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, 22 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 9.31 am.

WATKINS, HON JOHN, Chair, Little Company of Mary Health Care
DORAN, MR MARK, Chief Executive Officer, Little Company of Mary Health Care
KMET, MR WALTER, National Director—Public Hospitals, Little Company of Mary Health Care

THE CHAIR: Good morning everyone and welcome to this public hearing of the Standing Committee on Health, Community and Social Services inquiring into the Calvary Public Hospital options. We will begin this morning with the Little Company of Mary Health Care. I welcome members from the Little Company of Mary, the Hon John Watkins, Mr Walter Kmet and Mr Mark Doran. Thank you for joining us this morning.

There are just a couple of housekeeping things that I might mention to you. There is a privilege card. I presume that you would have appeared before a few committees, but let us not presume things. Have you had an opportunity to read the privilege statement and are you comfortable with the contents of it?

Mr Watkins: Yes.

THE CHAIR: Thank you. Mr Watkins, I would like to give you the option of making an opening statement. Would that be by yourself or—

Mr Watkins: I would like to, if that is okay with the committee, chair.

THE CHAIR: That is fine. We invite you to do that.

Mr Watkins: And possibly follow it briefly by Mark and Walter, but we will keep it quite brief.

THE CHAIR: That is fine. Just before we get to that, by way of introduction, our committee is a bipartisan committee. We have representatives of the opposition, the crossbench and the government. Mr Hanson is an ex officio member as a shadow health minister. He can sit on the relevant committee, so he is sitting with us in this instance. I invite you to make your opening statement.

Mr Watkins: Thank you, chair and members. It is good to be with you in Canberra. Mark Doran is the national CEO of Little Company of Mary Health Care and Walter is the national manager of public hospitals of Little Company of Mary. I became the new Chair of Little Company of Mary Health Care in November. We welcome the opportunity to join you to give evidence. We hope that we can assist the committee in its deliberations, which are really important in guiding the development of health care needs and services in Canberra.

You are aware that the sisters of the Little Company of Mary and their hospital in Bruce have played an integral part in the lives of Canberra citizens for 31 years. It has been the mission of the Little Company of Mary Health Care to be for others, to care

for people who are in great need and to provide health services for people at some of the most difficult and also the most joyous times of their life.

It has been a rare privilege to provide health services to the community and to do that in partnership with the government of the ACT as part of the public health network. We are confident that we have done that well and we are confident that we can continue to serve the needs of the community well into the future in a cooperative endeavour with the ACT government through ACT Health.

The Little Company of Mary Health Care is well set up to deliver on that commitment. We are one of Australia's largest not-for-profit organisations. I will give you a very brief rundown of what and who we are: we operate in the ACT, New South Wales, Victoria, Tasmania, South Australia and the Northern Territory. We have got over 9,000 staff. We run four public hospitals—Bethlehem in Melbourne, Calvary Kogarah and Calvary Mercy in New South Wales and Calvary Bruce in the ACT.

There are 13 private hospitals in the network. All up, we provide annually about 566,000 hospital days, 164,000 in-patients are cared for, 6,000 babies are born in our hospitals and 75,000 people are treated annually in our emergency departments. We have got a long history in Canberra. As I said, 31 years ago we set up here following an invitation from the federal government to provide a 300-bed public hospital. We are still honouring that agreement and we look forward to honouring it for many years to come.

We acknowledge the uncertainty of the past year. We believe that all parties would like to see that come to an end. That uncertainty was inevitable in a way, I suppose, following the offer by the government for purchase. That led to a long and complex term of discernment within the wider community by you as elected members and certainly within the Catholic community of the ACT.

As the government advised that it did not wish to proceed with that course of action, we really now believe that it is time to look to the future. Where are we going to go? Where are health services going to be in the ACT? Where is Calvary Bruce going to go?

You are aware that there was a joint submission referred to the inquiry by the Little Company of Mary Health Care, the Archdiocese of Canberra and Goulburn and Catholic Health Australia. That outlined the view that we are united in our commitment to the continuation and expansion of public and private health care through the Little Company of Mary at Bruce for many years to come.

What do we believe the future should be? We have a clear intention to remain as the owner and operator of the public hospital at Bruce. We wish to expand the public services at Bruce and develop additional private healthcare services, and we want to do that in close partnership with ACT Health and the government. It is how we have always operated at Bruce, and we are confident we can do that into the future, and do it well.

The terms of reference for this committee specify four possible options. I will very briefly run through those. We support option 1, which suggests that Calvary maintain

its crown lease and explore a new activity-based agreement. We intend to keep delivering health services at Bruce and we would really welcome a new activity-based agreement, acknowledging that that is where healthcare funding is going in a national reform in any case.

Option 2 suggests proceeding with the network agreement in its current form. We reject that option. I am advised that it is inconsistent with our long-term agreement with the government.

Option 3 explores the government assistance for expanded not-for-profit private healthcare services on the campus, assuming that the acute public hospital continues. We support that option as it would ease the burden on existing public services and prepare for future growth in demand.

Option 4 considers a new acute hospital in Canberra's north. Our position on that is pretty clear. We believe there is no need for such a third Canberra public hospital, because that is what it would be. As we have a continuing agreement to operate a 300-bed hospital at Bruce, any such new hospital would be a third public hospital for the territory, which we do not believe would be value for money and it would replicate and fragment services.

Committee members, it is our view that we can continue to serve the needs of the Canberra community as we have faithfully done for 31 years; that we do it well; that we are more than happy to cooperate with the government on new models of care; and that the territory's needs are best served by the acceptance of our continued role at Calvary Bruce. I thank you for your attention and I will ask Mark to add to that briefly.

