LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Inquiry into Calvary Public Hospital Options)

Members:

MR S DOSZPOT (The Chair)
MS A BRESNAN (The Deputy Chair)
MS M PORTER

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 1 DECEMBER 2010

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 21 January 2009

The committee met at 9.03 am.

GALLAGHER, MS KATY, Deputy Chief Minister, Treasurer, Minister for Health and Minister for Industrial Relations
THOMPSON, MR IAN, Acting Chief Executive, ACT Health
THE CHAIR: Good morning, minister and Mr Thompson. Thank you for joining us this morning for this first public hearing of the Standing Committee on Health, Community and Social Services into Calvary hospital options. We will begin this morning with the Minister for Health, followed by the ACT Treasurer, who look remarkably alike, and we will move on from that point.

First off, I would like to remind you about the privilege statement. I guess I do not need to tell you more about that. You have gone through that a few times. With that, I declare this hearing open. Minister, would you like to make an opening statement?

Ms Gallagher: Thank you, Mr Chair. Yes, I would like to make an opening statement. As you know, I do not normally like to make opening statements—not long ones—but I do have one today. To go through, I guess, the history of what has brought us to today would be useful.

Firstly, I would like to thank the committee for the opportunity to talk with you today around the status of negotiations with Little Company of Mary and the future of north side public hospital services. Negotiations commenced with Little Company of Mary to basically enable us to examine the opportunities to look at how we provide health services across the ACT in order to meet our current needs but also our projected needs.

We entered into those discussions in an attempt to bring Calvary Public Hospital, operated through Calvary Health Care ACT, within ACT Health's direct management. This was based on a need to recognise and invest in the additional capital infrastructure required to deliver the additional bed capacity to meet our demand but also to improve integration and coordination of hospital services across the ACT.

It was also my objective, with my Treasury hat on, throughout this process to protect the investments that the government was going to make and the ACT taxpayers were going to make on the Calvary hospital campus. It was very clear, in advice to government, obtaining ownership of Calvary Public Hospital would have enabled us to capitalise on those investments and own those investments at the end of the day.

Those discussions continued and progressed, with the willingness of the board of Little Company of Mary and the sisters of Little Company of Mary. They started in August 2008, when ACT Health's chief executive at the time, Mark Cormack, and I met with Mr Tom Brennan to discuss the opportunities for the ACT government to buy Calvary hospital from Little Company of Mary.

From August 2008 till October 2009, those discussions progressed, with the government and Little Company of Mary in October 2009 announcing in-principle agreement to a proposal for the ACT government to purchase the hospital and for us to operate the hospital. As part of that agreement also was the transfer of ownership of

Clare Holland House to Little Company of Mary from the ACT government.

We then went through extensive public consultation, which attracted considerable opposition, particularly from stakeholders within the Catholic Church, and of course concern around the transfer of ownership of Clare Holland House. Following internal church processes and discussions, Little Company of Mary in February told the government, and I think we announced it the next day, that it would not be able to proceed with the original proposal.

From that day on, I think we had a meeting where the board informed us that they would not be able to proceed with the current proposal. We also followed with discussions about what to do next and what the opportunities were, because the situation had not changed; the demand and service requirements continued and the difficulties in investing in an asset we did not own remained as well.

I outlined to Little Company of Mary that the preferred way forward for the government, considering the withdrawal from the original proposal by Little Company of Mary Health Care, was for the territory to purchase Calvary Public Hospital but for Calvary Health Care to continue to operate the hospital under a renegotiated operating agreement which became known as the network agreement. I also tried to provide comfort to Calvary Health Care by saying that we would look to draft legislation in the Assembly which entrenched their role as operator under a model where we would own the building.

We continued to discuss this with people within the Catholic Church. I met, and the Chief Minister met, with the archbishop, Sister Jennifer Barrow, Mr Tom Brennan, Martin Lafferty from Catholic Health Australia and Father Brian Lucas, as leaders within the Catholic Church, around the opportunities for this proposal. There was support provided from those players for this proposal.

However, before proceeding to the formal signature stage of any agreement—and we were negotiating the network agreement, which was outside an ownership agreement—the territory sought advice, through Treasury, from PricewaterhouseCoopers on the accounting treatments of the draft network agreement which had been developed through the consultations. And this was through discussions with officers from Treasury. I needed some confirmation that under this model, even though we owned the building, we did not necessarily have a say about what went on in that building and that, under the accounting standards, we would demonstrate economic control of the asset, which is what we needed in order to account for the asset on our books.

That advice was sought. It coincided with the Australian Accounting Standards Board releasing an exposure draft of ED194, which I am very happy to provide to the committee if you are interested, of a proposed 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.

In May 2010, PricewaterhouseCoopers provided advice to the territory on the proposed arrangement, which was the idea that we buy the hospital, that Calvary Health Care operate it and that there be a new network agreement in place. The advice

that came back from PricewaterhouseCoopers advised that the draft network agreement that had not been signed, if signed, would result in a service concession arrangement which meant that the territory would be able to register the hospital on our accounting books as our asset, and we would not need to buy the asset in order to achieve this. This advice obviously was extremely significant and changed the course of action for both the government and Little Company of Mary.

Treasury provided a briefing to me, as the Treasurer, advising of the PWC advice that the draft network agreement represented a service concession arrangement and that the territory would be able to capitalise Calvary hospital assets without legal ownership. Given the advice and the changes it posed, Treasury then engaged PWC to provide accounting advice on the existing arrangements with Calvary Public Hospital under this new interpretation of ED194. PricewaterhouseCoopers then advised that they believed that, under the existing arrangement, there is currently a service concession arrangement in place and informed the territory that we should recognise Calvary Public Hospital as a territory asset now.

Given the magnitude of this advice and the obvious changes it posed, the office of the Auditor-General were contacted to provide a view on the current arrangements. The audit office then engaged a major accounting firm, which was not PWC, to provide them with advice on this issue and to review the advice received from PWC. Treasury and Health, at my request, met with the audit office on the draft report, and this confirmed the PWC advice that the territory can and should recognise a service concession asset.

A final report was provided in early June 2010, which confirmed that the territory could choose to recognise the service concession asset. I met with Little Company of Mary and discussed this matter with them. Obviously, it significantly changed the negotiations. I arranged the meeting to ensure that they were aware of the new advice available to the government and the implications of this advice. I wrote to them, on receipt of this advice, prior to that meeting, that the negotiations needed to stop, based on this advice.

Little Company of Mary have consistently advised me, and I think they have advised the committee in their submission to you, that they do not support or agree with this interpretation that the agreement currently constitutes a service concession arrangement. They have sought their own legal and accounting advice and they continue to inform me that they do not agree with our interpretation.

If the territory did invest hundreds of millions of dollars in building new facilities on the Calvary hospital site, under the previous advice and accounting standards in place, this would have resulted in the government gifting the facilities to Little Company of Mary and not being able to capitalise on the investment made. Obviously, this picture has fundamentally changed.

I reported to the Assembly that there are now four options available to the government. The first option is that Little Company of Mary maintain a crown lease for the land, with the establishment of a new activity funding agreement. This is quite a complicated lease-sublease arrangement of different terms and was the preferred option by Little Company of Mary.

The second option is to proceed with the service agreement in its current form. I think this is a problematic option as it will continue to create tension between the territory and Little Company of Mary around the accounting issues that I have described earlier. Basically, the parties are in disagreement about the interpretation of that.

The third option is to assist Little Company of Mary in developing a stand-alone private hospital as a public-good investment. This would allow the existing beds at Calvary that are designated for private patients to be converted for use as public patients, while still maintaining a private hospital on the north side of Canberra, which is highly desirable. If this option is to be pursued, it would be important that we would have to justify any such investments with regard to public benefit. However, it is also important to note that there will still be an interim need for the territory to purchase the additional beds required to service the public health needs of the community. This option does not directly address the accounting issues, which are of course a major focus of both parties' attention.

The final option is to build a new acute public hospital on the north side of Canberra. This would allow the arrangements for Little Company of Mary to continue to own, operate and run a hospital separate to the running of a public hospital. There are opportunities under that proposal for the territory to enter into some sort of long-term arrangement if we need additional beds on the Calvary site.

The government is currently in the process of reviewing these options, talking with Little Company of Mary and considering the most financially responsible way ahead. Due to the disagreement that exists between the parties around the accounting standards and the use of the service concession arrangement, I requested that PWC confirm their advice at the highest levels and was recently advised that they have confirmed their advice to government around the service concession arrangement.

I also acknowledge the time and effort that have been put into the negotiations over the future governance and ownership arrangements at Calvary Public Hospital by Little Company of Mary Health Care. My preferred option, and I think the government's preferred option, remains to own and operate the hospital, as this is considered the best way forward to provide an efficient and effective health system across the ACT. However, I also accept that various factors have meant that this will not proceed.

Following careful consideration of the issues raised by Little Company of Mary, the government has decided, in the interim, 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.

I held a stakeholder briefing meeting in September to discuss the four options available to the government. That was with interested healthcare stakeholders. I am happy to provide you with a list of people that attended. I do not think they will mind. I think between 15 and 20 people came to that meeting to discuss the options and what people are thinking about them. That work is running alongside this.

At the same time, we are updating all our demand projections right across the ACT

but are specifically doing a piece of work about demand for services on the north side of Canberra. One of the things we are very keen to do is ensure that some of the important criteria are met in whatever decision we take—that is, that we think there should be one tertiary-level hospital for the ACT and the surrounding region and that role is played by the Canberra Hospital.

We believe there is room for improvement in relation to enhancing rehabilitation and subacute services for the ACT. We think there are opportunities to improve and enhance the links between networked health facilities. We will be assessing and evaluating our first full year's experience of running a construction site at our current hospital, Canberra Hospital. All of these are feeding into the discussions that we are having.

I would say, in conclusion, Mr Chair—and I thank you for the indulgence of making a long opening address—the negotiations with LCM have been extremely complex and, whilst negotiations have taken time, we have not rushed into decisions which have resulted in a poor outcome. We had no idea that the accounting standards would unexpectedly change the way they did, and we are committed to identifying the most financially responsible way forward, negotiating with Little Company of Mary as a provider of 30 per cent of our public hospital system. This, of course, has created unavoidable delays.

We do need to make a decision, I think within the next five months, about what we do on the north side of Canberra, because I do not think we can take another year to consult and discuss this at length. I think the important thing at the end of the day is to ensure that the north side public hospital services are adequate for the community and that, with this opportunity, we seriously look at the opportunity to improve on the system that we have now. Thank you, Mr Chair.

THE CHAIR: Thank you, minister, for those opening remarks. I would like to make a comment on the letter we received from you apologising for the fact that your submission was rather late. You pointed out quite rightly the important subject matter and that the government needed to consider the content of the submission carefully. I presumed cabinet had considered that.

I guess it is a very brief submission and when you have a look at the content, compared to the presentation you have given to the Assembly—there are some differences and some additional information—in the main it is very much the same document. I guess I am a little surprised that it has taken so long for cabinet to consider the paper. Has the government already made a decision on which direction to take at this point?

Ms Gallagher: No, we have not.

THE CHAIR: This is as complex a document as exists at the moment?

Ms Gallagher: Obviously there is other work that underpins this. I have gone to that in my address, where I have said we are currently examining all of those options. That work has not been finalised for cabinet's consideration yet; so I am not in a position to share that with the committee. I am here to answer as much as I can, through the

committee, questions that you might have. But in terms of being able to provide to you the detailed cost-benefit analysis of each option, that work has not been completed.

THE CHAIR: Thank you, minister. Ms Bresnan?

MS BRESNAN: Thank you, chair. My question is in relation to what you have just talked about, the various options and obviously what detail we can get there. And it is about future projections for the public health system and how many public hospital beds we will need. Under the deal that would have been done with Calvary, we would have gained about 95 beds. I think that is right. It is about that?

Ms Gallagher: That is their private beds, yes.

MS BRESNAN: If there is a new hospital, it would be about 220, something around that. It is an issue which is noted in the Health Care Consumers Association's submission to this inquiry. When the paper about the future ownership of Calvary and Clare Holland House was put together, it was noted that it was believed that future demand could be met within the current two hospitals and that a third hospital was not required.

There is work being done on the capital asset development program, which goes to 2030, looking at how many beds we have currently got in the system. There is also the issue of the statement that we did not need a third hospital. A third hospital is being put forward as possibly a preferred option. How many beds do we actually require? When do we need them by? This is based on whether or not we do have that third hospital. That is what is seen as a preferred option. There are also those issues about what sort of acute, subacute and non-acute beds we actually require.

Ms Gallagher: Yes, sure. That work is being finalised and I can give you rough numbers. In terms of when do we need them by, we expect hospital needs to peak between about 2018 and 2022; that is roughly. We can provide this information to the committee.

We could manage as a two-hospital town, very clearly. I think some of the difficulties with that are under the current governance of that. If we had ownership and control of the land where Calvary hospital is currently located, we could develop that site into a second hospital which would meet all the needs of the Canberra community for the north side, between that campus and Canberra.

I guess the issue we have is that we are not in that position to develop that site or have any control over decisions that happen on that site, and that presents us with the challenge that we are currently trying to work through. So, yes, we could remain a two-hospital town. It would fully utilise the two sites that the two hospitals are currently on. It would present some challenges, as I said, from having two hospitals under construction at the same time for the same amount of time, and I think we have had considerable learnings this year from trying to manage Canberra Hospital whilst there is some fairly heavy construction work going on. So we are having a look at the impact of that. But we could absolutely live and be a two-hospital town. In a way, you could be a one-hospital town if you made Canberra Hospital big enough to service the

whole of the ACT, but it is really about, I guess, how much capacity we have as a community to direct what happens on that site.

In terms of bed numbers, I think the projections for the north side of Canberra—and it does depend a little bit on how we deal with this issue of subacute beds—are that we would probably need about 160 subacute beds. But that is not particular to the north side; that is across the city. How we manage that will dictate how many beds you need on the north side. These are some of the decisions where it is difficult to say because we have not determined how to deliver the beds. You could build a north side hospital that did all your subacute work for the whole of the ACT, plus the north side needs, and have quite a large hospital, if you see what I mean. Or you could have your subacute beds somewhere else and that would obviously reduce the need for beds in the acute hospital.

Probably the most useful thing would be to give you an idea of the beds we need across the city and—

MS BRESNAN: That would be useful.

Ms Gallagher: Yes. It is just hard to say that the north side needs this many—because we have not taken the decisions about how we would construct the facility and that then impacts on cost and design and size and all of that.

MS BRESNAN: If option 4 was pursued and having that third hospital was, say, for argument's sake, determined to be the option that was deemed the one to go forward with, has there been any examination of what would happen to acutes? If Calvary stayed there, and understanding that there are a whole lot of complications about what would then happen to Calvary if we went ahead with the third hospital, would we presume that all acute services would then go to the third hospital and that that would not remain there?

