantial. HCoA would not have to outlay the large expense normally outlaid by a private hospital for theatre facilities, equipment, specialised nursing and allied staff, coronary care, intensive care etc. but

⁹ Australian Medical Association, *Transcript*

would reap the rewards of substantial revenue from patients for their treatment.¹⁰

4.20. Government officials advised the Committee that negotiations relating to use of public hospital facilities for cardiac surgery were continuing. The officials' preferred position was that resources such as operating theatres and immediate post operative facilities should be shared.¹¹

4.21. Since the number of procedures to be performed on public patients appears to be far below the expected demand JJMH asked:

... why any extra capacity is being used to provide services to privately insured patients (patients of a private hospital) and not used to treat more public patients?¹²

4.22. HCoA was adamant however that their intention is to be totally free standing in respect to cardiac surgery. This included the use of their own theatres, the equipment to be utilised and intensive care facilities to be utilised in the post-operative phase. HCoA commented that:

... I know there has been comment in the press that we were going to undertake cardiac surgery within the public hospital facilities and I can say that is absolutely totally not our intention. And we will be having our own equipment within our hospital - the cardiac bypass pumps and the like that will be not owned by the public sector.¹³

4.23. HCoA also rejected the notion that a 160 patient throughput would be insufficient to make their cardio-vascular unit viable. They advised the Committee that data published on the outcomes achieved from units with between 150 to 250 patient throughputs showed that those units stand up to mortality rates and other indicators of the bigger units. In fact, some of the smaller units performed far better than bigger units.¹⁴

4.24. The Committee is deeply concerned that negotiations relating to the provision of Cardiothoracic Surgery, such an important feature of the ACT's public hospital system, had not been settled before the initial agreement to proceed was reached with HCoA. The Government has left itself in a poor negotiating position and this may have a negative effect on the viability of this type of surgery in the public system.

¹⁰ John James Memorial Hospital, *Submission*

¹¹ ACT Government, *Transcript*

¹² John James Memorial Hospital, *Submission*

¹³ Health Care of Australia, *Transcript*

¹⁴ Health Care of Australia, *Transcript*

Conclusions

4.25. The Committee shares the concerns of a number of witnesses about the competitive advantage provided by co-location. The Committee notes that ACT Government officials commented that Calvary Hospital and JJMH had an equal opportunity to tender for the proposal. The Committee finds it surprising that the officials see the tender process as a substitute for proper consultation. This comment ignores the tens of millions of dollars of investment at other sites in the ACT. It also ignores their concerns relating to the viability of three private hospitals in the ACT. The Committee has recommended elsewhere in the report measures to ensure that co-location operates on a proper commercial basis.

4.26. The Committee notes the comments of JJMH concerning the unfair advantage access to A&E gives HCoA. The Committee also notes the comments of the AMA concerning the need for a private A&E at TCH site.

Recommendation 5

4.27. **The Committee recommends that:**

- . The Canberra Hospital only enter into arrangements with National Capital Private Hospital concerning access to Accident and Emergency which are effectively available to the other hospitals;**
- . numbers of patients admitted to the three private hospitals from The Canberra Hospital Accident and Emergency be monitored and that data be reported to the Assembly after twelve months of operation of National Capital Private Hospital; and**
- . protocols be developed and published concerning the roles and conduct of private and public staff in The Canberra Hospital Accident and Emergency, particularly as the conduct relates to the patients' choice of admission as public or private patients.**

Wayne Berry MLA

Chair

Appendix 1

LIST OF WITNESSES

Friday 8 August 1997

Health Care of Australia

Mr Ian Ronald Thorley
General Manager
New South Wales and the ACT

John James Memorial Hospital

Dr Stephen Bradshaw
Board Chairman
Dr Maurice Macgregor Herring
Consultant.

Calvary Hospital

Mr Pat Brazil
Chairman of the Board of Management
Mr Paul Dyer
Chief Executive Officer

Department of Health and Community Care

Mr David Bruce Butt
Chief Executive
Dr Penelope Anne Gregory
Executive Director
Health Outcomes Policy and Planning

The Canberra Hospital

Mr Brian William Johnston
Chief Executive Officer
Ms Irene Dorothy McKinnon
Project Manager

Wednesday 20 August 1997

Health Services Union of Australia

Mr Paul Ingwersen
Industrial Officer.