Mr Doran: Thanks, John. It is probably important to understand the context in which the original agreement would have been undertaken. In fact, its history, if you have read the quite voluminous amount of work, goes back probably 50 or 60 years, when there was a view that Canberra needed to reflect contemporary Australia and there was a need for faith-based organisations to come into this city. Indeed, if you follow it through, you can see that the sisters would have been well known to Robert Gordon Menzies. In fact, Bethlehem is still operated in that same electorate. Indeed, the sisters have been here for 125 years as of 4 November last. So there is a long history of providing public facilities.

In fact, 100 years ago they went to Adelaide and built North Adelaide. Seventy to 80 years ago, they went to the Riverina and Wagga to build a public hospital there. They went to Hobart to build one there. In Lewisham, there was quite a famous hospital in Sydney. It was one of their first. So they have had a long history of doing this, and it is quite appropriate that they would have been approached to do it.

In Canberra, we still have quite strong connections. In fact, we have two of our board of directors resident in this city. Also, Walter, as you heard, is a national director. We also have a network of services here. You would be familiar with our aged-care facility, our community care facilities and our two private hospitals. In fact, we have a network of healthcare community support facilities in this city. So it is consistent with the mission of the sisters, as John was saying.

It is therefore important to understand the nature of the relationship, and I refer you to Neil Young's work. If you do not know who he is, he is probably one of Australia's finest legal minds. He was a Federal Court judge. His view, which we take quite seriously, is that it is akin to a joint venture. That is what it was always meant to be. If you read back, you can see that the sisters were actually asked to contribute a quarter of the capital cost. In fact, for the last 31 years, they have provided that service; that is their part of the bargain. And when you dig deeply into it, you can see that the arrangement, that joint venture, that partnership, is evidenced by the fact that the lease was perpetual. It went on forever, as indeed the intent was that it would go on indefinitely.

As part of that arrangement, you can see that the territory has no contractual ability to terminate either the lease or the agreement, which again supports the very interesting nature of that agreement. Oddly enough, they, if you like, are the providers of the care and the government is the purchaser of the care. Ironically, that is where we find ourselves today in the reforms.

Governments do not want to be the provider necessarily. In fact, a lot of funders do not, as evidenced by Bupa around the world moving out of being providers. MBF are no longer providers. Veterans Affairs are no longer providers. They simply procure the service.

This appeared to be an ideal arrangement back then. The fact that it is on the books, Young points out, is quite supportable and is an accounting and legal requirement. It is in the first supplementary agreement, indeed the 1971 agreement, of course, that you actually see government trying to signal that this provider should be allowed that autonomy, should be running a 300-bed hospital and should do it with a high degree of autonomy and just submit a budget. In other words, if you look at the annexure to the first supplementary agreement, you will see it is a statement trying to underline that autonomy which was being provided. They were trying to keep the separation of funding and provider.

Therefore, it is important to understand that there has been a high degree of cooperation. Walter will talk more about that later. We were required to provide that service in accordance with policy. Looking at integration, rationalisation and efficiency, we think we have done that. If you look at how we have, I guess, agreed and submitted to the wishes of the system to be involved in clinical streaming and role delineation, it is not simply an alternative hospital. It is certainly a hospital that plays its role in the greater ACT health system.

From our perspective, to try to examine the proposition about control equals efficiency, I am not so sure that is the case. In fact, the Productivity Commission recently looked into public-private hospitals. The report showed that there was no evidence of that.

As I said before, the reforms that are going on world wide, where the purchaser and the provider are separating, are quite interesting. We have lots of examples of it in Australia. Some of them are still quite contemporary and are changing and evolving as late as last year. The Mater in Brisbane is an example. Those hospitals are now protected by legislation and have converted themselves to private facilities but

contracting back to the government. Ramsay's hospital in Joondalup in WA has public-private and has been rapidly expanded by the government there, with the upgrade by Ramsay. Noosa is one that I had something to do with back in 1995. It has been functioning quite well since that date.

Oddly enough, both Walter and I worked in the UK under the Blair reforms, where we saw the independent treatment centres, effectively private treatment centres, associated with the large public hospitals over there. It has been happening all around the world. It is odd that people back in the 1970s and the early 1980s saw the potential of it.

We are reasonably experienced in that area. As you have heard, we have run both public and private hospitals. We have a fairly deep wealth of experience within our organisation. As I said, I have been involved in most of those. Our director of clinical services has just been recruited from Joondalup, where she was the deputy CEO. Walter worked in the UK for many years on privatisations there. It is a wonderful wealth of experience to bring to the ACT health system in understanding how these systems can work.

When you put it with our aged, our private and our community care, the value of our system, our network, that can do all sorts of things—for example, elective surgery most of us are familiar with, and I have worked in the Surgery Connect initiative in Queensland that was largely run by the Mater—I suppose that proposition that control gives you efficiency just does not stand up. I have been a hospital administrator for 40 years and I have seen all of the models and I can tell you that control does not necessarily equal efficiency.

The one thing that I do see, though, is that hospitals that continue in that tradition of caring—that follow, I guess, what was the original intention of the sisters in those traditions, which John alluded to, which is being there for others—will always give you a great result. I think that should not be undervalued.

I will hand over to Walter to give you some clue as to where we think we perform and how well we perform.