Ms Gallagher: Yes. Under option 4 that would entail a new hospital being built to service the acute needs of the north side of Canberra.

MS BRESNAN: Okay. I guess this is possibly the detail that has not been worked out too: has there been any examination of what exactly would qualify as acute services?

Ms Gallagher: Yes, there has. Some quite detailed work has been done. It has not been finalised, but you would be looking for your emergency department, surgical capacity, medical capacity, cardiac capacity, ICU.

MS BRESNAN: So basically all those services would go to the third hospital?

Ms Gallagher: Yes. And potentially—and I guess this is where we do have to come to a decision—some of the work that is projected for Canberra. If you were building a new purpose-built building, you could actually consider moving some of those things that you were going to do at Canberra to a north side hospital. 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.

Under option 4 as well, implicit in that, my thinking around that is—and this is where it does get tricky, because we would require agreement from LCM—for LCM as, I sense, a lifeline, because I have never wanted through any of this to see that hospital not function as a hospital; examine the opportunity for that to become a rehabilitation or subacute 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.

MS BRESNAN: And has there been any discussion, if that option was pursued, about if that would be funded purely through LCM's own funding, or is that something which the government would have to still provide funding to, given that you would be running the acute services in the third hospital but they would still be having this focus on rehab?

Ms Gallagher: I guess the idea I have floated with them under option 4 is that we provide a service agreement with them to operate those beds. It would mean that you would not build those beds at Canberra or, say, under option 4 a north side public hospital, which you could still do and not have any relationship with Calvary Health Care. But they also do subacute care very well. They currently run the Keaney Building. They run 2N. They have expertise in palliative care. They are a very good organisation in how they provide services.

MS BRESNAN: And they would be public services?

Ms Gallagher: Yes, under that idea it would be—

MS BRESNAN: Under that service agreement.

Ms Gallagher: We know in the public system we need about 160 subacute beds. They have either got to be built at Canberra Hospital, under option 4 a north side hospital, or through a long-term agreement with Calvary on another site. I think there are some benefits under that, but under that model they would have to agree and at this point in time I think their preference is to continue to operate an acute public hospital on that site.

MS BRESNAN: Thank you.

THE CHAIR: Thank you. Ms Porter?

MS PORTER: Yes, thank you. I just wanted to clarify something in the submission first; it is just a typo, I think, on page 3. It is in the second para, the last sentence and it says "Extensive negations". I presume that means negotiations?

Ms Gallagher: Yes, it does.

MS PORTER: Just for the record, to clear that up.

Ms Gallagher: Thank you.

MS PORTER: I also wanted to ask you if you could explain the difficulties in

relation to coordination that you mentioned in your opening remarks. You said there remained some difficulties in coordination, having the existing system that we have at the moment with the public and private hospital at Calvary and our own hospital over here in Canberra. The word you used was "coordination" and I have some difficulties around that. Could you give the committee some more information around those current difficulties?

Ms Gallagher: I would start this by saying that ACT Health and Little Company of Mary, or Calvary Health Care, have a very good relationship and manage the hospital system, to a large extent, very well on a day-to-day basis. There have been—and there will continue to be, regardless, as we move into the future with the long-term lease that Calvary have there, if governance and ownership arrangements do not change, if we do not change them substantially—some difficulties we experience, and that is really about not having a final say; we have a say, but not having the deciding say about how 30 per cent of your public hospital services are delivered.

Those complications and lack of coordination can be resolved, but it takes time and management. There is willingness between the parties to look at ways we can improve integration, but I think there is a fundamental difficulty there when 30 per cent of your public hospital beds and capacity are managed and governed by another organisation. So we can set out what we expect under our service agreement with Calvary—you must do this, you must do that—but we do not have a say about, I guess, beds opening and closing, some of the industrial disputes that occur and some of the decisions that are taken around rosters and theatres and things like that. We do not have the deciding say. That is all managed by another organisation.

I think there are also some very complex difficulties, which the Auditor-General has outlined, with the interaction between the public and the private hospital operating within the same building. Calvary Health Care have done a very good job at trying to sort of disentangle that, to ensure that public money is very transparently being provided for public services. But, because of the disentangling of that, it has actually created a whole load of inefficiencies in how they run their business, which is actually presenting them with real problems. I think the complexities are not just between us as public to the public; the complexities exist as public to the private as well—and those are not going to change while this situation remains the same.

MS PORTER: So it is not so much in, like, transferring a patient, at that practical level?

Ms Gallagher: The day-to-day stuff works very well between the hospitals, yes.

MS PORTER: That is fine. So, if a patient like that needs to go from Canberra Hospital to the public site at Calvary, that all happens seamlessly and that is not a problem?

Ms Gallagher: To the largest extent it can, yes. Another example I would give you is our IT systems, although we have made some considerable progress on that. We put in ACTPAS four years ago and at the time, despite discussions that occurred, Little Company of Mary were not willing to join in that piece of work, which meant that our hospitals do not have the same patient administration system. I think we are making

progress on that; we are working towards getting ACTPAS. We have also had some specific projects like in ICU, where there is a shared kind of access for electronic information. Again, they are problems that under other state systems, for example, just do not exist and they are certainly some of the things we would like to see change.

MS PORTER: Thank you.

THE CHAIR: Thank you. Mr Hanson.

MR HANSON: Minister, I have only received your submission just now, so I just want to clarify something. It would appear from your statement, from what I can see, that of the four options it is really coming down to two.

Ms Gallagher: Yes.

MR HANSON: The first seems unacceptable to the government and the second seems unacceptable to the Little Company of Mary. Is that a fair characterisation of—

Ms Gallagher: I think that is fair. Option 1 was put in there because it was the option that LCM provided us with. That was their response to the advice we had about the service concession arrangement.

MR HANSON: Yes.

Ms Gallagher: I have written back to them around that option, saying that it is very complex where they sublease to us their lease, essentially, and then we sublease back to them the responsibility to operate it. They disagree with this. I wrote to them and said that it appeared to me that they were seeking to avoid the service concession arrangement being considered and that I could not consider that as a legitimate option—they disagree; they say that that is not what they were intending to do—through option 1, that the Calvary hospital would remain on their books and not on ours.

MR HANSON: Yes. So we are down to—

Ms Gallagher: So that is a problem with option 1, and I can say that we would not seriously consider that because that is, I think, being constructed to get out of an accounting problem.

MR HANSON: Yes.

Ms Gallagher: We have got the options mixed up a little bit there—sorry. That is option 2 in the submission, the one that I just spoke to. Option 1 is—

MR HANSON: So essentially, we are down to the last two then. Of the other two, one is unacceptable to you and one is unacceptable to the Little Company of Mary.

Ms Gallagher: The status quo exists as an option and we just upgrade it, which is pretty much option 1.

MR HANSON: Yes.

Ms Gallagher: Option 3 is that we take over the hospital, that we assist them to build a private hospital. So that is still on the table. And option 4 is a new facility. So there are really three. Option 2 in the submission we are not considering.

MR HANSON: Yes. I just want to get my head around how we are going to sort of formulate that decision and what the time lines are. So there is a formal cost-benefit analysis now being done on each of those issues, each of those options?

Ms Gallagher: Treasury is certainly doing analysis on it, yes.

MR HANSON: But is that being done in a health context as well?

Ms Gallagher: Yes.

MR HANSON: So that is the health benefits, cost and so on?

Ms Gallagher: Yes.

MR HANSON: That then will go to cabinet, I assume?

Ms Gallagher: Yes.

MR HANSON: And have you got a time line on when that goes to cabinet?

Ms Gallagher: No, not at this stage, but the budget is pressing the timetable, I think.

MR HANSON: So you would expect that this is a budget decision for our next budget?

Ms Gallagher: I think we have to, because if we do not take a decision we will need to invest in Calvary to build a car park.

MR HANSON: Right.

Ms Gallagher: As the first stage of the redevelopment at Calvary. I do not want to spend $20-odd million on building a car park if three months later we decide to establish a new hospital.

MR HANSON: So the time pressure is less on the fact that you have got to deliver something by 2018 and more about the fact that you do not want to invest somewhere now because—

Ms Gallagher: It is more about what we need to do now. Yes. We need to start it off.

MR HANSON: All right.

Ms Gallagher: And there is the fact that if we took a decision around a north side hospital, from that decision it would be a five-year period, I would imagine, before we

had a hospital up and running.

MR HANSON: But essentially, once that decision is made, because you have stopped investing in one location, you have to start building and building up capacity pretty soon somewhere else, I assume.

Ms Gallagher: Yes. Under a new north side hospital option, you would have to maintain the current arrangements for a minimum of five years with Calvary Health Care, which would require some additional capital investment in that short term.

MR HANSON: So essentially what you would need to do, I am assuming, or what would be delivered would be through cabinet rather than just simply saying, "This is what is happening with Calvary." It would be a matter of saying that this is where we see the health system ending up in 2022, or whatever figure you pick, because you would have to see how all those bits integrate with each other. So you would say, "We are not doing this here because the subacute is going to be down south and we are going to make this a cancer centre" or—

Ms Gallagher: That is right. Everything is interlinked.

MR HANSON: So we would see that level of decision. When the decision comes and it gets put through, it will be difficult for us if it is simply a matter of saying that we are going to build a third hospital, for example, and we do not see the way the rest of it is integrated with that decision over the next few years. So you would expect to deliver that sort of—

Ms Gallagher: In a way, if a decision is made about the north side hospital, things will flow from that. In making a decision about a north side hospital you could just say, "We are going to go away and design the best, most cost-effective way to deliver that" or you could make the decision and say, "We want a 300-bed hospital with subacute facilities," and that will then dictate the detailed planning work. There is a series of decisions that need to be taken, in a way. Health is providing advice on different scenarios but, because cabinet has not taken a decision, it is hard to do all the detailed decisions that flow from that.

MR HANSON: I appreciate that but I am just trying to think of it. Part of that decision, let us say, if you were going to build a third hospital, would be that perhaps you are going to move, as you said before, some of the bits planned for the Canberra Hospital campus.

Ms Gallagher: Yes.

MR HANSON: And you put that as part of it.

Ms Gallagher: Yes.

MR HANSON: So in that sense, that would need to inform what you are doing.

Ms Gallagher: Yes.

MR HANSON: So you will have a third hospital in the north and it is going to have this piece that was previously done at or planned for the Canberra Hospital and it is going to have a focus on acute rather than subacute.

Ms Gallagher: Yes.

MR HANSON: So that is the sort of thing that you are working towards, I assume, on that option—and similarly on all of the other options as well.

Ms Gallagher: Yes. There are constraints. 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 use of that land, what could be built and how new elements of a building on that site could feed into the existing infrastructure.

MR HANSON: All right; thanks.

THE CHAIR: Thank you. Mr Smyth?

MR SMYTH: No—

THE CHAIR: Just carrying on from what Mr Hanson was exploring, obviously you are considering a lot of options and the location of the new facility if, say, option 4 is one of the options you are looking at. We have received quite a few submissions, and some of them indicate the benefit of having even a new facility in that same area because of the University of Canberra and so forth. How important will that be in your consideration?

Ms Gallagher: The community submissions?

THE CHAIR: Some of the submissions indicate, propose or suggest that, even if a new hospital was sited, it should be sited within the broad precincts of near the University of Canberra as well as the current hospital. Is that part of your consideration?

Ms Gallagher: Yes, and again that will be easier to determine. It is a chicken and egg thing. It is hard to just put all your eggs in and go, "Right; we're just going under option 4."

THE CHAIR: Sure; I understand that.

Ms Gallagher: We are negotiating with the LCM and looking at a variety of options. There has been some early work done around potential sites. Obviously, it is a large site. We would prefer the land to be not unconstrained by what is designated—so

looking for community facility land of that sort of size in that area. There are limitations on that, obviously. But any decision to build a new hospital would have to take into account access to major transport routes, time to the major hospital and opportunities for research and training. All of that will form part of a decision about a preferred site if option 4 is determined to be the way forward.

THE CHAIR: Under our terms of reference we are looking at not only the four options but any other option that may emerge.

Ms Gallagher: Yes.

THE CHAIR: At this point has any other option emerged?

Ms Gallagher: Not over the ones that we have outlined in the submission. There are always variations on a theme. There are subleasing and leasing arrangements. There are obviously different scenarios that could be constructed around how you would make the Calvary site work. I am not ruling out other options. Indeed, from some of my discussions with LCM I am sure that they are thinking of other options as well, but none that we are actively pursuing.

THE CHAIR: Are you having consultations further afield as well with other groups? You mentioned you met with 15—

Ms Gallagher: Yes. I can get you a list of them. I met with the health care consumers and I think the unions that are involved—with LCM, obviously. I am trying to think who else was around the table. We can provide you with that list, yes.

THE CHAIR: That would be useful.

Ms Gallagher: I think the Public Health Association might have been there.

THE CHAIR: I guess you have got a listing of the submissions we have received.

Ms Gallagher: Yes.

THE CHAIR: Are they roughly compatible with—

Ms Gallagher: Yes, I think so.

MS BRESNAN: Was that a roundtable meeting?

Ms Gallagher: Yes.

MS BRESNAN: It would be good to have a list.

Ms Gallagher: I just pulled everyone together to say: "This is where things are up to. You do not need to tell me what you think now, but have a think about it." I sensed that the majority of people wanted a new hospital, but I am not sure whether that is just because everyone wants a new hospital. What is bad about a new hospital? I think some of the unions have their own issues. They wanted to be under the management

of ACT Health. They have got protections now, but I think they feel that they would have more protections industrially that way. I certainly acknowledge that it is not as easy as that; it is not as easy as just saying, "We'd like one of those, thanks." There are other considerations, including our long-term relationship with LCM, to consider as part of that.

THE CHAIR: Thank you. Ms Bresnan?

MS BRESNAN: I want to go to a couple of the claims; I think they are made by LCM. I think you have mentioned their submissions, but have you seen their submissions?

Ms Gallagher: Yes, they gave me a copy.

MS BRESNAN: One of the claims which they have made is that, under the current arrangements that are in place between the territory and Calvary, even if the government decided to build a third hospital, there would still be an obligation on the government to pay for the 300 beds that are there. I am just wondering if that is something which you have looked at and if you actually agree with that statement which has been made by them.

Ms Gallagher: Yes, we have seen it. They have certainly put that to me. I do not think it is a view that we share. We have taken some advice on this. They currently do not provide a 300-bed public hospital facility.

MS BRESNAN: No, they do not.

Ms Gallagher: And we currently do not fund a 300-bed public hospital. Can you expand on that, Ian?

Mr Thompson: I would preface this by saying that we are dealing with 30-year-plus agreements, developed in a different time and place. One of the inevitable consequences of that is interpretation. As the minister said, the legal advice that we have and our interpretation are different. I think that the fact of the varying interpretations—and it is similar to the question around the accounting standards and service concession agreements—indicates that the way forward is most certainly not about strict legal interpretation and definition. It is actually about negotiating a constructive arrangement between both parties.