Royal College of Nursing

Mrs Elizabeth Foley
Professional Programs Manager
Ms Jean Shelley
Member

Australian Medical Association

Dr Colin James Andrews
President ACT Branch

Appendix 2

LIST OF SUBMISSIONS

ACT Government

Australian Association of Surgeons

Australian Medical Association (ACT Branch)

Calvary Hospital ACT Incorporated

Doctors Reform Society

Garran Primary School P&C Association (Inc)

General Practice, ACT Division of

Health Care of Australia

Health Services Union of Australia, ACT Branch

John James Memorial Hospital Ltd

Pharmacy Guild of Australia - ACT Branch

Royal Australasian College of Surgeons - ACT Committee

Royal Australian and New Zealand College of Psychiatrists

Royal Australian College of General Practitioners

Royal College of Nursing

Strutt, B A

APPENDIX 3

JOHN JAMES MEMORIAL HOSPITAL - COMMENTS ON COMPETITION

Medical Consulting Rooms

The [N]CPH is advertising to medical specialists that the Canberra Hospital has provided part of a public hospital building to be refurbished so that it can be used as consulting suites, whilst the [N]CPH consulting suite building is being constructed. This is clearly designed to allow [N]CPH to try to persuade medical specialists to take up rooms on the campus at this time, in anticipation of the completion of new consulting suites next year. These specialists for the most part will have to vacate rooms at other sites to accept this offer. It is interesting to note that there is already a surfeit of medical consulting space in Canberra. It is also of significance that the JJMH lease forbids the hospital from constructing medical consulting suites on its site.

Catering

Many reports have stated that Canberra Hospital is to supply catering to [N]CPH. This will save substantial outlay by [N]CPH on both staff and equipment. Private hospitals often use the quality, choice and presentation of meals as a marketing tool, one that provides a competitive advantage over a competitor. Does this mean that the Canberra Hospital staff will be providing different meals to the patients of the [N]CPH? What message will that send to staff, public patients and the community? If there is so much spare capacity within the catering service of Canberra Hospital, why has it not been reduced previously?

Radiology Services

The [N]CPH is apparently to be able to purchase radiology services from the Canberra Hospital. Whether this includes equipment is not known. Radiology services at Canberra Hospital are currently provided by a number of full time staff specialists and two private radiologists. The two private radiologists are employed, presumably, because there is too much work for the staff specialists to cope with. The added burden of providing services to the private hospital could only be accommodated by employing more staff for the Canberra Hospital. The benefits from this arrangement would be entirely [N]CPM The Canberra Hospital would charge [N]CPH for service provision but would have to, in turn, pay for more staff of their own.

One can only assume that [N]CPH would enter into this arrangement if their costs were less than going to the open market.

JJMH has no such advantage.

Pathology and Pharmacy Services

As with radiology, [N]CPH is apparently to be able to use the pathology and pharmacy facilities of Canberra Hospital. If this is the case, the terms under which such services are to be provided should be known. The question must again arise as to whether there is such spare capacity within the current pathology service that the needs of the patients of a 110 bed private hospital can be satisfied. If so, why was the excess capacity allowed to remain, if not, will extra staff have to be employed to meet the extra demand created. A further question surrounds the provision of pharmaceuticals which are free to patients in the public hospital but which have to be paid for in other private hospitals.

MRI Services

Medical Resonance Imaging is funded by Medicare only in the public sector. When private hospital patients need MRI services, they have to use a private MRI and pay for it or take their chances and their turn at a public hospital. There is some indication that patients in the [N]CPH will be able to access the public hospital on an 'as required' basis at no cost. Such an arrangement, if it were true, would provide a major advantage to the patients of the [N]CPH over other private hospital patients.

Obstetrics

The [N]CPH is advertising in its brochures that it will provide postnatal services for private patients. This presumably means that private obstetric patients will use the facilities of the public hospital for delivery and then be moved to the private hospital. No other private hospital in Canberra has that convenience. JJMH had to spend millions of dollars to provide a full range of obstetric services. It appears that the [N]CPH will not have to undertake any of that expense and simply cream off the low cost bed days associated with postnatal care.

No mention has been made of neonatal intensive care so presumably the Canberra Hospital facilities will again be utilised if there are problems with very sick babies.

[N]CPH staff in A & E

The ACT Government has indicated that significant numbers of privately insured patients who are currently admitted to Canberra Hospital (either as private or public patients) will be admitted to the [N]CPH. This Submission has questioned that assertion except if patients are coerced.

JJMH has been informed that arrangements are being put in place for a member of the [N]CPH staff to be present in the public A&E to 'suggest' to privately insured patients that if they require admission, they be admitted to the private hospital.

JJMH hopes this information is incorrect for if it were to be correct there would be potential for the grossest breach of a patient's right to elect to be treated as a public patient under the terms of the Medicare system. It would also provide the [N]CPH with an advantage, which would be so enormous that it would dwarf all the others, alluded to in this submission.

Statistics show that where private hospitals provide a full A&E service some 18 percent - 25 percent of all admissions to the hospital originate from this service.

A comprehensive A&E is very expensive but some large private hospitals accept the expense because of the resultant admissions.

If [N]CPH can 'direct' patients to its hospital without the expense of providing the A&E service, it will potentially improve occupancy and profitability enormously.