Mr Kmet: Firstly, to reinforce what Mark and John have said, what we are doing now does reflect the original intentions of our agreement with the then commonwealth government and that is to operate a public hospital and to operate that hospital in an integrated fashion with the rest of the health system and for the benefit of the people of Canberra. We believe that being part of the original agreement is something that we want to continue to do. We believe that approach in which we operate public services for the benefit of the people of the community and integrate those services as best as possible with the rest of the health system makes sense. It makes sense not just for us as a public hospital; it makes sense for the system more generally.

So, whatever the provider, whether that provider be a community provider, a GP, a hospital, a private or public institution, the best healthcare services are ones that work in close consultation and work together to serve the overall needs of the community; those needs being not only those that the community need but also those that the government believe that they need to provide on behalf of the community.

Our approach in Canberra is no different from our approach right across Australia in our public hospitals and indeed in all of our health services. As Mark has mentioned, whether it is our exposure to aged and community care, exposure to community services, private hospitals and other public hospitals in other jurisdictions, it has been our approach in all of those jurisdictions, not least here in Canberra, that what we do needs to integrate and needs to work in concert with all other parts of the system.

In the case of Calvary Public Hospital, the cooperation and planning that takes place with ACT Health is very deep. We sit on numerous committees and so we should. We make a contribution to those committees in respect of the healthcare needs and the role delineation the two hospitals play. That role delineation is very clear; it has been very clearly made in planning documents over many years, for over a decade in terms of the role of the Canberra Hospital and Calvary hospital. We believe we fulfil that role delineation well and we fulfil that in the context of the needs not only of the people of north Canberra but the broader needs of the community here in Canberra.

There are examples in which that integration is critically important; for example, accident and emergency services. You have had the benefit of seeing the hospital, the way it integrates and the way the people working at the hospital integrate in terms of the things they do on a day-to-day basis and what happens in our other acute public hospital in Canberra—critically important at Calvary being the numbers of people we see in the accident and emergency unit; the importance of not to do that alone.

We have, as Mark has mentioned, a number of stream services, services that cannot operate unless they work very much as stream services across the territory, including older persons, mental health, cancer services and the like. Indeed, I think Calvary is there to respond to immediate needs in the healthcare community, whether it be those that might have been seen only two weeks ago in terms of the floods but also in terms of elective surgery. We have been able to flex our volumes of elective surgery this year up 20 per cent because of needs of the government to increase its elective surgery in the territory. We have been very responsive to that. And we would not have been able to do that without a good relationship, without a close and integrated relationship, with the needs of ACT Health and indeed the needs of the people of north Canberra.

I also would state that we stand on a record of good performance. That might relate to quality and it might relate to efficiency. For example, for the first time since the introduction of ACHS' accreditation surveys 10 years ago, Calvary was awarded outstanding classifications for three criteria and, in addition, was awarded extensive achievement in another 11.

I do not think we would want any less from Calvary, but they are, in my 25 years of service in the healthcare industry, outstanding results in the 2009 survey. Those areas of outstanding achievement included consumer feedback and incident management reporting, strategic and operational planning development, emergency and disaster management. The surveyors also noted that there were another four areas in which we were very close to achieving outstanding award classification, that being in care of the dying and deceased, medication safety, risk management and quality improvement.

That is one of the areas with which we can identify in quality. There are others, and

we can certainly talk about issues of complaints and compliments—we did very well, an improving record in that area. With respect to clinical indicators—indeed, the clinical indicators that are becoming a national standard—all of those indicators are ones on which we can stand behind a very good record.

In terms of efficiency, I am happy for the secretary to hand out a brief performance report here for this year. I will not go through this in detail, but on all of the major indicators, and those indicators that are now being published nationally on My Hospital, Calvary has a very strong record, not only in the past but also, as I said, as to the recent history and current performance. We are achieving all of our volume and activity targets. In emergency department access, we are either on or above the target for accident and emergency performance, as well as triage times. Indeed, our cost per weighted separation at the hospital is something on which we are achieving our targets. So even in respect of the targets being achieved, we are able to achieve those targets at a good value-for-money cost.

In that respect, we believe that future investment in Calvary, ongoing investment in Calvary, is something that is a logical thing to do. We believe it provides value for money, and we also believe that it is a low-risk option. It is important to health care to ensure that we do look after the needs of our patients in the safest possible way. We believe that the investment in that site, and investment in new services and further expanded services on the site, provides not only a logical and value-for-money basis but also a low-risk option.

As an organisation, Little Company of Mary has, I think, a very strong and successful track record not only in developing Calvary from the days when it was essentially a community hospital through to an acute hospital, as it is designated now, but also in other parts of our organisation, including what we have delivered in Newcastle, with a $250 million redevelopment of the Calvary Mater Newcastle in the last two years. That was a major public infrastructure development that we had a major role in delivering. I can say we delivered that on an existing site without any major incidents, on time and on budget. I think that is something that we would stand behind. As Mark has mentioned, we are here to make that contribution to the ACT and the ACT community, in addition to that.

Mr Watkins: Thank you, chair and members, for your attention. We are more than happy to take questions.

THE CHAIR: Thanks for your opening statements. Each of you made mention of the fact that Little Company of Mary Health Care has honoured the agreement that is in place. Has there been any suggestion at any stage by the ACT government that there was a problem with either the performance or the agreement that is in place?

Mr Kmet: I am not aware of any notification to us at any time in the history about a breach of or a divergence from that performance with the agreements that are in place. I am just not aware of anything of that nature.

Mr Doran: The only thing I can think of that you might be referring to would be the separation of public and private and the rules around that.