That is really the approach that we are trying to take. We want to get an arrangement that meets the health needs of the community and which, at the same time, is also satisfactory to both the territory and the Little Company of Mary. It is not a very direct answer to your question, but it is a consequence of the fact that we are dealing with the agreements that are now so old.

MS BRESNAN: So what you are saying is that it is not really based on what the current arrangements are as such; it is based on what will actually be the negotiated outcome. Given that they are saying this, you are saying, "We don't agree with that." It would be actually negotiating a halfway point or something.

Mr Thompson: Yes.

Ms Gallagher: And we would avoid at all costs any sort of litigious angle to this. I do not think it would be good for anyone to have these 30-year-old agreements before the courts to determine whether or not we can run a public hospital system in the ACT.

MS BRESNAN: So it is not really about removing yourself from an obligation? That is not really the question at stake here?

Ms Gallagher: The exact wording—I do not have it—is about a 300-bed hospital, isn't it?

MS BRESNAN: That is what they claim, yes.

Ms Gallagher: That is not the reality now and it has never been the reality. Obviously, there is a capacity there to provide such a hospital. I sense from LCM that they do not want to go through legal processes to deliver the outcome, but I think they have sent us the message. The message we are hearing is that they would like to continue to provide an acute public hospital service for the people of Canberra on that site. We hear that. We do not necessarily disagree with it, but there are some issues about how we can deliver that, and constraints on that site.

MS BRESNAN: One of the other claims they have made was not actually in the submission. It was in a statement which was attached to the submission which was made by the previous chair. There was this issue of economies of scale—that the ACT health system was too small to be providing, I guess, economies of scale or efficiency in terms of services, including personnel that it could attract to the ACT, and that LCM, because it was a nationwide healthcare deliverer or service provider, could provide a better economy of scale, even though it was just operating—

Ms Gallagher: Which was—

MS BRESNAN: I am just wondering what your response would be to that.

Ms Gallagher: Part of their original justification for wanting to leave the public hospital was exactly that. They said to us: "We recognise as a national healthcare provider the difficulties in running two hospitals under two different managers with two different contracts for everything. That is actually why we would like to go out and let you run them, so that you can get more economies of scale from running both public hospitals." That was one of the original discussion points.

I guess the point to be made there is that their comments were around running three acute hospitals. I agree there is no way you could run three acute hospitals. I think part of that is their belief that we have a responsibility to fund a public hospital on Calvary. If we build another campus and have TCH then we are trying to run three, and I agree we cannot run three intensive care units. 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.

I saw that one of the doctors at Calvary—Dr Peter French, a cardiologist—said in a submission that we cannot sustain three public hospitals, and I agree with him. But you could sustain quite safely, and with the same workforce and the same workforce projections that we are projecting now, two acute hospitals and a subacute campus. You could do that.

MS BRESNAN: That increase in bed numbers—I probably should have asked about this in my previous question, so I apologise—like you said, is about working out the balance. You just said acute and subacute.

Ms Gallagher: Yes.

THE CHAIR: We need to move on now, Ms Bresnan.

MS BRESNAN: Okay.

THE CHAIR: Thanks. Ms Porter?

MS PORTER: On the staffing issue, on your calculations at the moment in terms of leasing in some way the subacute at Calvary—

Ms Gallagher: That is under option 4.

MS PORTER: The staffing issue would not be an issue? We would have enough nursing staff to go across those into the future?

Ms Gallagher: Staffing is going to be an issue. There are significant workforce shortages across the board, across Australia, across the world. There will still be workforce shortages, but we are not increasing the capacity more than we will have to do on the Calvary site anyway. The expansion in services will be the same under option 1 or option 4. We will still need the same amount of beds, no matter who is running them or how they are configured. The workforce issues I think are really a non-issue in a sense, but they are a separate issue.

MS PORTER: They are a separate issue. The Calvary submission seems to indicate—although I am not quite sure whether I am reading it correctly—that they are concerned that their private hospital would suffer under option 4, possibly, and that they would be unable to continue it—that the private hospital would actually cease on the north side, and the population would be worse off.

Ms Gallagher: I do not have access to the data around their private hospital and its profitability. I have no doubt that a redeveloped public hospital on the Calvary site taking over their current private hospital within that building, and increasing services, would allow for a very—if you chose the right services to provide through your private hospital—good private business. However, there is no other private hospital operator on the north side of Canberra. The north side of Canberra needs a private hospital, so even if option 4 was pursued I cannot see how a private hospital could not operate quite profitably. But I am not involved in the running of the private hospital either.

THE CHAIR: Thank you, minister. Mr Hanson?

MR HANSON: Yes, still on option 4. When you look at both the Canberra Hospital and Calvary, they are on precincts.

Ms Gallagher: Yes.

MR HANSON: It is not just the hospital; it is everything that goes with it. If you were to build a new acute hospital on the north side somewhere, how would you see that working? Are you building a whole new campus or are you simply building a stand-alone hospital? Would you see the assets that are currently there at Calvary to support Calvary moving to the new campus, or would you see them remaining?

Ms Gallagher: I think that really is getting to a level of detail that we have not got to yet. I think it would depend on your location as the site, the particular block—what size it is—and what opportunities there are to provide other services around the hospital. It would depend very much on the location, the size of the block of land and what you were trying to achieve. For example, you could get a large block and say, "Great; there's a big slab of land there for a private hospital," but if you have still got Calvary running a private hospital on the Bruce site, would you actually want to deliver that sort of outcome anyway? In a way that would determine, I guess, the final straw for that site.

Under option 4 I think the ideal sort of outcome would be to have two functioning health precincts on the north side of Canberra. By taking a decision about the public provision of acute services, I would not want, necessarily, to seek to destroy what is currently operating on the Calvary site now just for the sake of what else you could do on that site. But, again, we have not gone to the detail of that because we have not decided to build a third hospital and we have not decided—if we did take that decision—where it would go.

MR HANSON: If I can just touch on the staff stuff as well, I know that, depending on which option you take, there is a need for additional staff. When you start thinking about a whole new hospital and maintaining what we have got at Calvary—although I accept that you might move some of the acute beds out of Calvary under your option—you are still talking about an enormous demand for staff to run the additional X number of beds. Have we got projections that suggest that it is actually achievable before we build it or before we go through any of the options?

Ms Gallagher: But the bed numbers remain the same. Under any model the bed numbers remain the same.

MR HANSON: They do, but I suppose my point is that, whatever it is—let's say we are going to take it to 1,200 beds—have we actually done the analysis to say, "Yes, we can staff this"? Although we might say we need 1,200 beds, if we know that we can only staff 1,000, are we actually building capacity for 200—

Ms Gallagher: Too many?

MR HANSON: That is right—empty beds. Is that in itself wasteful? The aspiration

might be 1,200 but, as you know, the beds are simply the bricks and mortar. What we need is the people to make it work. My concern is that we are saying that is our target and we build something—whichever option it is to build that capacity—that we can never actually achieve. We are currently having shortfalls in various areas of ACT Health right now. I am a little concerned that we would then go off and build something—whichever option it is—that looks like it is good for the future and sets up our plan, and then we find that in 2020 we simply cannot—

Ms Gallagher: There is not the staff around, yes.

MR HANSON: staff these beds and maybe the option was for something else. If the option is not in the bricks and mortar, if it is in further investment in staffing or other innovative ideas—

Ms Gallagher: Preventative health, yes.

MR HANSON: It could be more collaboration with New South Wales or whatever those options are. Are we sure that, whichever option we take, we are going to be able to staff the system that we are building here?

Ms Gallagher: We have done quite detailed workforce projections as a component of the CADP. I am certainly not sitting here saying that we will have no staffing problems. There is an international shortage of health professionals, so that is going to remain a challenge. I guess the point you then get to—to work back from what you are saying—is this: do you then under-plan what you know your need is in order to—

MR HANSON: I am talking about a quantum. If it looks like it is broadly achievable, of course there are always going to be issues going—

Ms Gallagher: I would say it is broadly achievable, yes, but the pressures that we are seeing now will continue for a period of time. Certainly by 2020 there will be a significant easing of the pressure around doctors, and that is because of all the extra places that were started a few years ago now and we are starting to see them come through.

But the other thing is that the health planning is not static. There are changes all the time. Part of the challenge, I think, in projecting forward to 2020 and 2022 and taking these decisions is that you need to look at the last 10 years of developments in e-health, at the workforce diversification that has happened—assistance in nursing, advanced allied health practitioners, assistance in allied health—at nurse practitioners, and at the sort of the diversity that has occurred just in the workforce alone. And that is partly driven by the need to deliver the workforce of the future.

There are enormous opportunities within this timetable to refine and redesign, in a way, what your needs are across the system. In chronic disease management now, we have got home monitoring going on and tele-monitoring going on. These are all things that are just starting now but in 10 years they will be very well advanced, as will electronic health records and all the rest of it. As best you can, you project what your needs are. Certainly based on the size of our community and the health demands that we can predict, the workforce needs are, to use your terms, broadly achievable

but not without some pressure.

With anything less, you are getting to this question: are you going to build the system to deal with 65 per cent of the demand or 70 per cent of the demand? Then you would start getting to some other issues about whether you meet demand.

THE CHAIR: Thank you, minister. We are reaching the end of this session. I have one final question that will not take long, I do not think, for you to answer. There was a discussion paper provided at that stakeholders meeting that you spoke about. Is it possible for you to provide us with a copy of that discussion paper?

Ms Gallagher: Yes, sure. I do not think it says a lot more than I said in the Assembly because I think it was about a week after it. No problem at all.

THE CHAIR: And were there any outcomes from that meeting that we could have a copy of?

Ms Gallagher: I think the only outcome was to just keep discussing it with people and people were aware of this committee process and the fact that they were going to remain involved and wanted to continue to be consulted.

THE CHAIR: If there is any documentation that you feel could add value to our deliberations, we would appreciate that as well.

Ms Gallagher: I am not sure. It was a pretty informal meeting but yes, I will have a look.

THE CHAIR: Thank you, minister, as Minister for Health. I think now it is time for you to put your other hat on.

Ms Gallagher: Yes.

GALLAGHER, MS KATY, Deputy Chief Minister, Treasurer, Minister for Health and Minister for Industrial Relations
AHMED, MR KHALID, Executive Director, Policy Coordination and Development Division, Treasury
HOLMES, MS LISA, Executive Director, Finance and Budget Division, Treasury

THE CHAIR: Mr Ahmed, I presume you have presented evidence to one of these hearings before, have you?

Mr Ahmed: Yes, I have.

THE CHAIR: So you are aware of the implications of your statements and—

Mr Ahmed: Yes, I am.

THE CHAIR: You do not need any further assistance on that?

Mr Ahmed: No.

THE CHAIR: We welcome you to this hearing. Minister, thank you for joining us as Treasurer for the next hour or so. I will give you the same option I gave you at the start of the meeting. Do you want to make an opening statement as Treasurer?

Ms Gallagher: Thank you, no, you have indulged me enough.

THE CHAIR: The opening question I would like to start with is: under the terms of reference, we are looking at the relative merits of the four options presented, including the financial and health impacts of these options. We have received a submission from the government but we have not received a submission from Treasury per se. Is there a submission that we can expect from Treasury regarding this?

Ms Gallagher: In terms of?

THE CHAIR: Of the hearing, of the inquiry?

Ms Gallagher: The financial analysis of the four options?

THE CHAIR: Yes.

Ms Gallagher: The answer that I gave under the previous portfolio was that work is being developed. It has not been finalised. Obviously these discussions really changed between July and September this year. It does take some time to pull together that information.

THE CHAIR: Do you have any idea as to the time frame that Treasury is working to at the moment?

Ms Gallagher: I have not seen the finished work yet. The advice will come to me. There is work underway, doing as much detail as we can about potential costs of a third hospital. We are also refreshing the work around what the costs are for the refurbishment of the existing hospital. They are really the options that remain.

THE CHAIR: We are simply trying to be fair. We will give you every opportunity for Treasury to present us with all the facts so that we can base our deliberations on that.

Ms Gallagher: Yes.

THE CHAIR: Could we leave that as an opportunity?

Ms Gallagher: Yes, absolutely. I am working with my agencies to pull together another paper. We are just not ready at the moment. I did not want to rush it and provide information which would just lead to other questions but I wanted to provide to the community information around the options as we go forward. I am very happy to provide that to the committee before I do that.

THE CHAIR: We would like to see them. Obviously we have a reasonable amount of time between now and the end of January or even the beginning of February for

that to happen.

Ms Gallagher: We will be working through Christmas.

THE CHAIR: There will be some other questions on notice coming from the committee to you as well.

Ms Gallagher: Yes.

THE CHAIR: Thank you, minister. Ms Bresnan?

MS BRESNAN: Mine is a follow-on question from that and you might not be able to answer it, given the answer you have just given about work still being done. Just waiting on that, though, under the original proposal for Calvary, about $200 million was planned for capital works. Obviously there was the $77 million for the purchase of the hospital.

Is the committee able to even get an indication, if we were to pursue, in particular, option 4, which is about constructing a new hospital, whether there would be an increase—I imagine there would be—on that original cost that was set for what was going to happen with Calvary? If there was going to have to be a service agreement with Calvary to actually provide some subacute services there, would any works still be required on that hospital site?

Ms Gallagher: We will try to provide the committee with more information as it becomes available. It is going to be very difficult to compare the cost of the original work that was done with the cost of a new hospital. Can I say that the $200 million figure I used at the time was always a minimum of $200 million. We have not done detailed work on Calvary because it is not our building.

In the CADP, we have done a lot of work on the Canberra Hospital. Calvary have been a little different because Calvary have done their own master plan themselves and we have tried to share some of that work. But that figure was a very broad-brush figure and we expect that, if we do follow that work of refurbishing the existing building and staying at the Bruce site, that figure will be larger than $200 million. We do not have a final cost.

But I think it is very difficult to compare that with the opportunity of a new hospital. For example, the blank canvas really does give you the opportunity to provide more services on that site than what you were doing under a refurbishment. You would have to look at things like six-star, green star ratings and the opportunities for sustainability measures to be put in place on a new building. Again, the opportunities would not necessarily be there in refurbishing the building.

That will be one of the challenges for the government in taking the decision. I do not think it is a straight comparison of either or because you can think more broadly under a new hospital than you can under the refurbishment. But we are doing some work in Health, and Treasury are working with Health about the cost comparison, as much as we can, between a refurbishment and a new build.

MS BRESNAN: With the CADP and the budget projections which have been made, will we then be seeing a significant reworking of the capital asset development program? Would that go ahead as planned, and then we would have a separate process for the third hospital?