Approval for this [N]CPH action, if it is true, would almost guarantee the success of the [N]CPH whilst condemning the other private hospitals to non-viability.

Sharing of other staff

The [N]CPH brochure indicates that they will include 'the potential to enhance registrar training positions in a variety of specialties across the campus'

JJMH believes that this can only mean that registrars in the public hospital will be used by private medical specialists in the private hospital. [N]CPH may even pay for their time.

No other private hospital in Canberra has the advantage of being able to use public hospital staff to look after private patients.

Patients are admitted to private hospitals so that their doctor of choice can care for them. JJMH and the insured community would be concerned if public hospital registrars began taking on aspects of the treatment of private patients - clearly the responsibility of the treating medical specialist. There would be even greater concern if this included performing surgery.

Cardiac Surgery

The need for cardiac surgery has long been recognised amongst the Canberra community. Successive governments have made various attempts to establish a service in the ACT. One of the major reasons that it has taken so long to come to fruition is the establishment and maintenance costs (millions of dollars) of providing the necessary facilities and equipment.

A further reason has been the uncertain demand. Without adequate demand, the costs become prohibitive, surgical, nursing and allied health staff become less safe and the ability to attract a competent cardiac surgeon becomes more difficult.

Private hospital operators are well aware of these factors and, accordingly, have only invested in providing cardiac surgery services where demand is high. There are only 12-15 private hospitals in Australia which undertake cardiac surgery and not many more public hospitals.

The ACT Government is in the process of commencing cardiac surgery at Canberra Hospital and is negotiating with a well-regarded cardiac surgeon. It is estimated that there will be approximately 260 operations performed on public patients in the first year. This is considered to be the absolute minimum number performed to maintain competence but will almost certainly not meet the public demand for surgery.

In its brochure advertising the [N]CPH, HCoA indicates that the hospital will be performing cardiac surgery.

Statistics from the Health Insurance Commission indicate the number of Coronary Artery Bypass Grafts for privately insured patients living in Canberra or the surrounding regions in 1995 and 1996 were as follows:

Coronary Artery Bypass Grafts Canberra and Regional Areas Privately Insured Patients		
	1995	1996
Canberra	92	84
Region	73	79
Total	165	163

The numbers would not indicate that the demand is sufficient to justify this cardiac surgery facility nor would be sufficient to attract a private cardiac surgeon.

In the Canberra Times recently the Chief Executive Officer of Canberra Hospital was quoted as saying:

"I believe that over the next 12 months, we will negotiate an arrangement with HCoA. It may well be that people can be admitted to the private hospital as a cardiothoracic patient, they'll have their surgery done in facilities within the public system and then their post operative recovery in the private."

If this information is true, the advantages to the [N]CPH are, again, substantial. HCoA will not have to outlay the large expense normally outlaid by a private hospital for theatre facilities, equipment, specialised nursing and allied staff, coronary care, intensive care etc. but will reap the rewards of substantial revenue from patients for their treatment. Since the number of procedures to be performed on public patients appears to be far below the expected demand, the question should be asked why any extra capacity is being used to provide services to privately insured patients (patients of a private hospital) and not used to treat more public patients.

JJMH believes that if a government was to indulge in such activity it could be rightly accused of allowing privately insured patients to 'queue jump' simply to increase revenue for the government.

Source: John James Memorial Hospital, *Submission*, pp11-15.

APPENDIX 4

DISSENT BY MR HIRD

I am disappointed with obvious bias in the majority report of this Committee. When the Committee was set up, the Government said it predicted a political sham and it was not wrong. The Chair made his dislike of the development of a private hospital clear in both his public comments and during the debate in the Assembly when the terms of reference were passed.

However, the most extraordinary turn of events has been the alliance between the Chair, the proponent of public provision of hospital care, and the John James Memorial Hospital (JJMH), the hospital which considers itself most at risk from the development of new private hospital.

The majority report has been overly influenced by JJMH and the Chair's strong ideological stance.

The committee has not done its job. Its first recommendation clearly says it did not, as it was required to do, "*inquire into the current provision of public and private beds ...*" by suggesting "*the ACT Government should commission an independent review of public and private bed needs ...*".

The ACT Government is accused of lack of consultation. To have consulted behind closed doors with the very hospitals which may have been in competition to submit a tender to develop the new hospital, as suggested in the majority report, would have been totally inappropriate.

The ACT Government went through an open, well publicised call for expressions of interest and a second stage select call for tenders, permitting the widest possible interest. I am advised that both private hospitals obtained expression of interest documentation.

Furthermore, Calvary Hospital was successful in receiving agreement to develop the soon to be completed Private Psychiatric Clinic which was advertised at the same time as the private hospital opportunity. No-one has suggested there was insufficient consultation there.

My final major concern is the lack of appreciation of the commercial environment the Government operates in and that it must be even-handed in how private sector business develops.