Mr Kmet: In the end those were subsidiary agreements with ACT Health in respect of the operation and conduct of public and private services. So that is not—

Mr Doran: So none that we are aware of, in other words.

Mr Kmet: None of the fundamental agreements.

THE CHAIR: What I want to get a bit more of an understanding of is where this process of acquisition by the government of Calvary started. Was there ever any request by Little Company of Mary for this to happen?

Mr Doran: It was to do with the accounting approach and the credit rating of the ACT government, as we understand it. Back then, obviously, if you refer to Neil Young, you will see that we were obliged basically to bring it on to our books. The government at that stage believed it could not, and that was affecting the credit rating. The view was that it was not in the best interests of the ACT to invest where it could not reflect the investment in its books. There is some debate over that in the industry because there is always a capital component paid in any price, whether you see it up-front or whether it is dissolved in the price, it is always there. Somebody pays for the capital. There are many examples of how that is done around the country. Other jurisdictions just do not worry about it. It might be that it was just a large part of the ACT budget.

Mr Watkins: But it is my understanding that the government approached Little Company of Mary. It was before my time.

MS BRESNAN: My question leads on from what you have just asked, chair. You mentioned the separation between public and private moneys, and that was an issue that was raised by the Auditor-General in terms of separating those costs and having a clear separation between them. Is that something which has been dealt with by LCM, in response to the—

Mr Kmet: Absolutely. If we go back to the reason for the public and private hospital operations being there, it was at the request of the ACT government that we were able to provide additional services and utilise underutilised infrastructure for private services back in the late 80s. That had evolved over time until such time as 2006, when there was an inquiry into the conduct of public and private operations, and that inquiry found, in monetary terms, a very insignificant issue—I think it was $54,000, from memory—in terms of what might be considered a grey area between public and private cross-charging.

Since that time we have adopted all of the recommendations of the Auditor-General's review. We have agreed on a cross-charging protocol with ACT Health and all of those agreed have been in operation for some considerable time, since last year. There have been no issues that I am aware of that should mean that there is anything but a clear compliance with the request of the Auditor-General and also the needs of ACT Health in the way we conduct public and private services.

MS BRESNAN: One of the things that the Auditor-General said was that it was difficult to establish clear accountability because of the cross-funding there. Does that

have any impact on efficiencies across the hospital when you have the two, public and private, operating? Does it have an impact at all?

Mr Kmet: In all health services, there is absolutely no question that the greater the volume of what you do, the more likely you are to be more efficient in what you do. That is one question, but the corresponding question is that, in doing that, you need to provide services at a quality level. Some services provide very high volumes and very poor quality. Our view is that we need to provide both public and private services at the highest possible quality we can. I think that has been indicated in the way in which both the public and the private hospital have performed. In doing that, the private services and the public services I think provide a mutual benefit to each other. I do not think there is any question about that as something that is on the Calvary site that is a mutual benefit. We believe, as we state in the submission, there are opportunities to expand that opportunity in the future.

MS BRESNAN: When you say "expand that opportunity", is that expanding the private?

Mr Kmet: Both. There is an opportunity, for example, for the public hospital to do more elective surgery for the public. We do that efficiently and we do that at a high quality level. Indeed, there are growing needs in private services, for example in ophthalmology and orthopaedic surgery, and with the ageing population in cardiology, as we have outlined in some parts of our report, that provide an opportunity also for the private sector to further participate and provide choices and expanded services to the residents of north Canberra. I think in both categories there are those opportunities, and the history of public and private services working together shows that we are not doing it for the first time. It is something that is very much apparent right across Australia.

Mr Doran: I think it is interesting to note that the proceeds of the sale were to be put back into developing more infrastructure on that site. It would have freed up the space that the private hospital now occupies—let's say 50 to 60 beds and two to three theatres—but we were going to put those proceeds back into developing that campus. They were not going anywhere. Those proceeds were going back into the infrastructure, which is effectively option 3. That is what we were intending to do.

MS BRESNAN: In relation to option 3, if, for example, that option were to proceed—if that was the one which went forward—would LCM still assert ownership over the public hospital?

Mr Kmet: Our chairman made that very clear in respect of our future intentions.

MS BRESNAN: So you would still be asserting that ownership. So even if you got the funding—if it was seen as being in the public good to create the private hospital on the site—you would still be asserting your ownership over the public hospital?

Mr Kmet: I think there is a public good argument for both our role in public services as well as expanded private services.

Mr Watkins: I guess it is not an either/or. It is about delivering the best quality health

care for Canberra. We think we can do that, certainly through the public hospital, through expanded private hospital services. They are going to be needed as Canberra grows. We are good at delivering that as well. We see that as bringing an extra benefit to Canberra citizens.

THE CHAIR: Ms Porter?

MS PORTER: Thank you, chair. On page 9 of the Calvary Health Care submission it talks about activity-based funding and about the fact that you believe this funding agreement to underpin the operation of Calvary represents a significant opportunity both for yourselves and also the ACT health system. You say that at the moment the government is unable to move forward on that activity-based funding. Am I correct in the way I am reading it or am I not correct in the way I am reading it?

Mr Kmet: As to the history of respective negotiations of sale and then post-sale and the various options that were put on the table—in the case in which Calvary was to be continuing as an operator of the hospital, as it does now—there were discussions about an activity-based funding agreement. That was there because that is the way the system was moving right across Australia.

At the time of those discussions, understandably, the government was not in a position to conclude that agreement because, in fact, national agreements were not concluded. The notion that we were not able to conclude agreements was as much a reflection of the status of reform in Australia as it was to particular circumstances here in the ACT.