Ms Gallagher: The CADP work is being updated for population projections and will be impacted on by this decision. If you could shift some more services to a new hospital, then obviously what you do at Canberra could be modified. And the opportunities between Canberra and a new hospital and Canberra and a refurbished hospital are different. Did you want to add anything, Khalid, about that?

Mr Ahmed: I had the benefit of hearing the Minister for Health in the earlier part of this hearing. As the minister said, the bed projections are being updated, and that is continuing work. How the costs will pan out underneath will depend on the configuration you get for various hospitals and how you deliver those beds. So it flows from the top. That is why we probably need to do work continuously on costing those options.

MR HANSON: I have got a follow-up on that if I can, chair.

THE CHAIR: Sure.

MR HANSON: There is a sort of bottom-up way of doing it—add all the bits together and see what it comes to for the various options—but the CADP seemed to be top down: "Right; let's look at the budget. We have got a billion; we want to spend $1 billion on health infrastructure over the next 10 years." Have we looked at what the budget pressures will allow, looking forward to 2018 or whatever the time frame is and saying, "To an extent there is always money to spend on health, but what is the parameter of what we can actually spend on infrastructure?"—and say that, between the CADP and the new hospital, between now and then, we need to spend or could have the capacity to spend $2 billion or $1.5 billion? I assume you have looked at the order of magnitude there.

Ms Gallagher: Yes.

MR HANSON: And then you are going to try and say, "Let's cut our cloth to meet that." I am just trying to work out which way it has been done.

Ms Gallagher: No; absolutely.

MR HANSON: And whether it is bottom up or top down.

Ms Gallagher: It is very much bottom up. Unfortunately the bottom up is always the most expensive way to go. You say to everybody—all our clinicians—"What do we need?" The CADP has been a very organic piece of work, and people have been very involved in it. We have identified it; we know what our service demands are going to be. The point you go to is: how do you achieve it and how do you pay for it? That is very much in the government's mind, very much in our minds.

MR HANSON: At some point Treasury looked forward 10 years or whatever and

said, “There are a lot of pressures on the budget in a lot of areas; this is but one of them. How much are we realistically going to be able to pay into this?” And having done that, what is that figure?

Ms Gallagher: Again it comes down to questions, and it is really a community discussion about what you provide? Do you provide 100 per cent of your demand to meet demand or do you provide less? If you provide 100 per cent, obviously that is going to cost more. Or do you plan for less than the provision of 100 per cent, which is what you can afford? They are very difficult discussions to have with the community. At the moment the health budget is just over $1 billion. I think it is about 30 per cent of the ACT budget. As we move forward and head to the peak levels of demand, factoring in the assumptions we make as part of the budget process, under what we know the service projection is, and depending on how you deliver that, we would see a shift and a growth in the share of the budget, in the order of about 40 per cent.

MR HANSON: That is what I am trying to extrapolate. At the moment we are talking about the detail of what we deliver. But, as you say, this is driven for the most part on what we can afford. Are you able to provide us with that, as you did with the CADP? That was essentially “Look, we are going to spend $1 billion over 10 years. This is phase 1 in a bit of detail; phase 2 is a bit fuzzy but we are going to do something similar and say, ‘Between whatever the time frame is, 2011 through to 2021, we are going to spend this amount of the budget on infrastructure.’”—and get an idea of what is beyond the current growth that is built into the health budget, the 10 per cent per year on a billion-odd dollars, and whether that is going to be taken from that for infrastructure or whether it is in addition to that.

Ms Gallagher: The growth that is built into the budget is actually growth for recurrent services; it is not the capital component at all. What we said under the CADP in our commitments around that was that this was the first phase of work, that we expected it to be in excess of $1 billion and that we would allocate money in each budget as we go through that. The first money that was allocated to Health to do this was to finish off the phasing—to say that the first phase has been done. We know that we need the women’s and children’s, the acute mental health and the car park. We need refurbishment of the community facilities. And now we are getting to the big bits of what we do about the tower block, how we provide the intensive care, where the helipad goes and all of those. That work is almost finished. We have got a briefing towards the end of December; I can talk to you some more about that. But it has not reached the point of cabinet sign-off. This is a big piece of work. It has been to cabinet at least four times in terms of discussions around the planning, the assumptions and some of the budget implications. It will continue to go back until it is finished. It is the major issue facing the ACT.

MR HANSON: If you did go to option 4, how radical would you see, potentially, the changes for the current phases of the CADP being? If you are saying that you are having problems in building at the current campus—

Ms Gallagher: We are not having problems; it is expensive.

MR HANSON: Okay.

Ms Gallagher: There would be some potential to reconfigure, but not massively because Canberra Hospital, under any scenario, must remain the tertiary referral hospital so it must have the capacity for all of the emergency surgery and intensive care. It is going to be by far the majority of inpatient beds, and it is the regional hospital. So not to a huge extent.

The issues that we have counted within this first—really what we have seen in the first full year of construction work on the Canberra Hospital campus is some increases in costs. I am not sure that we can detail exactly what those costs are—I think there will be attempts to do it, but it is early days—around OH&S, ensuring that work is done at night or away from patients, and some issues with how the site is managed at both the end sites at the moment. We are taking what we know from that and trying to project forward about what it means if we do the same work at Calvary. And also this is only touching the surface at Canberra; we have not started the major redevelopment of that hospital.

MR HANSON: So there is already a bit of a blow-out—

Ms Gallagher: I guess we are trying to learn.

MR HANSON: and we are expecting that it would continue on because of the problems—

Ms Gallagher: There is no blow-out.

MR HANSON: that you extrapolate.

Ms Gallagher: It is just that it is taking people a lot of time and effort to manage the construction projects to ensure that they are safe, that staff are protected, that patients are not disrupted. For the staff who are trying to manage this in business and infrastructure—it is a massive undertaking for them to continue. They are dealing with the doctors, the nurses, the patients and the construction workers, and everyone has a bit different—

MR HANSON: Risking the wrath of committee members, I will just ask this. You are saying that you are not characterising it as a blow-out, and that is a choice of language, perhaps; but if you are saying that it is more complicated and it is taking more time, surely this is going to lead to delays and cost increases or some consequence.

Ms Gallagher: The projects at the moment are running to budget, so I cannot say that there have been cost increases. The feedback I am getting is that, as the redevelopment ramps up, there potentially will be increases in the costs of managing the campus safely. I think that is fair enough. This community has not had this level of activity at its hospitals before; it is going to be a long process, and I want to make sure that it is all done in a safe and secure way. That may come with additional costs on a brown field redevelopment. If you look around brown field redevelopments across the country, where they are happening, you are seeing similar concerns being raised. There has not been an increase in costs at this point, but as the redevelopment ramps up we are going to have to be mindful of it.

THE CHAIR: Thank you. We will move to Ms Porter now.

MR SMYTH: Just before you finish, can I ask this. You did change your language. Up until now the CADP has been a $1 billion project. You have now said that it is in excess of $1 billion.

Ms Gallagher: I have not changed my language; I think I have always said—

MR SMYTH: I think you sold us a $1 billion project.

Ms Gallagher: that we believe it is in excess of $1 billion.

MR SMYTH: It has been sold as a $1 billion project. How much in excess of $1 billion is it now?

Ms Gallagher: That work has not been finished. It really is dependent on the decisions the government takes, which goes to Jeremy's point. If you go back and look through all of my statements around the $1 billion, you will find that more often than not I have said in excess of $1 billion.

MR SMYTH: But you do not know how much in excess of $1 billion.

Ms Gallagher: The work is being done around that and I guess it is what you compare. The in excess of $1 billion was for the first phase of the CADP. We are finishing, and part of that initial investment at the time under the CADP was to do the detailed design of the whole thing right to 2022. That work is being finalised, and we will share that with the community. It will come at a cost. It is the biggest cost facing the ACT budget and we do need a conversation about how we manage that.

MR SMYTH: But you have no idea of how much the excess is?

Ms Gallagher: I have got a figure in my head of where this is heading, but it is dependent—

MR SMYTH: May we know what the figure is?

Ms Gallagher: The difficulty I have, Mr Smyth, is that the final figure will be dependent on decisions that the cabinet has not taken. It is just not at that point. But it is not something that the government is going to hide either: this is about providing the health services for the community that our community needs. It will not be in my time when the benefits of this work are realised, but it is—

MR HANSON: I look forward to it, minister.

THE CHAIR: Thank you, minister. We will hold supplementary questions at that point. Ms Porter, no questions? Mr Hanson.

MR HANSON: I will defer to Mr Smyth. He has got a question to ask.

MR SMYTH: I have lots of questions. Minister, what advice did you ask Treasury to provide when this whole process started?

Ms Gallagher: Back to the beginning?

MR SMYTH: Yes.

Ms Gallagher: I sought a range of advice—extensive advice—on a whole range of matters. The advice I would have needed would have been about the current difficulties with investing on the site which we were experiencing through the Keaney building and the ICU and the fact that we knew we had a major refurbishment underway. We took some advice on that. My advice from Treasury was really around the financial implications of the decisions before the government.

MR SMYTH: When did Treasury advise you that, under the change to the accounting standards, you may, in fact or potentially, already own the Calvary hospital?

Ms Gallagher: They told me pretty soon after they got the advice, on 6 May.

MR SMYTH: That is the Pricewaterhouse advice?

Ms Gallagher: Yes. The advice was commissioned in, I think, late April.

MR SMYTH: And what prompted you to ask for that advice?

Ms Gallagher: Well, it was the opposite reason, actually, as it turned out. What prompted me was that we had reached a point in the negotiations where everyone was happy. We had a draft network agreement, we had all the players from LCM and the broader Catholic Church agreeing that they would sign the network agreement and that we would buy the hospital, and then they would operate it on our behalf. It had got to that point and I, in discussions with Treasury, said: "I want to make sure that we can count this on our books." The whole issue of economic control had been a part of these discussions and I had understood it, in an accounting sense, to be quite an important component in that you had to be able to demonstrate that you had economic control of the building in order to account for it on your books.

The question before me was: yes, we might own the building but do we have economic control of it? Calvary own the lease or have some rights there, but they also have the right to say yea or nay to what goes on in the building. For example, if we wanted to sell the building, could we actually do that? I had some doubts in my head. If they had a service agreement for the next 80 years enshrined in legislation, could we realise that asset which was sitting on our books?

In discussions with Treasury, I said, "We need to test this with some additional advice to give the government comfort that, at the end of this, we will pay the money and be able to capitalise our investment in it through having this asset on our balance sheet." So that was the situation which led to the advice being sought. I expected, and I think in the initial discussions between Treasury and PWC the advice was that, yes, they were comfortable. Then, while this matter was before them, this draft standard was released. So they then had a look at the impact of that and changed their advice

accordingly.

MR SMYTH: Why would the government ever want to realise the asset and sell the hospital—

Ms Gallagher: Well, you would not.

MR SMYTH: when you have just gained control?

Ms Gallagher: No, you would not. It is really a test. I guess I use that as an example of a test of being able to demonstrate economic control and that under the accounting standards that was an important test to meet, in order to account for it on your books. It is not that we ever wanted to do it, but the whole purpose of this was to be able to account for it on our books and then put the cash in, as we do in our other assets. That was the whole idea. At the end of this, if we signed the deal, paid the money and then the accountants say to me, "Well, actually, you don't have economic control, so you can't do this and it remains on their books," I think I would have looked a little bit silly. So I wanted to test that and really get some rigorous advice around it before we made that decision.

MR SMYTH: Tony Harris in his advice said that, of course, if you put the money in, you retain control. Why wasn't that enough?

Ms Gallagher: That was not the advice that we—

MR SMYTH: That was not the advice?

Ms Gallagher: And it was not the advice that we were given. This Tony Harris advice was earlier than this. That was not the advice under the current accounting standards as they operated—and, indeed, as they have operated since self-government.

MR SMYTH: When did you first become aware of the draft standard? Was that only when Pricewaterhouse told you that—

Ms Gallagher: Me personally, it was through—

MR SMYTH: Or Treasury?

Ms Gallagher: Treasury and PWC.

MR SMYTH: Is Treasury aware of how long interpretation 12 had been worked on?

Ms Gallagher: We have got some very technical advice for you now.

MR SMYTH: Thank you.

Ms Holmes: Would you mind repeating the question?

MR SMYTH: How long was Treasury aware of interpretation 12 and did you have any part in its development?

Ms Holmes: Interpretation 12 was released by the Australian Accounting Standards Board in February 2007. The interpretation actually only applies to operators of service concession arrangements. So it did not at that point in time clarify how governments are supposed to account for service concession arrangements. In fact, the AASB in December 2007 came out and said it did not automatically apply to governments. So we actually had a lack of clarity right until when this exposure draft was released in April of this year as to how governments should account for service concession arrangements.

MR SMYTH: Do we have a service concession arrangement between the ACT government and Calvary Hospital?

Ms Gallagher: Our advice is that we do. Calvary's advice is that we do not.

MR SMYTH: And what is the basis of your advice that we do?

Ms Holmes: Would you like me to work through all the accounting for you?

MR SMYTH: Yes.

Ms Holmes: I will go back a step. We do not currently have a specific standard for governments in relation to service concession arrangements. AASB 108, which is on accounting policy, says that if there is not a specific standard which is applicable, you look at, within the other Australian accounting standards, whether or not there is a similar and related standard that you can apply. So in this instance interpretation 12, being for private sector operators of service concession arrangements, is regarded as a similar and related standard. We then looked at that as the most applicable thing to apply.

The importance of the exposure draft which was released in April is that it clarified that it was the most applicable accounting treatment to apply. Prior to that, there was a lot of uncertainty, particularly given the statement that the AASB had made when interpretation 12 first came out. Also importantly, on 14 July the AASB, in its submission to the International Public Sector Accounting Standards Board, in relation to this exposure draft, supported that exposure draft and supported the principle that governments should apply the same principles as operators for service concession arrangements.

MR SMYTH: So to have a service concession arrangement, what conditions apply?

Ms Holmes: Firstly, for a service concession arrangement, you must have an arrangement between a government and a private sector operator. In this case, clearly we meet that test. The next thing is that you have to be putting an obligation on the private sector operator to basically be providing a public service. That is often an interesting test to meet. However, in this case I do not think there is really any debate within the community that the government has an obligation to be providing public hospital services. That is what the PWC advice came back very clearly with. So they are the first two tests to meet. That then says you have a service concession arrangement.

In order to actually apply the accounting in interpretation 12, you then have an additional four tests that have to be met. The government has to be able to control or regulate the service provided, to whom it is provided, at what cost and then, lastly, the government either has to have a residual interest in the asset at the end of the arrangement or the arrangement has to be for the useful life of the asset.

Walking through all of those particular tests, the first one is whether or not the government can control or regulate the service to be provided. Under the supplementary agreement which is in place, it states that basically a public hospital service has to be provided by Calvary. Do you want me to quote paragraphs?