These matters lead me to submit this dissenting report and fundamentally disagree with the substance, conclusions and recommendations of the majority report.

Comments on the Introduction

The committee was not restrained in its inquiry as is claimed. The inquiry was agreed to by the Assembly, with the full knowledge that the Agreement to Lease had been signed.

The majority report makes a major issue about the lack of consultation with the current private hospitals about a decision to develop a co-located private hospital. I question the appropriateness of consultation when these two hospitals have a major potential business interest. The probity adviser and the selection committee made it quite clear that the Government should not appear to have any favourites in this process.

I note that a public announcement of the Government's intention to encourage a private hospital was made in July 1996 (reported in *The Canberra Times* see attachment 'A', also attachments 'B' and 'C').

Comments on Impact on Existing Hospitals

The majority report relies heavily on JJMH evidence which claims that there is insufficient demand to justify a third private hospital. It appears to discard the bed number and service demand projections provided by the Department of Health and Community Care. These projections were confirmed by the ACT Division of General Practice and Australian Medical Association.

It focuses more on an anticipated loss of business by existing hospitals, particularly JJMH. It resorts to concepts such as the need to pressure patients to use private health insurance to fit specialist business interests - does it assume this happens now at JJMH? Why should it be different for NCPH? It ignores business experience provided by Health Care of Australia (HCoA), which I think has most to lose if this venture fails.

While noting the loss of income which TCH receives from private patients, it ignores that the public system is currently subsidising these private patients.

Apparent low bed occupancy in the private hospitals is stated as a reason why the private hospital should not proceed. However, it does not compare these levels to similar national levels. It also ignores that the ACT private hospitals virtually close during weekends.

I cannot agree with the recommendation that an independent inquiry be set up to explore the impact of the additional beds provided by the private hospital.

This was the job of this committee. The available facts are before the committee, however, in the majority report, it has chosen to be waylaid by JJMH assertions and ignore both local and national evidence on bed and service usage trends.

Comments on Financial and Employment Aspects

The majority report quotes submissions made but does not come to meaningful conclusions.

The first recommendation is that the ACT Government Solicitor examine the contract to ensure it complies with the Commonwealth Trade Practices Act requirements. This has already occurred. Both the ACT Government Solicitor and a private legal consultant with access to trade practices advice were on the selection and negotiating teams and made sure the Agreement complied with all relevant legislation.

Similarly the implication that the Government or TCH would accept a less than an advantageous commercial arrangement flies in the face of the need for both to work within budgets. These budgets do not have capacity to subsidise private sector operations.

There was no evidence presented to the committee which might suggest that the government would subsidise the private hospital. In fact, in all relevant documentation, proponents were clearly advised they were not to anticipate Government business.

Comment on Co-location

This section repeats the recommendations made in the previous section and adds little to the discussion of commercial return.

The advantages of co-location are stated, however, the implication that this leads to unfair advantage is misleading. The open call for expressions of interest permitted all interested ACT parties to submit a proposal. How much fairer can the Government get?

The reference to the effect of the NCPH consulting suites on Calvary Hospital consulting suites appears to ignore that Calvary Hospital had at least two years lead time to market its consulting suites and sign up leases.

The report claims, with no evidence, that NCPH will place a staff member in the TCH accident and emergency (A&E) department to suggest admission to NCPH.

The committee was, in fact, advised that a NCPH staff would be available to assist the transfer of patients - they would not be based in A&E.

I do not agree with the requirement to report after twelve months on transfers from A&E to private hospitals to the Assembly. This will create yet another reporting system for busy A&E staff and another bit of trivial information for the Assembly, once this storm in a teacup has passed.

In relation to cardiac surgery, the majority report again appears to rely on JJMH evidence about the need for coronary artery bypass grafts (which does not conduct such procedures) and ignores HCoA evidence which runs cardiothoracic units.

It somehow assumes that the Government will subsidise NCPH (presumed) use of TCH operating theatres. This skewed presentation of evidence severely undermines the credibility of the majority report and its conclusions.

Conclusion

I do not believe that the majority report has fairly weighed the evidence. The Chair has been overly influenced by the evidence, and most often opinions, of the new private hospital's major competitor, John James Memorial Hospital, to the extent of attaching that hospital's evidence to this report.

It has not accepted the need for an impartial selection process. It suggests collusion with, and unfair commercial advantage for, local private hospitals through consultation not afforded to other potential proponents.

I do not agree with the majority report that the ACT Government has ignored the role and investment of other ACT hospitals. It has carefully considered the supply of private hospital beds in the ACT and the level of complexity of service offered by those hospitals. It found a gap and took even-handed action to fill that gap.

These factors have led to flawed recommendations which either replicate what the committee was required to do or address issues already resolved through the private hospital selection and negotiation process.

Harold Hird MLA

7 November 1997