What we are saying really is that there is an opportunity to be consistent in the way in which we are treated respectively with the way the rest of the system is going. We believe that it will be an activity-based funding structure for us, as it will be for ACT Health in the context of its commonwealth funding arrangements.

MS PORTER: What is your view about the reforms that the commonwealth government are proposing?

Mr Kmet: We are excited by the reforms. I think the reforms provide, certainly in terms of activity-based funding, the ability for us and our performance to be measured very clearly. We have always intended to be measured transparently and clearly in what we do and we want to provide that at the best level. I think that activity-based funding, for some parts of what you do, and let us not forget that activity-based funding is not relevant to everything you do—it is certainly relevant to a lot of what we do, but not all of what we do—is something that puts us very clearly in a situation where we can perform to the level required of us.

Mr Watkins: When would it not be relevant?

Mr Kmet: There are areas, for example, where you start to get away from purely episodic-based funding. For example, there are cases in which you simply cannot measure all the cost interactions. We do not have those systems in place in Australia to do that, not forgetting that activity-based funding in its own right is based on experience. Numbers come out of experience. If we are not measuring that, it is difficult to have a system to actually apply. There are a lot of parts in the health care

system where we do not measure what it cost to provide those services. You can over time, but at this stage it would not apply because the systems just are not in place.

Mr Doran: But we have a great deal of experience in that because we operate 13 private hospitals and about 130,000 weighted separations that are largely done on an activity-based funding model, which is really what the private sector runs on. They have been doing it now for about 20 years and expanding on it and learning from it as they go. It is nearly the universal language. Just recently I ran into a doctor from Patagonia who is grappling with it. It is just the way the world will finance health care.

THE CHAIR: Thank you. Mr Hanson?

MR HANSON: The ownership issue is, I think, half of the reason the government wanted to pursue the purchase of the hospital. Having the ownership would, in their view, enhance the network. But the ownership issue seems to be unresolved. There is advice from Deloittes and Neil Young, which you have, that says one thing and there is advice from PricewaterhouseCoopers, which the government has, that says another in terms of the ownership. Is that an issue that needs to be resolved or can we continue on with the difference of opinion?

I do not know if you have read the *Hansard* record of what the minister said when she appeared. Basically she indicated that the accounting advice that was provided by the government was that you can have ownership appearing on both books and you can both account for it, essentially. Is that your view? Do you see that this is going to be an ongoing point of friction or disagreement and, if so, how does it get resolved?

Mr Doran: There are two different issues there. One is a legal issue, and that is beyond doubt: we are the owner. On the accounting issue, there are accounting conventions—IFRIC12—which allow somebody to bring it onto their books and recognise it. We think that if the government has got that advice, that is fine—it can do that. But obviously we have that advice as well, largely based on the work that Neil Young has done, and we are quite comfortable with our position. To be honest, we can wonderfully coexist. It says something about accounting, though.

MR HANSON: Yes, it does.

Mr Watkins: You said, "Would it be a cause of ongoing friction?" No is the short answer.

MR HANSON: I do not think the legal issue was the point of friction; it was the accounting applied. If the ACT government put that on their books you are comfortable with that?

Mr Watkins: Yes. We do not believe it will change the day-to-day delivery of what we do in close consultation with the department.

THE CHAIR: Further to Mr Hanson's question—this is referring to the advice that the government's advisers were giving them—apart from the accounting aspect of it, I guess there were possible taxation implications. To seek clarification: are there any federal taxation implications for the territory and for yourselves, I guess, by having

the same asset appear on both financial statements and what are the taxation implications of that? Do you have any view on that?

Mr Doran: No. It has been on our books for 30-odd years. It is quite appropriately there.

THE CHAIR: On your books, but it has not been on the government's books for 30-odd years.

Mr Doran: That is for the government to decide. We are quite comfortable in our position.

THE CHAIR: Obviously this situation has been ongoing for quite a while. What impact has the lack of resolution of this issue had on the Little Company of Mary?

Mr Watkins: You mean the current debate over the last couple of years.

THE CHAIR: Correct.

Mr Watkins: I suppose what you are getting at is: has it affected the operational day-to-day atmosphere in hospital?

THE CHAIR: I am asking: what implications are there out of what has been going on? Has it had an adverse effect on the way that you are delivering current services?

Mr Kmet: Just to go back to essentially the beginning of last year when the announcement was first made in respect of the potential sale, one of the things that we did as an organisation was to make it very clear to the management of the hospital that their role was to manage health services, not to manage potential acquisition, sale and any other events associated with that. That was a very strong management structural issue that we put in place at the time.

So our CEO at the hospital was given those instructions. His focus right through from the day he was appointed, let alone what has happened in the last 12 months, was that he has been and will continue to be providing the best possible healthcare services, and I think our track record over the last 12 to 18 months, in spite of the uncertainty that you mention, stands on its own. We achieved all of our activity targets last year and in terms of certainly this year we are continuing to do so.

The uncertainty of course is something that we would like to see an end to. Clearly it makes sense for us to be able to look forward, and that is what we are doing. We still believe there are a number of opportunities for us in developing services and they are currently under discussion with the government, as they have been for the last 10 years of strategic planning, as we have outlined in our report.

Mr Watkins: Clearly, any level of debate about the future of the hospital causes uncertainty for the people who work in it day to day. They have wondered, "What is going to happen to my place of employment?" if they are a cleaner, a nurse or whatever. So we would like to bring that to an end so that they can concentrate on their most important task day to day without that there in the background. Any of us

who have been through an employment uncertainty know that it affects you in a way. We would like to move past that.