MR SMYTH: Which supplementary agreement was that? Was it the first or the second?

Ms Holmes: The supplementary agreement between the territory and Calvary.

Mr Ahmed: Calvary Health Care.

Ms Holmes: Clause 7 of the supplementary agreement states that Calvary has to conduct a hospital in accordance with sound hospital practices and the laws enforced in the territory applicable to the hospital. Further, there is clause 3(a) of the crown lease. The crown lease was reissued in 1999 and that provides that the land can only be used for a hospital and ancillary services. So for those two combined, the advice is that that meets the test that the government controls or regulates the services to be provided.

The next test is that we have to regulate to whom the services are to be provided. Clause 16 of the supplementary agreement states that the hospital services have to be made available to all persons, irrespective of their creed or individual ability to pay. So we are basically saying that the hospital services have to be provided to anyone who walks in the door.

The last test is that we have to control or regulate the price for which that service is provided. Clause 16 also specifies that Calvary can only charge patient fees in accordance with the scale of fees determined by ACT Health from time to time. Basically, because of the clauses in the supplementary agreement, we are saying those first three tests are met.

In relation to the last test, around whether or not we would have residual ownership of the hospital or whether or not it is for the useful life of the hospital, the crown lease is for 99 years. Effectively, with the supplementary agreement, there is no end date, so it clearly meets the test that the arrangement is in place for the useful life of the hospital. So all of those things combined say that we have a service concession arrangement and that, because those last four tests are met, the territory is able to recognise the service concession asset.

MR HANSON: This is an issue that is disputed by Little Company of Mary and they provided advice from Neil Young QC and Deloitte.

Ms Holmes: Yes.

MR HANSON: I would have thought that, when you were doing your cost-benefit analysis of this, you would need to have this issue resolved, because when you are looking at all options other than option 4, this has a $200 million plus impact on the budget bottom line.

Ms Gallagher: Yes.

MR HANSON: So we need to actually resolve this, don't we?

Ms Gallagher: That would be ideal but I do not see that occurring, in the sense that the fundamental disagreement is around LCM believing that we do not have any control over what they do on that building. That is why they argue that a service concession arrangement does not exist. Our advice, the Auditor-General's advice, is that we should now be booking this asset on our books. I do not, as minister, believe that I am in a position to not accept that advice, and we will be doing just that.

MR HANSON: So you are going to do that. So you are—

Ms Gallagher: We will have to and—

MR HANSON: Sure, that is fine.

Ms Gallagher: without the agreement of LCM. I do not think there is another way for the territory to respond.

MR HANSON: I want to confirm what you are doing. So you are going to say that, on the assumptions you are making, you have ownership of the asset?

Ms Gallagher: Yes.

MR HANSON: If you then decide to pursue option 3 or anything other than option 4, you will find yourself, I imagine, in a position where we are in court over this and it is litigated.

Ms Gallagher: No, because the beauty of the accounting standards is that we can both disagree.

MR HANSON: So you can both put it on your books, can you?

Ms Gallagher: Well, in a sense. I have not asked about this because I would like to put a few more things on my own books. We could all go around doing that.

MR SMYTH: Two people can't own the same asset.

MR HANSON: Or can you?

Ms Gallagher: I have asked this question, too. The issue is for the auditors of LCM to manage. They have indicated to me that they will be retaining it on their books.

MR SMYTH: Which the Deloitte advice makes entirely clear.

Ms Gallagher: Yes, and our advice is entirely the opposite.

MR HANSON: So if you do—

Ms Gallagher: I cannot ignore our advice—

MR HANSON: No, that is fine, but have you—

Ms Gallagher: and not act in the interests of the territory. But it is a matter for our auditors. It is not a legal matter. These are accounting standards. These are not questions of law.

MR HANSON: Maybe my question is more for the accountants. Is it then feasible that you put the asset on your books, they put it on their books and we all live happily ever after?

Ms Holmes: Accounting standards are principle based, they are not rules based. So it is then up to the judgement of each individual reporting entity as to how those principles apply to the particular facts of this matter. It is not unusual to have circumstances where you have major accounting firms disagreeing with what they think the interpretation is or how those principles should apply to the facts. As the minister has stated, not only have we had PWC advice; the audit office also went out to a major accounting firm provided—

MR HANSON: Who is that major accounting firm, Ms Holmes?

Ms Gallagher: We are not allowed to say, apparently.

MR HANSON: Why aren't we allowed to say?

Ms Gallagher: Confidentiality.

Mr Ahmed: If the accounting firm was engaged by the audit office then—

Ms Gallagher: You could ask them.

Mr Ahmed: They may have the discretion to disclose it to you. By the way, we did go back again—

Ms Gallagher: It is a confidentiality agreement.

Mr Ahmed: to PWC, once we got the advice from Calvary Health Care, and asked them again to reconfirm, and also to sight the documents that they relied on in reaching their conclusions.

MR HANSON: Okay. I just want to finalise this one. Sorry if this is a bit repetitive but I just want to clarify that you have it on your books, they have it on their books

and essentially there is no consequence to that; that that is fine in terms of when our books are audited and theirs are audited, they have both got it in those books and no-one has got to change to conform with the other?

Ms Holmes: No. There is no one sort of overriding body that you can go to to rule on accounting standards, unlike the law profession. So each reporting entity has to make their own judgement and that is then reflected in your statements. It is then up to the audit office that you engage to look at your financials and reach a view as to whether or not it presents a true and fair view. There is no obligation on the audit office to go to the other audit office to have a discussion in relation to the matter, so it is very much reaching a view independent of each other.

MR HANSON: Thank you.

THE CHAIR: Thank you, Mr Hanson. A supplementary to this, Ms Bresnan?

MS BRESNAN: My question has possibly already been answered, because you said that there is no obligation then for each party to go to whomever and get it. So was there an analysis done of the advice which LCM got by Treasury?

Ms Gallagher: Yes.

Ms Holmes: Yes, we have certainly looked at it.

MS BRESNAN: Yes, but basically both parties are saying, "This is our advice; we agree with that," "This is our advice; we agree with that" and "We are both going to book the asset and that is where we stand."

Ms Gallagher: My sense of it is that we are operating on our accounting advice. In my discussions with LCM, they are actually relying on their legal advice in order to deliver an accounting outcome and it is around issues of control. This is at the heart of, I guess, the discussions. LCM cannot accept the fact that we would form the view that we had control over what goes on in their building. I have tried to explain to them that this is not us using an accounting standard in order to take more responsibilities away from them. But they are using Neil Young's advice around the control that they have to dictate what goes on and not on in their building as a way of declaring that the accounting standard does not apply.

MS BRESNAN: So, even if we were to pursue, say, option 3 where funding was provided to construct a private hospital, would there then be potential for LCM to still be exerting their control over the current building?

Ms Gallagher: Yes.

MS BRESNAN: So they would still be saying, "We can control that"?

Ms Gallagher: Yes.

MS BRESNAN: So government would possibly not have control of what services were provided there?

Ms Gallagher: Yes.

THE CHAIR: Thank you, minister. Minister, did you ask Treasury for a cost-benefit analysis of each of the various four options?

Ms Gallagher: As I think we have understood, there are probably three options that we are looking at. The second one, around the sort of complex leasing/subleasing arrangement, is there because it was LCM's preferred option, but we have informed them that that is not something that we want to pursue. I thought in the interests of the discussion that it was important to put it out there, but we are not actively pursuing that. We will take advice from the committee, but we are not actively pursuing that.

But certainly we are doing the analysis around refurbishing the existing facility with the service concession arrangement in place, a new hospital and also whether there is any public interest test or benefit from supporting the delivery of a new private hospital on that site. That is really to acknowledge that LCM are not receiving $77 million or whatever the final figure would have been. $77 million was actually the value of the buildings at that particular time, but it would have been less whatever staff liabilities and things like that. We never actually got to that point, but, anyway, because they are not getting a payment for the building, their response to government was that it will be impossible for them to invest capital in a private hospital.

If we refurbish Calvary, we need to resume the private hospital and we believe we need a private hospital on the north side of Canberra. But whether that should mean a grant or a gift to LCM to deliver that is another question which is being analysed.

THE CHAIR: So, further to my question, you have asked for a cost-benefit analysis on three of the other options then?

Ms Gallagher: We are doing further work on all three, yes.

THE CHAIR: Okay. Could the committee have a copy of that as appropriate?

Ms Gallagher: It is not finished.

THE CHAIR: I understand that—as appropriate, when it is completed.

Ms Gallagher: Yes.

THE CHAIR: Did you ask for due diligence to be conducted on the value of the Calvary Public Hospital as such?

Ms Gallagher: In terms of the original valuation? Yes, there was an incredible amount of work done. There were valuations at a hundred paces. We had our value; they had their value. We then tried to get a joint value, because the values were different, and in the end we went with the book value of the asset as a starting point for discussions. But neither of the different proposals ever reached a point where the cost was determined. The cost was always going to be the last thing determined. We never got to that point, as negotiations were finished before that.

THE CHAIR: Okay. In the interests of making sure everyone gets a question, on to Ms Bresnan.

MS BRESNAN: Thank you, chair. One of the things we have talked about this morning is the need for a level of efficiency across the hospital system and why we either need control of Calvary or have a third hospital as the best option. I am just wondering if there has been any analysis done by Treasury about what the level of inefficiencies currently are because we do not have this full integration. Is this something even that can be quantified by Treasury? There are things that can be quantified but others cannot. Has any work been done by Treasury on that?

Mr Ahmed: We have not gone about explicitly quantifying the level of inefficiency in the current structure or organisation of our hospital services. I think that is probably a task which would be quite complex. I think the question would be: what do you compare it with? We do analyse the relative level of efficiency of services in the hospital system and there is an enormous amount of data that gets published by a range of sources, like the Australian Institute of Health and Welfare and so on, and that compares the level of the unit cost across various systems.

I guess the difficulty with following that approach is: what do you compare it with? What is the organisational structure that you are comparing it with? We have not really explicitly done that. Having said that, it would not be unreasonable to think and perhaps assess that, if you organise your services differently, there would be efficiencies in the overall system.

MS BRESNAN: I guess I am probably asking the same question: has there been anything done on efficiencies then or is that the same sort of situation?

Mr Ahmed: Yes. Perhaps the pertinent question would be the effectiveness of the services as well. You could have the same number—I am just giving it as an example here to elaborate on the point—of acute beds, say X, and they are all acute. With that one configuration of your beds, you could convert some of them into sub-acute. Even if you keep the overall number the same, your flow in the system becomes better. Those are the kind of things. The permutations are enormous here around configuration, so it almost becomes hypothetical if you start looking at the possibilities. You could start with a clean slate and say: how would you design your hospital system? That is an easy way to look at it. But, given what you have, it is a complex exercise and hypothetical in some sense.

THE CHAIR: Thank you, Mr Ahmed. Ms Porter?

Mr Thompson: Could I just add that there are, however, some 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.

What that means is that, if you take the split between the acute and sub-acute that

Khalid talked about, the more you can have a specialised centre or core of a particular campus that focuses around sub-acute, generally speaking the more efficient and effective your sub-acute service delivery will be and the better it will be divided from the acute pressures that tend to dominate in hospital systems.

Similarly, when it comes to the allocation of particular acute services, and this is a directly relevant point to the current arrangements at Calvary, the more you can look at particular hospitals focusing on a core set of services where they can specialise and develop high levels of expertise, the better.

The situation we have currently got with Calvary is that Calvary tends to provide quite a broad range of services and the process of changing that is something that we need to negotiate with the Little Company of Mary. And the Little Company of Mary have other interests and other imperatives that are inevitably associated with their corporate structure and the association with the private hospital that put a countervailing view to where the territory or ACT Health might desirably want to have the services allocated. That is an illustration of the sort of issues that the current arrangements and the split management create when it comes to looking at the allocation of health services in the most efficient and effective way.

THE CHAIR: Thank you, Mr Thompson. We will move on to the next question. Ms Porter?

MS PORTER: Just to clarify what you were saying, Mr Thompson: centres of excellence are more economically viable in terms of co-locating all the things that that particular centre of excellence needs in that one site, and at the moment the Calvary hospital is not of a mind to have a centre of excellence in any particular area? Am I reading something into what you are saying there?

Mr Thompson: You are taking it a little bit further than what I was saying. I think the best way to look at centres of excellence is in fact more from the service effectiveness point of view and the efficiencies that flow from the service effectiveness. Think of a simple example: if a surgeon and the theatre nurses do knees only, they get very, very good at it and they get very, very quick at it, so what you get is a very high quality of service and you also get a high throughput of service. If you extrapolate that concept out more broadly, that is the core concept underpinning the notion that centres of excellence are both more effective and more efficient.

As it stands at the moment, the Little Company of Mary, or Calvary, have quite a broad range of acute services they provide and from the perspective of what is in the interests of the Little Company of Mary, the staff who work there and the doctors who work there, the board, the private hospital and so forth, there are a number of countervailing interests and pressures that will not necessarily—and we definitely have examples that do not necessarily—align with the territory's interests and the health planning that we would do.

What I mean is that it is not that they are resistant and they are not prepared to negotiate; it just means inevitably that each time we want to look at a change in the services it requires a negotiation process and agreement from a third party that we cannot guarantee that we can get, and therefore it does constrain our capacity to plan

and allocate services according to the planning principles that we would want to follow.

Ms Gallagher: Two examples I can give you there recently would be the fractured hips and the heart attacks. Up until a few years ago, fractured hips were being done in both hospitals. I think there were some concerns around that, because they can be very serious, particularly for elderly Canberrans or those from New South Wales who might come through Calvary and have to wait or be transferred to Canberra. So we have reached agreement that fractured hips are done at Canberra. We have reached agreement that ambulances with people experiencing a heart attack or chest pain also go to Canberra Hospital. But we have negotiated those separately with Calvary in order to deliver that outcome, to provide a safer service.

MS PORTER: Right. What I was going to suggest—sort of draw the conclusion from what Mr Thompson was saying—was that, if you have to negotiate every time around those kinds of efficiencies that you might want to achieve, that negotiation in itself is an inefficient process and wastes both time and other resources like money and you may not actually get the outcome you are looking for. Is that what you are saying?

Mr Thompson: Yes. I think that is fair.

MS PORTER: So in looking at the fourth option, a new hospital, you would be looking at which centres of excellence you would establish at the other site. Minister, would that be right?

Mr Thompson: Yes. Should we proceed with the fourth, with the option for the third hospital, yes. I will be recommending to government that what we looked at is establishing a clearer role for that hospital that focused on the needs of the local community but also the level of complexity that the hospital was established for and therefore could focus on particular types of elective surgery, for example, which would free up space at the Canberra Hospital—not to do as much elective surgery but also create the centre of excellence.

MS PORTER: Which would bring efficiencies as far as that—

Ms Gallagher: And effectiveness.

MS PORTER: And effectiveness, yes. You have got to have both. Thank you very much.

THE CHAIR: Thank you, Ms Porter. Mr Hanson, a question?

MR HANSON: I will defer to Mr Smyth.

Mr SMYTH: Minister, the Fair Work Act prescribes that there be a responsible person for a workplace. Who is the responsible person for Calvary?

Ms Gallagher: The chief executive of Calvary Health Care is my understanding.

Mr SMYTH: The Minister for Health and the Minister for Industrial Relations are

not listed as a responsible person under the act?

Ms Gallagher: I think this is an issue that Calvary has raised with me separately or that the Little Company of Mary has raised with me separately. I cannot recall exactly. Is the point around the employment status of the individuals who work at Calvary?

Mr SMYTH: I am just interested as to who the responsible person is.

Ms Gallagher: My understanding is that it is the chief executive of Calvary Health Care, but we can check.

Mr SMYTH: All right. Could you check?

Ms Gallagher: Yes.

Mr SMYTH: If you are not aware, could you also find out what the circumstances were if the Minister for Industrial Relations and Minister for Health is one of the responsible people—how that came to be?

Ms Gallagher: Yes.

Mr SMYTH: Thank you. The legal advice that the Government Solicitor's office provided on 30 October 2009 says in part B, section 6:

> The buildings or other improvements on the Calvary land are, in accordance with usual principles of law, an integral part of the land on which the buildings or improvements are situated. As the Crown lessee, Calvary has an exclusive right of possession …

And it goes on a bit. In paragraph 8 it says:

> Until the Crown lease expires or is terminated or surrendered, Calvary effectively "owns" the buildings and improvements on the land.

How are you able to include something owned by another party on your books?

Ms Gallagher: I think we have just gone through this.

Mr SMYTH: Your own solicitor does not agree.

Ms Gallagher: Exposure draft 194—this is an accounting—

Mr SMYTH: Sure.

Ms Gallagher: It is not exercising legal ownership of the building; it is demonstrating that a sort of service concession arrangement exists. It is not about legal ownership. We do not pretend we own it. We do not want to own it—we did, actually, but we know we cannot own it. This is around reflecting the accounting advice that we now have. I think that one of the people that you always go to—it might have been Tony Harris—said, "If this is an accounting problem, let the accountants fix it." The accountants have fixed it. The lawyers have not.

Mr SMYTH: Apparently not, but we will get there.

Ms Gallagher: The accountants have fixed it for us. The accountants have fixed it.

Mr SMYTH: Deloitte do not agree with the interpretation.

Ms Gallagher: That is right. I would be interested in what the opposition's view is—that the government should ignore our own accounting advice and not declare a service concession arrangement?

Mr SMYTH: I am just intrigued with the legal advice.

Ms Gallagher: And disadvantage the territory in that way. It is a surprising stand for the opposition to take.

Mr SMYTH: We are here to ask you the questions; you will get your turn to ask some questions after 2012.

Ms Holmes: Mr Smyth, it is a well-established accounting principle that we look at even when it comes to accounting the substance of the transactions. Whilst their legals are one of the considerations, it is certainly not the sole consideration. We look at all the facts of the substance of the transaction.

MR SMYTH: Was the Government Solicitor's advice of October 2009 provided to Pricewaterhouse?

Ms Holmes: Yes, it was.

MR SMYTH: You mentioned accounting standard 194. What input did Treasury have to standard 194?

Ms Holmes: The exposure draft is actually an exposure draft issued by the International Public Sector Accounting Standards Board. The ACT, as a member of HOTARAC, the Heads of Treasuries Accounting and Reporting Advisory Committee, always looks at all its major drafts which are released and provides input and comment on exposure drafts.

MR SMYTH: Did the ACT make submissions to HOTARAC over this issue during the 12 years in which it was under consideration?

Ms Holmes: The ACT certainly made a comment when HOTARAC was forming its submission to the AASB on the exposure draft.

MR SMYTH: And what did that submission say?

Ms Holmes: The ACT supported the principles contained in the exposure draft. We actually differed from the views of some of the other members of other jurisdictions. The key thing here is that a number of other jurisdictions actually formed their policy in relation to service concession arrangements prior to the release of interpretation 12.

As you can imagine, the things that they have done under private-public partnerships involve considerable dollars; they would not want to change accounting treatments that they have got in place. That was the key driver of a number of other jurisdictions who had a number of those sorts of arrangements in place and who did not want to change the treatments that they had formed prior to interpretation 12 coming out.

MR SMYTH: What was the date of that government submission?

Ms Holmes: I would have to double-check.

MR SMYTH: All right.

Ms Gallagher: Tom Brennan has raised all this with me—all of these questions that you are raising. I have gone back and had a look through the advice. I accept that LCM do not agree with our interpretation. But again I would ask you, Mr Smyth, what you would do if you were in our shoes, with two major accounting firms confirming the advice. Would you just want me to ignore all that and go and purchase the hospital? My hands on this are tied. I do not want to disagree with LCM.

MR HANSON: If you recall, we never wanted you to purchase the hospital.

Ms Gallagher: My hands on this are tied.

MR SMYTH: We questioned the purchase right from the start. When was that submission made?

Ms Gallagher: Not around the service concession.

Ms Holmes: I would have to double-check, but one key thing which is really important—

MR SMYTH: We always said this was an accounting problem.

Ms Holmes: is that regardless of—

Ms Gallagher: So you are agreeing with us then.

Ms Holmes: the overall submission of HOTARAC—

MR SMYTH: We are not saying that we do not; we are just questioning—

Ms Holmes: where, as I said, a number of jurisdictions—

THE CHAIR: Order, please!

Ms Holmes: had a different view from the ACT; they did not support the exposure draft. The AASB considered all submissions to it for the exposure draft; they have come out—regardless of the fact that some jurisdictions did not support it, the ACT did. They came out on 14 July in their submission to the International Public Sector Standards Board supporting governments applying the same principles as

interpretation 12. They considered all of that and that is their view.

MR SMYTH: So you will find that. Could the committee please have copies of all the government submissions regarding this issue?

THE CHAIR: Thank you, Mr Smyth. I have one very final question on that. Ms Holmes, are there any taxation implications for two entities listing the same assets in their financial statements?

Ms Holmes: Each entity, of course, would have to make their own considerations on tax as well as on accounting, I am not a tax expert in this, so I would not like to comment.

Ms Gallagher: We can take that on notice.

THE CHAIR: I would like an answer on that, thank you.

Ms Gallagher: Yes.

THE CHAIR: That concludes the session. Thank you, minister, for joining us in both your capacities. We thank members of your department for their attendance.

Meeting adjourned from 11.05 to 11.23 am.

MIRAGAYA, MS JENNY, Branch Secretary, ACT Branch, Australian Nursing Federation
CULLEN, MR TOM, Industrial Officer, ACT Branch, Australian Nursing Federation

THE CHAIR: I would like to welcome you, Ms Miragaya and Mr Cullen, to this first public hearing of the Standing Committee on Health, Community and Social Services inquiry into Calvary Public Hospital options. We have begun this morning with the Minister for Health and the Treasurer, so now we have the pleasure of your company. As this is your first appearance before a hearing, I will read the privilege statement to you and if you have any questions to ask, please feel free to do so:

> The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings.
>
> All witnesses making submissions or giving evidence to an Assembly committee are protected by parliamentary privilege.
>
> "Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committee and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution. Witnesses must tell the truth, and giving false or misleading evidence will be treated as a serious matter.
>
> While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

That was amended on 21 January 2009. Are you comfortable with that?

Ms Miragaya: Absolutely, yes.

THE CHAIR: Thank you. Could I ask if you want to make an opening statement?

Ms Miragaya: I have prepared an opening statement, but it relates to the written submission we submitted last Friday. The ACT ANF represents the professional and industrial interests of nurses and midwives employed within both the public and private sectors of the ACT. As stated in its written submission, the ACT ANF is supportive of option 4, as outlined in the briefing paper.

Currently, ACT public sector nursing and midwifery staff face a number of problems regarding staff and the workload at both public hospitals—the Canberra Hospital and the Calvary Public Hospital. This has been particularly prevalent at Calvary Public Hospital over recent times and has been the subject of many critical incident form notifications, correspondence, meetings with staff and management, and also the subject of discussions at both the workplace consultative committee and the agency consultative committee.

The ACT ANF is currently involved in an ongoing dispute with Calvary Health Care ACT in respect of occupational health and safety risks which may exist in relation to unsafe work practices and conditions. However, during a telephone conversation with Calvary Public Hospital CEO Mr Ray Dennis yesterday, 30 November, it would appear that some of these issues may have been resolved prior to Christmas. I have seen on my iPhone prior to coming into here that we have had a copy of a memo from Calvary that suggest this issue may be resolved commencing on Monday, 6 December.

I think this issue has been the subject of quite a number of discussions, ongoing meetings and commitments given on 1 June by the CEO, which were not met, and the subject of an ongoing discussion with staff and management on 5 November. As of 5 November it still could not be resolved. In fact, we took some actions with regard to this issue to WorkSafe ACT. Maybe that is why it is now being resolved.

It is unfortunate—but illustrative of the frustrations experienced by the ACT ANF and its members when seeking to resolve issues with Calvary Health Care—that Calvary Health Care ACT has appeared to be reluctant to participate in consultative provisions of the industrial instrument which cover all ACT public sector nurses and midwifes, whether employed by ACT Health or the Little Company of Mary Health Care ACT.

At times it has only been through seeking the assistance of WorkSafe ACT, as in the current instance—and that was a letter that we submitted on 15 November, with coloured photos of some of the issues that were related to the occupational health and safety risks at Calvary. As I said, because we have now introduced another party into those negotiations we appear to be having some resolution. Even though we have gone through the processes and have been discussing this for well over 12 months—and we had commitments given by the CEO on 1 June—up until 5 November and a meeting with management, the issue could not be resolved. Having approached WorkSafe on 15 November, it now looks like this issue will be resolved on 6 December.

We have also had to seek the assistance of Fair Work Australia in matters relating to working hours and pay and conditions. These types of issues have only been progressed and resolved because of taking action on behalf of members through these other forums. It does not appear that we can actually get them resolved through the normal industrial and consultative provisions that are applicable under the industrial instruments that cover public sector nurses and midwifes in the ACT.

At the agency consultative committee held on 19 August, the Calvary representative present at this consultative forum questioned the ability of the ACT ANF to raise staff and workload issues pertaining to Calvary at the agency consultative committee. Following a re-tabling of the terms of reference applicable to this forum at the meeting held on 16 November 2010, which state that OH&S concerns and workplace consultative committee issues can be raised at the agency consultative committee, the Calvary representative again objected to these matters being raised.

So we have had ongoing difficulty actually addressing pertinent occupational health and safety issues, work conditions and hours through the appropriate forums that are available under the industrial instrument. Because Calvary Health Care ACT is a

private company, even though it is a signatory to these industrial instruments, it considers that it is not quite often required to actually comply with those industrial instruments.

So for the ACT ANF it is of considerable concern that 30 per cent of ACT public health services are provided by a private company, a company which does not appear to consider itself bound by the consultative provisions and the mechanisms applicable to the rest of the public sector. We would be concerned if this situation were to pertain in perpetuity.

While not disputing the quality of the services provided by Calvary Public Hospital, the ACT ANF considers that the proposed new public hospital option may address a number of the industrial and consultative issues that have arisen and also ensure consistency of service provision across the ACT public health system. The ACT ANF further considers that a new purpose built hospital with a management function will closely align with the existing legislative and industrial responsibilities applying to other public sector health services and, consistent with safe work practices and related conditions, such as those currently administered by ACT Health at the Canberra Hospital, will benefit both staff and patients and the ACT community more generally.

This is an issue because, within Canberra Hospital, there is an injury management prevention system but Calvary is not party to that. Again, through the agency consultative committee, we are not provided with injury management data, OH&S infringements notifications. We are provided with that information through ACT Health through those instances that occur at ACT services, in particular at the Canberra Hospital.

The concept of a teaching hospital involving an educational partnership with the University of Canberra is an attractive option and may provide an interesting discussion in respect of a proposed site close to the University of Canberra campus as the university currently offers courses in nursing and midwifery, pharmacology, physiotherapy and other health-related fields.

Because the hospice is currently managed by The Little Company of Mary Health Care, the future management and utilisation of Clare Holland House is of concern to the ACT ANF and its members. This is particularly so in relation to its ongoing management and function, but also in respect of its relationship with a new public hospital if option 4 is implemented, and the service specialities which may be offered at the new public hospital.

In respect to the maintenance of sub- and non-acute beds at the current public hospital site, the ACT ANF considers that alternative funding and management models must be explored. This is particularly so in respect of operational control, which should be firmly vested with the ACT government, with ACT Health having absolute operational control.

THE CHAIR: Ms Miragaya, could I just interrupt you for a brief moment? Is this the same as your submission?

Ms Miragaya: It is based on it. I have almost finished, if that is all right?

THE CHAIR: I am simply thinking of you, because we have got some questions we would like to ask.

Ms Miragaya: Okay. This is especially so in respect of staffing and workload, pay and conditions of employment and other industrial matters, but equally so in relation to the fundamental clinical operational issues such as consistency of practice, protocols, policy and procedures et cetera to ensure that the public services provided by Calvary Public Hospital can be fully integrated into the ACT public health network. This will facilitate an easy incorporation of these services within the proposed local hospital network associated with the national health and hospitals network agreement.

Further, the ACT ANF considers that with the removal of acute beds at Calvary Public Hospital, as suggested in option 4, the ACT government has the opportunity to investigate the provisions of a publicly funded palliative care unit under the operation and control of ACT Health, with such services having a greater focus on rehabilitation and convalescence, as well as palliative care. The ACT ANF supports option 4 in principle, but is cognisant that there are many issues that need to be clarified and adequately addressed before progressing this option further.

The ACT ANF considers that ACT nurses and midwives are the backbone of the public health system. As such, the ACT ANF considers that adequate consultation with ACT nurses and midwives must occur if option 4 is to be progressed. Genuine consideration to ACT nurses' and midwives' concerns and suggestions must be given by the government, with these professionals playing an active role in the decision making process.

THE CHAIR: Thank you, Ms Miragaya. We also thank you for your detailed submission. Obviously a lot of thought has been put into it. We appreciate your putting that in. I think members of the committee would like to ask some questions on that. I will lead off with a couple of questions. Taking into account all that has gone on with this whole exercise, what was the earliest period when you were consulted by the ACT government on this proposal?

Ms Miragaya: I am not quite sure of the dates. It is in the submission as to when those dates were, but I think that we first were party to them on—was it 8 September that you attended the stakeholders forum? I was actually on leave and Mr Cullen attended the stakeholders forum on 8 September.

THE CHAIR: Of this year?

Ms Miragaya: Yes, of this year, and we were provided with the briefing paper.