THE CHAIR: That was what my question was referring to—the potential issues with regard to recruiting staff and recruiting some fairly qualified staff in specialist areas. Have you had difficulty in attracting high-level staff over this period?

Mr Kmet: At some levels, yes. There is no question that during the sale, where there was a doubt as to whether Little Company of Mary Healthcare would continue to be the operator, there were people who essentially waited until some of that was resolved. Clearly, that has been resolved now by virtue of the statements that have been made by all of us in recent times, so we are beyond that. But, yes, at some level there have been ups and downs in respect of that.

Mr Watkins: Importantly, the results that Walter referred to earlier show that the staff are doing an exceptional job.

Mr Kmet: We have an incredibly committed group of people. We have kept them constantly informed, constantly engaged, constantly open in terms of management-staff interaction, and I think that has helped not only our stewardship of public services but also the ability of the staff to have the confidence in us in being able to support them in what they need to do.

Mr Doran: I think the process has also made the relationship clear. We have gone back and trawled up 60 years worth of advice and correspondence to understand fully what it was meant to be. That allows us to go forward, and the recent advice—that the government can bring the asset onto its books as well if it wishes—clears the way for further investment. We have been aware that there has not been a great deal of investment in Calvary over the last 10 years. That is all out of the way. We know the nature of the relationship. What we are saying is: "Good. The dust has settled. Let's get on with it. We are here to serve the people of north Canberra. Let's do that."

MS BRESNAN: You have mentioned that you have the four public hospitals which you operate—obviously Calvary but in the other states. The public hospital here in the ACT provides a fairly large percentage of public services to the ACT, being the second major hospital. Do you have any figures of what percentage of public services you provide in the other states where you operate public hospitals?

Mr Kmet: Much less, clearly. I think those figures have been in the public domain last year at some stage where there was analysis of our role here relative to what our role might be in other states—indeed what the role of other not-for-profit organisations might be in those states. There is clearly a very big difference there.

Mr Watkins: But, if you compared Canberra to Newcastle, for example, and the region, which would be comparable in some ways, with Calvary Mercy in Newcastle, we provide—what—50 per cent—

Mr Kmet: Certainly between us and John Hunter, which are the two hospitals in the Newcastle region, there would probably be a similar percentage, I would think. I do not have those numbers to hand.

Mr Watkins: But it is probably a better comparison to look at a regional delivery of service rather than comparing us to all of New South Wales or all of Victoria.

MS BRESNAN: People in New South Wales probably have other hospitals they can go to if that is the case.

Mr Watkins: They do. Newcastle people tend to stay close to home—

MS BRESNAN: True; they do indeed. Just on that, one of the things that has been made clear in your submission and your statements this morning, and I guess through the whole debate we have had about Calvary in recent times, is the need for LCM to be a part of the public health system. You also said in your statements that the needs of the community are best served by having LCM continually involved in the provision of that public health care. Can you outline a bit more how the community's needs are best served by having LCM's continued involvement in public health; also why there is that need that you as an organisation see to have that continued involvement in public health care?

Mr Watkins: I can kick off in general terms. Because we have done it well for 30 years and achieved outstanding results for the people of Canberra, that is good enough justification in itself to remain closely involved in the delivery of health care. We believe that for us not to be involved would remove that level of quality service. This is in no way commenting on the quality of service delivered at Canberra Hospital. But what we do at Bruce we do well, we have been doing it well with a very high level of care and we believe that it benefits the citizens of Canberra

Mr Kmet: I agree. Our view is not based on the structure of the system; it is based on meeting the needs of the community. That is how we measure our success and we believe that is something that we have a long track record of doing and I think all the performance figures for Calvary Public Hospital support that.

Mr Doran: I think history tells us too about diversity in providers. If you think about the reforms in the LHN, the local health network, which is an authority which can purchase services, not only does it manage the ones that are in its public sector remit but it can buy services from other people.

The world has shown us that if you go to one end of the pole—ie, the national health service—you get a service that knows no difference. I have been there. I have seen it. Laparoscopic surgery is an example. Australia does roughly 40 per cent of surgery in that way. Johns Hopkins, who are a partner of ours in the Netherlands and the UK, are up around 60. The UK at that time was in the 20s.

The idea was to get the technologies, the experience, the front line, the cutting edge introduced into those systems which basically have been closed to some extent because they only did what they always did. They were closed systems. They were not getting the input from outside.

We have a variety of other things that we do. Canberra is very fortunate that we have two private hospitals. We have large aged care and community care. If you think

about where the reforms are going, they are connecting all of that.

One big gap in the health services in this country is the gaps that you fall through between primary care, aged care and acute hospital care. We have got the ability to demonstrate that. In fact it is quite ironic that tomorrow we have to submit tenders or expressions of interest for the patient centred electronic health record projects. Canberra features in two that we are associated with. Because we have that infrastructure, we can actually demonstrate that. We could be good examples of how this works. That is the tremendous advantage we bring. We have all those elements—hospital avoidance, aged care.

As the baby boomers come through, one of the prime thrusts of healthcare is going to be keeping people out of hospital, keeping them supported at home and supporting them to be able to stay at home. That is so not only in aged care but in chronic diseases and palliative care.

As you know, Calvary stands for, and it is core to our mission, palliative care. Palliative care is not only end of life; it is also the management of chronic disease and pain. We are well placed. We are strategically focused on doing exactly that. Canberra could benefit well from what we are learning and what we are doing. We are researching it very heavily at the moment.