THE CHAIR: We just got a copy of that briefing paper this morning as well. So that was the first time—

Ms Miragaya: The minister made a statement on 19 August, so we were aware of the minister's statement on 19 August. I left the country on 21 August, on election day. So we were aware of this. Then on 8 September Mr Cullen attended on behalf of the ACT ANF at the stakeholders forum at which the briefing paper was tabled and that

was provided to our branch council.

We had a branch council meeting I think on 21 September. Having had an opportunity to look at the briefing paper, the branch council requested further clarification on the options, particularly option 4, but had actually adopted option 4. They thought that would be the best option in principle. Mr Cullen wrote to the ACT health minister seeking further clarification. Those questions were included in the briefing paper that the ACT ANF provided.

THE CHAIR: The whole Calvary hospital saga has gone on for quite a while and there were a lot of discussions between the government and the hospital. You were not involved prior to September this year in any consultation with them?

Ms Miragaya: We were involved in the consultation with regards to the sale, particularly the sale of the hospice. We were opposed to the sale of the hospice, but we were supportive of the sale of the Calvary Public Hospital because, from a union perspective, we considered that ACT public health facilities should be in public hands, not in private hands. That has been a position that the ACT ANF has had since the proposed sale was mooted I think in April 2009. I am not quite sure when it first became public knowledge. So we have certainly been concerned about the future of Calvary since that sale proposal first became public knowledge.

THE CHAIR: I will pass on to my colleagues in a moment. I just have a question on the actual briefing that was conducted between the stakeholders and the government recently. Was there any outcome from that meeting that—

Ms Miragaya: This is the one on 8 September?

THE CHAIR: Yes.

Ms Miragaya: I will have to ask Mr Cullen. I did not attend.

Mr Cullen: There was no outcome that I could ascertain from the meeting. It was just a general open-up-for-discussion forum.

THE CHAIR: From your point of view, the information was provided to you and the subsequent answers that were given satisfied all of your questions?

Mr Cullen: We have yet to receive a written answer to the letter dated 24 September.

Ms Miragaya: When we followed up with telephone advice—trying to find out before we submitted the submission what were the answers to those seven questions—we were informed that those further clarification questions could not be answered until it was determined what the decision would be.

THE CHAIR: The briefing paper that was supplied to you was given to you in time for you to consult with your membership?

Ms Miragaya: We sent it to our branch councillors who represent a variety of public and private employee groups within the ACT. So it was the branch council.

THE CHAIR: And you have had time to receive feedback so you are representing the views of your constituents, shall we say?

Ms Miragaya: Absolutely—certainly through the branch council. It was the branch council that directed Mr Cullen to write to the minister on 24 September to clarify these further matters.

THE CHAIR: Thank you. Ms Bresnan?

MS BRESNAN: Thank you, Chair. One of the issues which have been discussed this morning with the health minister and Treasurer, the same person, was staffing. Whatever option we pursue, whether it is to go to a third hospital and then have Calvary as a specialist subacute facility, staffing will be an issue. Is that something the ANF have put some thought into in terms of how many staff, particularly nursing staff, are required for subacute, acute and non-acute beds and whether we have the capacity to actually expand the system to be able to provide adequate staffing for those beds? Is that something you looked into in terms of the option which you think the government should pursue?

Ms Miragaya: It is difficult because we do not really know what will happen with the current Calvary site. If there was a brand new public hospital built, there are public sector employees at Calvary Public Hospital now. If they were not to maintain the acute and subacute beds at Calvary Public Hospital, those staff would be able to be transferred to a new facility.

I do not know what the capacity is to actually staff both hospitals. I do know that we have had problems finding a staffing methodology within the public sector. We have had a project in the last agreement to look at nursing hours per patient day. Again, one of the difficulties we have had with Calvary Public Hospital being run by a private company is that, 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. So it is hard to extrapolate those figures and we are still trying to benchmark those for a less acute hospital at Calvary Public site.

I am aware that the new graduates who completed their education at the end of this year were unable to be fully accommodated within the new graduate program at the Canberra Hospital and in fact a number of those graduates are only being offered part-time employment so that they could have a bigger number of new graduates participate in the program because there was simply not the ability to offer full-time employment to all graduates there. As we are producing graduates, I would think that there may be a workforce available.

I am aware that at the Ipswich hospital in Queensland, where they had 40 new graduate positions available—I will have to verify the facts—there were 800 applicants for the new graduate program. My colleagues in Tasmania tell me that they are a net exporter of new graduates because, although they are producing new

graduates through their university system, they are unable to provide them with employment within Tasmania. So there is a workforce available there. In New South Wales, they have been unable to provide all of their new graduates with employment within New South Wales.

I think that there may be an untapped resource of new graduates who may be available if those additional resources were required within a new public hospital if it were to be built in northern Canberra.

MS BRESNAN: You have probably already answered this question but I will ask it. There is an acceptance of nurse-to-patient ratios now and possibly we have that capacity which would not negatively be impacted potentially by whatever option was pursued? I think one of the things the minister said this morning in terms of what might be a preferred option was that, if they were pursuing a third hospital, acute services would move there and that potentially the existing Calvary site would have a subacute focus or would specialise in particular elective surgery. Do you think the patient-to-nurse ratios there could be maintained or—

Ms Miragaya: It would vary because nurse-patient ratios are not in fact what is available in the ACT. We are looking at nursing hours per patient day. So you look at someone's clinical need and determine how many nursing hours are required to provide the nursing care of that particular patient. But it would still work out to a ratio. It is a crude figure but it would be determined by the acuity and skill mix. It will be determined by the acuity of the patient loads.

If you have a complex, high-care patient in an acute tertiary centre, you are going to probably require more nursing hours per client per patient day than if you were in a subacute or less acute environment where somebody who is convalescing would not require the same number of nursing hours inputted into their care per day as somebody who was in an acute tertiary hospital.

THE CHAIR: Thank you. Ms Porter?

MS PORTER: Thank you, Chair. I want to go to those difficulties that you were describing when you were reading your statement about the matters that finally had to go to WorkSafe. Are these incidents that you were concerned about ones that have impacted on patient care, are they injuries to nurses, are they a mixture of both, are some allied staff being involved or—

Ms Miragaya: There is a mixture of both. It was in one of the particular medical wards at the Calvary Public Hospital. This particular ward had a mixture of acute medical patients and GEM patients, which are geriatric patients requiring assessment. But because we have only got one geriatrician currently in the ACT, rather than having 13 acute medical and 10 GEM patients, that number of less acute patients was changed so that there were only really two GEM patients and the rest were all acute medical on this particular ward. And the ward has been increased to 24 beds. Of that, 22 of them were acute medical. So there were difficulties with the client load because the establishment was related to having less acute patients in that ward when in fact they had acute medical patients in that ward.

The ward had a mixture of patients with vancomycin resistant enterococcus and methicillin resistant staphylococcus aureus; so we had MRSA and VRE patients there who required isolation. Some of those patients, particularly the VREs, I think there were two of them, were wandering patients. They were putting other clients at risk. We had insufficient staff to actually meet the workload. So there was an issue with regard to the staffing and the skills mix, which affected both the patients and staff.

There was a problem with regard to terminal cleaning within the ward because curtains, both at the windows and around the beds, were removed because they needed to terminally clean them because of the VRE and the MRSA. But there were insufficient replacements. So we had patients who had no curtains on the windows complaining that they could not sleep because it was light and we had bedspreads nailed above. There were no curtains around the patients for privacy. We had sheets sort of tacked around them so that we could try to maintain privacy for the patients.

There was an issue with the carpet, whether or not carpet was in fact a good form of floor covering to have, particularly when you have got VRE and MRSA patients accommodated within the ward. That was difficult. And the carpet was torn and lifting in places. So it was an occupational hazard for people walking over it, tripping over it, as well as the infection risk of having things that may not be readily cleaned, whereas if you had lino you could wash the floor.

There were issues with regard to the provision of wardsmen to assist with lifts and moves, and sometimes they were not replaced. So you had nursing staff having to move patients, even though there is a no-lift policy in place throughout ACT Health. There were problems with regard to one particular patient there. I think he was 160 kilograms and a paraplegic, but trying to move him on a lifter over carpet was a significant risk to the nursing staff because pushing a lifter over carpet causes occupational health and safety risks.

There was the inability to provide replacement ward clerks so that the staff were having to answer the telephone. There was the inability to provide a discharge planner so that, on top of their other workloads, they were having to do those things.

There were a number of issues related to both the patients and staff. We had one particular instance where a client, a patient, became quite disoriented and distressed, quite aggressive, and frightened a number of the patients on the ward. During the day shift and the evening shift, that patient was specialled. There was no special provided for the night shift. This happened on two occasions. After the patient had frightened the staff—in fact one of my members was actually assaulted—eventually, after two nights of having no special, this client was specialled.

There are a number of ongoing issues with regard to occupational health and safety issues and WorkSafe issues.

MS PORTER: Your point in relation to your recommendation of option 4 with provisos is that you still have not had some of your questions answered because that work has not been completed. With regard to your recommendation, one of the things that are concerning you is the difficulty that you have in resolving these particular issues. Are these issues, therefore, easily resolved if or when they arise? I am quite

sure they do arise in the Canberra Hospital setting. I want to ask you: is this influencing your recommendation?

Ms Miragaya: The issue is that when we have critical incident notices provided to us by members from the community, from Mental Health and from the Canberra Hospital, we have some action taken. We have had significant issues with regard to ACT Mental Health, and this has been an ongoing problem with staffing and the workload. Again, occupational health and safety issues are being addressed, particularly with the City Mental Health team and the number of staff employed in that team. But it has in fact been recognised and addressed, and there is some recognition that there is a problem and there are processes in place.

With Calvary hospital, when we have raised these issues, if the critical incident form has not actually been sent to the manager—and sometimes our members do not want to be recognised or identified—then the issue is that it is past and it cannot be addressed. So it is not investigated. We have come with these issues and raised them. All the staff on this particular ward I have just outlined—every one of those staff, members and non-members alike—had sent a letter to the CEO demanding action. And there was a meeting held with the CEO on 1 June to address these issues. A number of commitments were made. None of those commitments or very few of those commitments were actually fulfilled.

We had a further meeting on 5 November, at which they at least acknowledged that there was a problem and that those commitments had not been met. But there was still no ability to address those issues that had been raised since the beginning of the year and provided commitments to on 1 June by the CEO. By 5 November, they still had not been addressed, which is why we then actually put in a submission to ACT WorkSafe. But one would have thought that that could have been addressed at an earlier time.

MS PORTER: Yes, but my question was: is that influencing—

Ms Miragaya: That does, because when we go to the agency consultative committee we are told that these issues cannot be addressed through that forum, where we have terms of reference that are listed. And when we go there with those issues related to ACT Health and similar issues with regard to one particular ward at the Canberra Hospital, which had been raised at the agency consultative committee, and with mental health issues, they have been allowed to be addressed and explored and looked at as resolutions to those problems through those forums.

But it appears that Calvary Health Care, because it is 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 reporting of occupational health and safety incidents through the injury management prevention system. Those stats are not provided to the agency consultative committee. It is the same with protocols.

MS PORTER: Thank you very much.

THE CHAIR: Thank you, Ms Miragaya. We are running out of time. There is time

for one brief question from Mr Hanson.

MR HANSON: I am right. I think I have got everything, given the time.

Ms Miragaya: One issue I would like to raise is this—and I have said it with regard to policies, procedures and protocols: prior to being in this position I was a midwife at Calvary. The problem for me is that there has not always been consistency with policies, procedures and protocols across the service. If you had someone in Calvary who was in premature labour, you had a different protocol and a different procedure for managing premature labour. It took about five years to actually get the consistent protocol with regard to the provision of steroids, anti-tocolytics and salbutamol infusions and those sorts of things.

Once we finally got the protocol up and running, because there were two different facilities, even though we had the same protocol, you could not just take out the cassettes for the equipment when you went from Calvary hospital to TCH. You had to change all the plumbing for the infusions. If you had the same policies and protocols across the system, that would be consistent for the patients. It is the same for the information that you provide for patients. It would be consistent across the system.

THE CHAIR: I should remind you that we are here to evaluate the relative merits of the four options. It is a little outside the scope of this committee but it certainly is background information and we thank you for that.

Ms Miragaya: I do think that having consistency of policy, procedures and protocols is the way to go. I certainly know from my medical colleagues their difficulty with regard to the provision of particularly female-related services within the ACT public sector. It is certainly constrained because that service, even though it is providing a public service funded by the ACT government, cannot provide a full range of services and is required then to utilise the Canberra Hospital.

THE CHAIR: We thank you for presenting that information to us.

Ms Miragaya: Thank you.

THE CHAIR: Thank you very much for coming to talk to your submission. You will get a full transcript of what was said today and, if there is anything further that you feel that you want to bring to the attention of the committee, we would welcome any such further submission.

Ms Miragaya: Thank you very much.

COX, MS DARLENE, Executive Director, Health Care Consumers Association of the ACT
STEVENS, DR ADELE, President, Executive Committee, Health Care Consumers Association of the ACT

THE CHAIR: We welcome you to this first public hearing of the Standing Committee on Health, Community and Social Services, inquiring into the Calvary Public Hospital options. So far today, we have met with the Minister for Health and the Treasurer. We welcome you now to this hearing. Have you appeared before hearings before?

Dr Stevens: Yes, we have.

THE CHAIR: Are you aware of the privilege statement that you have?

Dr Stevens: Yes.

THE CHAIR: You do not need me to read that to you? You are quite comfortable with it?

Dr Stevens: We are quite comfortable with it and we have it here to remind us.

THE CHAIR: Excellent. Thank you very much for joining us here. Dr Stevens, can I ask you to make an opening statement?

Dr Stevens: Yes. The Health Care Consumers Association welcomes the opportunity to make a submission to the Standing Committee on Health, Community and Social Services. We have had extensive consultations with our members regarding the sale of Calvary hospital since September last year and we have drawn on input following these consultations for our submissions.

The Health Care Consumers Association was formed 30 years ago to provide a voice for consumers for local health issues and now provides opportunities for healthcare consumers to participate in all levels of health service, planning, policy development and decision making.

The government has indicated that there is a need to enhance public hospital facilities on the north side of Canberra to accommodate the growing health needs of our population over the next 20 years. We do not see that there is a need to replicate the Canberra Hospital in north Canberra and we are yet to be convinced of the need for a third acute public hospital. We base this on the government's clinical service plan and on our knowledge of the health service plans and the capital asset development process. We believe that the main focus of care needs to be in the primary health setting and that therefore a sub-acute facility, supported by primary health care centres, would better meet the needs of the Canberra community. This is consistent with a key element in the recommendations of the National Health and Hospitals Reform Commission's final report about expanding sub-acute services.

But I must say that we have in-principle support for option 4. We would not see it as a

hospital like TCH, but we see a need for sub-acute facilities and we think that we need to do a bit more work on exactly how we do that. We consider that a sub-acute facility rather than an acute hospital would supplement the new enhanced primary healthcare centres that are being planned for Belconnen and Gungahlin. That planning is well on its way. This would include rehabilitation, geriatric evaluation and management services, transition care and other step-up, step-down facilities.

We see great potential in building a sub-acute facility on the University of Canberra grounds to make useful connections with the faculties of health science and provide clinical placements for students as well as meeting the unmet need in our community. That would provide for clinical placements of students in areas including, but not limited to, nursing and midwifery, pharmacy, physiotherapy and psychology. This is consistent with the forecasts we have seen that identify an increased need for rehabilitation services. This would complement the medical education that currently takes place in public and private hospitals in the ACT with the ANU Medical School.

The National Health and Hospital Reform Commission also stated that we need to ensure that we have an appropriately trained workforce—and this is a concern of ours—able to deliver this expansion in sub-acute facilities. We see that a sub-acute facility built in north Canberra would develop our workforce as well as provide much-needed services to our community.

Sub-acute services play an integral role in the healthcare continuum, supporting patients to maximise their independence and functioning and, in doing so, minimising long-term health and community care needs; they are fundamental to improving effective and seamless care services across the continuum.

We are of the view that the same concept applies to people living with mental illness. We think there is a potential for this facility to contribute to multidisciplinary community-based sub-acute services that are effectively linked with and complement hospital-based mental health services. We will leave the details up to our colleagues in the Mental Health Community Coalition and Mental Health Consumer Network—to provide more details on these benefits and how that can be realised.

We accept that the government has an opportunity to reconsider health service for Canberra in light of the recent changes to Medicare locals and local hospital health and hospital networks, medical education and the GP superclinic. We want to stress that a superclinic does not necessarily need to be limited to general practice. It may be a GP superclinic by name but not necessarily by function. It can include a range of sub-acute facilities.

Thank you for the opportunity to address you.

THE CHAIR: Thank you very much, Dr Stevens. I note from your submission that you have had extensive consultation since September 2009. Did you also take part in the stakeholders meeting that the ACT government held?

Dr Stevens: Yes; I was present at that.

THE CHAIR: Did you get any further information or any new information out of that

meeting?

Dr Stevens: What we got out of that meeting was some discussion of the options paper, which was later circulated. Our discussion at that meeting was that we really needed to move on with this and consult the community more widely. We recommended or suggested at that meeting that we should go out to our organisations with that options paper. The government did agree with that, and we did circulate it to our members. This is an issue for the whole community.

THE CHAIR: Sure. Is there a time frame that you have been given that I would expect some response from you by?

Ms Cox: No firm time frame—just within a few months. We have a meeting with the minister on 14 December. At that meeting we will go through our proposal with her and give our thoughts on the options.

THE CHAIR: Are there any questions that you are waiting to get answers on at this point?

Dr Stevens: This morning? At this meeting?

THE CHAIR: Not at this meeting—at the meeting that you held with the stakeholders.

Dr Stevens: We did raise in our submission, as you will see, a number of areas where we think we need more information.

THE CHAIR: Was that raised at the stakeholders meeting as well? Did you have the opportunity to do that?

Dr Stevens: I think there was the opportunity, but at the beginning it was a time when we were getting new information. Up until that stage the government had not been talking about those options. It was a beginning discussion about where we go to from now. Since then we have been thinking about what additional information we need.

Ms Cox: Especially as we have been contemplating the role of the superclinic and the commitment of the funds for the superclinic. We have been thinking about medical education around the local hospital network, Medicare locals. There has been incredible activity around health and the way services can be delivered. As our thinking has developed on that, our thinking around the future of public services for the north side has also developed.

THE CHAIR: Thank you very much. Ms Bresnan?

MS BRESNAN: Thank you. One of the things we have discussed this morning, and you have discussed it in your opening statement and your submission, is how services should be structured around the acute services and sub-acute services. I want to get a clear understanding from your perspective, and this is again looking at Calvary specifically, because that is what we are looking at here, of what you consider to be acute services—which services provided at Calvary you consider to be acute services

and whether those services should actually stay in that location in Calvary.

Ms Cox: Our thinking to date has been that the services that Calvary could continue to reasonably provide to the community would be around elective surgery, intensive care and possibly emergency department services. We think that many of the other services that are provided at Calvary could fit within a sub-acute facility—rehabilitation, geriatric assessment and midwifery services. And we think that a sub-acute facility on the University of Canberra grounds could include an expanded community midwifery program using a midwife-level of care to follow low-risk pregnancies. Then high-risk pregnancies might be able to continue at Calvary. It could be that it is part of the service funding agreement between the government and the Little Company of Mary to work out the cost for that.

MS BRESNAN: Would I be correct in saying then that, while you believe that government should be expanding to meet growth and that there are benefits that come with public ownership, you are concerned about what the scale of a third option will be, particularly on the north side?

Ms Cox: Yes.

MS BRESNAN: We have heard Ms Gallagher as Treasurer and as Minister for Health this morning. One of the things she noted was that what is possibly being considered if they do go for a third hospital is that acute services would be focused there and Calvary would then potentially have a sub-acute focus, potentially also with certain elective surgeries. What would your views on that particular option be, given that that is a kind of variation on what you are saying? You are sort of saying that we would have the acute services in Calvary and then have a sub-acute. What they are suggesting is almost the opposite—the flip side of that. What would be your views on that?

Ms Cox: Calvary already has the infrastructure for intensive care and operating theatres. One of the options, in terms of the health dollar being stretched already, would be to make use of those resources rather than constructing new ones and then letting Calvary use that campus as a private hospital and having the government purchase those services from the hospital. So 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.

MS BRESNAN: This might be outside what you have been considering, but do you have any thoughts on how the current operational requirements at Calvary or the current operational environment might impact on the provision of those sorts of services, particularly acute services?

Ms Cox: No. We do not get access to that sort of information.

MS BRESNAN: Fair enough.

Ms Cox: I suppose what it demonstrates is that, while we have in-principle support for the fourth option of a new hospital, we are not necessarily agreeing with the minister on what shape that will take. We do think that there still needs to be a lot

more clarity around it. What we would like to know is what is at the heart of the agreement with the Little Company of Mary that the government must continue and what is the obligation that will go on for the next 80 years or more? Then we can get a sense that we are tied to Little Company of Mary to provide these services and look at how we can best meet the needs of the Canberra community in other ways.

MS BRESNAN: Thank you.

THE CHAIR: Ms Porter?

MS PORTER: Obviously the main aims of your association are about meeting the needs for health care and representing the needs of health consumers. You were listening just now to what the ANF was talking about and their difficulty in actually making sure that the needs of health consumers are met in some areas in regard to the agreement that happens to be under a private company.

Are your recommendations about acute services versus sub-acute? One of the examples they gave was that a particular ward had a lot more acute than there would normally be and that the balance, in their opinion, and apparently from the agreement, was the wrong balance.

Also there was an issue of transferring patients. For instance, if you maintain the emergency services, obviously some patients will be transferred, because they will go to the wrong place—say for a heart complaint, for instance, where they should have been sent somewhere else. Even though patients are recommended to get an ambulance, they will still come in their own car or be driven to an emergency service with chest pains. So there are those kinds of transfer issues. And there are the different treatments for premature babies, an issue which now appears to have been resolved but which has been a longstanding issue.

What would your response, on behalf of your health consumers, be to those issues that the ANF were really concerned about that you heard—and also the different operational difficulties. You did not hear the minister talk about the different operational difficulties that they currently had in trying to ensure that there is a seamless service for all patients in regard to having to go from one hospital to another for necessity. I do not suppose that you have been able to discuss those particular issues because you may not have had access to that information before.

Dr Stevens: I guess it comes back to the issue of we supported the transfer of Calvary hospital to the public sector, we supported the sale, and it was for a lot of those reasons that were talked about by the ANF representative—that we see problems in the transfer from a hospital that has different protocols to TCH. We would really like to see seamless transfer. Darlene, do you want to say anything more about that?

Ms Cox: No, but just support the intent of what Jenny Miragaya was saying in terms of it is a quality and safety issue and it goes to the heart of what is related to the options with Calvary. We need consistent policies. We need staff who are moving between them to understand what to do in each setting, agency staff included. We need standard operating procedures to be consistent. When a consumer who may have complex needs is normally dealt with at Calvary, they know how to deal with it there.

But their families go with them to the Canberra Hospital and all of a sudden things are a bit different. 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.

MS PORTER: In relation to that, I still cannot understand your recommendation that acute services continue to be provided at that site. It does not—

Ms Cox: But it is elective; it is planned admissions. Similarly, too, at the moment the government is using other private hospitals in town to complete public surgery, to address the elective surgery waiting lists, and it would be a similar thing. If you can plan for the admission and people know that their episode of care will take place there, that is fine. The issues are when you get more complicated cases that need to move from one hospital to another.

Dr Stevens: And that is where we see things go wrong when—

MS PORTER: But you would still maintain the emergency services; emergency ward would still be there?

Ms Cox: We have not developed our firm view on that because in fact the Garling report of New South Wales talked about the need to minimise the number of emergency departments in New South Wales or in the Sydney metropolitan area. Given that we have got a north side, south side town, I would be a very brave person indeed if I suggested we just had one emergency department at the Canberra Hospital for our population. But it could be that we do not have an emergency department at Calvary—and this is all part of the conversation we need to have as a community—and maybe we have an urgent stream, similar to what we have talked about in our submission about Melton Health, that deals with those people with the more minor issues. So the message you get through to the community is: if you are unwell, you call an ambulance. Then the ambulance is able to take you either to the Canberra Hospital or to Calvary for stabilisation before moving on. So there is a range of options around emergency department and one of them is potentially an urgent stream in a sub-acute facility.

MS PORTER: Thank you very much.

MR HANSON: Without going through the detail unnecessarily of exactly what it comprises, your call for more sub-acute facilities I think is a focus more on preventative and community care and separating the acute from sub-acute. Is that then the sort of priority, and then I guess the way in which that is delivered or the location in which that is delivered become the subordinate issues?

I just want to get around that because there are some very complicated ownership arrangements that we are all aware of—whether it is done at Bruce or at the Canberra Hospital; there are some arguments there. But basically what you are saying is that we need more sub-acute and you could build that potentially at the Bruce precinct or you can build it somewhere else—and then who owns it? You prefer public but you can see a way that it can be done by private ownership of the public facilities. So what you are saying really is: let us get the service right, which is an increase in sub-acute

facilities, and then there are some ways in which you can develop that. Is that right? Is that what you are saying?

Ms Cox: Yes. The other part of that which we would put down are priorities around making use of the health professionals in training at the University of Canberra.

MR HANSON: Yes.

Ms Cox: I think that is a real opportunity to provide more care for our community, more student placements, more student clinics.

MR HANSON: Indeed, but, given that Bruce is not actually that far from the University of Canberra, whether it needs to be co-located I guess is a subordinate question in some respects. I just wanted to make sure that that was your thinking on that.

Dr Stevens: In following with our support of the transfer of Calvary to a public facility, we are certainly much more in favour of having a public facility than enhancing facilities at Calvary.

MR HANSON: And I understand that. We have got to deal in realities as well. That seems to be an argument that in some ways has been and gone and now we are dealing with what we are dealing with, which is that Calvary is likely to remain there in one form or another and what is the best way to utilise it, I suppose.

I have a second question. You talk in your submission about the culture of care of Calvary that is brought forward by some of your consumers. Would you suggest that is a real thing? Certainly, anecdotally, it is something that I have been advised of—that there is a real culture of care and an ethos at Calvary. In your experience is that a reality or is that anecdotal?

Ms Cox: It is also to do with the size of the hospital. It is a Tier 2 hospital so it is not a tertiary referral. There are more medical cases, there are more sub-acute cases there and so the pace of life on a ward in Calvary on a good day is a much nicer place to experience. So, yes, there is the Calvary ethos, and many people in our membership and our community value that very much. But we would say that that is more of a function of the facility.

MR HANSON: Okay.

Dr Stevens: More a function of the type of facility that it is. If you had a similar type of facilities that was not run by the Little Company of Mary, you could also have a similar ethos.

MR HANSON: So if it is smaller and less acute you are likely to get a more pleasant workplace and more ability to focus on patient care and—

Ms Cox: That is right. And we know that when there is patient-centred care you have got higher staff retention rates, lower incidence of OH&S complications in the workplace and high staff satisfaction rates.

MR HANSON: So that is, in a way, an argument to separate the acute and sub-acute so that sub-acute patients, say, turning up at the Canberra Hospital do not find themselves in that acute environment. That is a large part of your argument I take it?

Ms Cox: Yes. We want appropriate care for people. Often, if you need access to rehabilitation or a step-down facility, it is more appropriate that you go to a sub-acute facility than spend a few days in a hospital ward, which, let us face it, is not the most restful and restorative place.

THE CHAIR: In the 2½ to three minutes we have got left, I would like to give you the opportunity of covering any other point that you wanted to make that you have not perhaps had the opportunity to at this point. Is there anything else that you would like to say?

Dr Stevens: I think we are really keen to explore the sub-acute facility. There are lots of different options for improving services through that. There is mental health. We know that for the community midwifery program you almost have to book in on the first day you know you are pregnant. It would be really nice to have a similar facility on the north side. There are lots of options that we could look at. We also are interested in hospice facilities. There is a whole range of things that we need to explore.

Ms Cox: If we have got a moment, let us talk about the potential to have a second hospice in this town to meet the palliative care needs and maybe have a secular service that the government runs. Currently we have got a palliative care service that is run through the Little Company of Mary at Clare Holland House, so you have got 19 beds at Clare Holland House, plus about 200 people receive services in the community on the consultancy-based model. We have certainly in the past asked that consideration of a review of palliative care be undertaken. This was in the context of last year with the sale of Clare Holland House on the table.

Our membership tell us that we are underserviced in terms of palliative care and that is why we call for an independent review of palliative care. That is something that we would be asking of the minister in the context of a sub-acute facility in north Canberra, because it could well be that a wing off this is a hospice, is the base for home-based palliative care to provide services.

THE CHAIR: Thank you. One final suggestion, if you like, on the consultation paper that you will be providing back to the government as a result of the roundtable discussion that you had: we would give you the opportunity of presenting a copy of that to us if you feel it is appropriate. We are certainly looking at all the information that is in the community at the moment and we would welcome any further input from consultation that you conducted with your membership.

Other than that, Dr Stevens and Ms Cox, thank you very much for joining us. There will be a full transcript of the hearings this morning made available to you and ,if there is anything else that you would like to add as an afterthought to our discussions, we welcome that as well. Thank you.

Dr Stevens: Thank you.

Ms Cox: Thank you.

The committee adjourned at 12.24 pm.