MS BRESNAN: In regard to that need for LCM to be involved in public health care, part of the mission, as has been discussed a number of times, is based on the things you said about your providing diversity and a quality service. Is that the primary reason why LCM has that need to be involved in public health care?

Mr Watkins: Obviously there is that historical link. We were talking about it the other night. It is about 1,700 years we have been doing it. It started in the cathedral cities. Health care and hospitals started because they were for the poor. The world has moved on a bit since then. They were not necessarily for the ultra poor. People were treated at home. They were not treated in hospitals. Hospitals were not for the poor people.

It has evolved. The church has taken up that mission, just like the sisters did a hundred years ago when they took off to places like Wagga. Eighty or 90 years ago it would have been an interesting place. That was part of the initiative. It is still part of it because there are gaps that happen in our system. We know that. We are positioning ourselves to do it. That is our role in life. That is what we want to do.

MS BRESNAN: LCM is a major provider of public health care in the ACT. Can people in the ACT community expect that they will receive through LCM the full range of services that they need from another public hospital?

Mr Watkins: There are certain services that are not delivered through any Catholic hospital in Australia, including Little Company of Mary hospitals. I think that is well known and generally accepted by the community. In the ACT community those services are available to anyone who wants or needs them through a range of public or private providers. The fact that some of those services are not delivered at Calvary at Bruce does not mean that the community of Canberra does not have access to those

services.

MS BRESNAN: As a major provider of public services in the ACT, it does have a slight impact?

Mr Watkins: But not all public providers across Australia deliver those services from their hospitals.

MS BRESNAN: I understand. LCM is a fairly big provider of public services.

Mr Watkins: But those services are well and truly available to the people of Canberra, as they should be, as their choice. They do not need to be provided by Little Company of Mary at Calvary at Bruce.

THE CHAIR: Ms Porter?

MS PORTER: Would you say that part of the reason for you believing you need to continue to provide the services is the spiritual side of the work that you do and that the archbishop often talks about? Do you see that emotional support of that nature can necessarily be provided by any hospital? It does not have to be connected to a spiritual basis. It can be provided by any hospital with the appropriate emotional support that can be provided through other services.

Mr Watkins: I do not know of any hospital in Australia that does not provide a good spiritual, supportive atmosphere for the people that come to them. I do not know of any group of nurses or doctors that do not see that as critical to their role—public, private, run by whomever. That is something special in the nature of the hospital, I think, to support other human beings in need.

We believe that there is something unique about the mission of the Little Company of Mary which brings great benefit to the people of the ACT. Not all parts of Australia have the provision of those particular services, based on the mission of Calvary, based on that sense of being there for others and a special level of care, especially in areas such as palliative care. We believe that is a real bonus or benefit that comes to the community of Canberra through the delivery of services by the Little Company of Mary. We wish it could be delivered more widely spread to other parts of Australia. But it is a real benefit that the ACT derives, as does the community in the Hunter and other parts of Australia.

MS PORTER: In doing that, obviously you are providing, in palliative care, a range of different services to people to meet their different spiritual needs. They may not necessarily be of the same faith as you base your work on. We know that Buddhism is a very popular and growing religion in Australia. They do not call it a religion. It is a way of life.

Mr Watkins: I was in what is known as the prayer room at Kogarah. That is the one that comes to mind. On the four corners there is material for the Jewish faith, material for the Buddhist philosophy, the Christian, the Islamic and, I think, one or two others. They are embraced and supported, if that is the wish and the desire of the person in hospital, as far as we possibly can. It is a Catholic hospital but there is an

understanding that there are people of other faiths that come to the hospital.

Mr Kmet: One of our core values is hospitality. I think our history and heritage, in terms of being non-discriminatory in respect of people's beliefs, faiths and ways of life, are on record. It is certainly on record throughout our hospitals. It is on record in Canberra in respect of Calvary Public Hospital as well as Clare Holland House, not forgetting that Clare Holland House was welcoming and hospitable to a number of people who were otherwise very heavily discriminated against in the early and mid 1990s, particularly those with HIV/AIDS.

I think some of you will know that the heritage of our faith and the heritage of the values of our organisation are absolutely non-discriminatory. I think that lives itself out every day. We have, right through our system of healthcare management, an ability for people to make submissions, complaints conferences and otherwise, about how we conduct ourselves in respect of that value. We do not see that as being at all an issue in what we hear from the community when the community come to use our services.

We respect that people do have different views. If those views mean, for example, that some parts of our service need to be modified or changed, we do that to accommodate that, as would, no doubt, all healthcare services or public services in respect of any particular issue. This issue needs to be dealt with.

Mr Watkins: We would be distressed to hear that, if someone of another faith came through one of our hospitals, that was not respected. That would be something we would hate to hear and we would take action.

MS PORTER: In the ANF submission, which I am sure you have read—it is online—they talk about some difficulties they are having with regard to standard operating procedures around occupational health and safety. They say there is a difference between the way those particular systems are run at Calvary as opposed to how the systems are run at the Canberra Hospital. How far are we from getting those kinds of things resolved so that the same standard operating procedures can happen across both hospitals?

Mr Watkins: Walter can perhaps give you a bit more detail. Once that submission was received by the committee, we took the opportunity to meet the ANF to discuss those specific issues of concern. We did not want to just hear that and not take that action. Those meetings have occurred. Walter, do you want to give a general update on that?

Mr Kmet: Absolutely. Following that submission we did have a meeting—not me personally but the management of the hospital had a meeting—on 10 December and went through every piece of that submission in respect of those comments made. I can report here today that there are no material issues outstanding in respect of our relationship and the conduct of our services at Calvary Public Hospital.

Obviously, there are always issues that need to be resolved. We are not saying there are no issues, but in respect of anything material, in respect of the relationship more deeply with the ANF and in dealing with issues that might come up from time to time,

we are very confident, not just here in Canberra but right across Australia—we employ 9,000 people—that our conduct and relationship with industrial organisations are very strong.

MS PORTER: So those particular issues are resolved. From what the ANF were saying, it is not necessarily the issues, because you are correct: they are saying the issues arise at both hospitals. We know that issues arise at every hospital around Australia; any institution has issues. However, they were saying that because of the two different operating procedures it was more difficult for them to get them resolved in the way that they would resolve them at other hospitals. Have you been able to adjust the operating procedures to match the ones at the other hospital? We were talking about having seamless services across both sites; have you been able to do that?

Mr Kmet: Certainly, at this stage, and following the meeting and clarification of a number of issues, we believe that is the case—that we have a fairly seamless relationship with the ANF in terms of issues management and a fairly consistent approach. Obviously, there are two organisations at play here. We are an organisation called Calvary Health Care ACT, and there is another organisation called the Canberra Hospital. So, respectfully, we do have differences in the way we do things from time to time. But more importantly, do we have a manner and a method of dealing with issues as they come up and is that consistent with what is expected in public health? I believe the answer to that is yes.

Mr Watkins: I was pleased that the hospital authorities at Calvary Bruce took the initiative in that meeting to try to resolve any of those outstanding issues. I think it was a good process.

Mr Kmet: One of the issues that has come out of the various pieces of evidence given is in respect of our performance around infection control issues. For the record, the measurement of that performance and our performance in those areas is certainly within accepted benchmarks and averages and certainly well and truly a level of good performance. So I am very comfortable with the underlying performance of the hospital, including some of the issues that may have come up in respect of those submissions.

MS PORTER: I do accept that you are two different hospitals and run separately. I would have hoped that critical incident management and occ health and safety would be uniform across any health facility across the whole of Australia. I am seeking some assurance from you that critical incident management and occ health and safety are uniform between these two institutions that we are talking about today.

Mr Kmet: I am absolutely confident and I can confirm here today that we run clinical incident management consistent with national standards.

MR HANSON: What we have established is that the government's logic in main part for pursuing the purchase over the last two years was about the accounting treatment and about having this hospital, Calvary, here on their books. That does not seem to be consistent with the way it is done in other jurisdictions. Other people do not seem as concerned about that. And there was some critique about whether or not that was a

logical way to go. But that aside, the government put that forward very strongly as their rationale for pursuing the purchase of Calvary hospital. At the time they argued strongly that they wanted to do that so that they could then invest in Calvary hospital at the Bruce site and said very strongly that that was the site to invest in. It had been demonstrated as such and there was no argument for a third hospital, and the minister at that point discounted that as probably not viable.

It seems then that as the accounting argument has gone, and we have got both sides of the debate agreeing that it could be on either book, so that the government's rationale for the purchase of Calvary hospital being an accounting treatment has now gone away, the government have changed their tune. So instead of saying, "We want to invest on the Calvary site because it's the preferred site," they are now saying that they are looking very strongly at the option of a third hospital, which is entirely contradicting essentially their previous arguments and the previous logic that they put forward, in my view, having looked at it.

I would like your opinion on this. I know it is a difficult one for you. It just seems to me that the government has changed its position, has changed its argument; the facts have changed and it appears to me that it is pursuing what appears to be an ideological agenda rather than necessarily pursuing something that is logical. Its position has changed almost 180 degrees on the issue of a third hospital and where to invest that money. As you sit where you are sitting, and you have seen the same thing that I have, do you have a view on that? Are you at the point now where you are starting to sense that this is not necessarily about anything other than the government getting control of public health assets and that it will do that at any length?

Mr Watkins: No, we do not have a view on that.

MR HANSON: You do not have a view on that?

Mr Watkins: No.

MR HANSON: Not that you want to share with the committee?

Mr Watkins: There has been a whole range of judgements and interpretations that absolutely recognise your right and duty to determine that. That is not something that we turn our mind to. Our job is to work within the limits that we have, and we do so willingly and we get on with the future of delivering healthcare services. But it is not up to us to try to divine the intentions of the government with regard to these matters.

MR HANSON: Can I touch on the third hospital. If the government do pursue that as an alternative, at the moment it looks to me like that is one of the two remaining options on the table. They do not seem to like option 1, which is broadly the option that you are pursuing; option 2 you have discounted, so I think the government understand that. That probably leaves options 3 and 4, and we had a lot of discussion last time we met with the government about the third hospital. What then happens if the government do say, "We're going to build a third hospital at another site"? What does Little Company of Mary do?

Mr Watkins: As I outlined in my opening comments, and as has been made clear in

everything we have said, we believe we have a right to continue to deliver a 300-bed hospital in north Canberra, where we currently are, and we will continue to do that. Therefore we believe that building a third hospital, and that is what it would end up being, would be inefficient. It would fragment services and would not necessarily improve the delivery of health care to the people of Canberra and would be mightily expensive. That is why we believe the continuation of the two hospitals and confidence in the delivery of services at Calvary Bruce is the way to go. Does that answer your question?

MR HANSON: That is fine. I appreciate that it is difficult. I guess I was asking for a judgement call that may be beyond the scope of what you are here to address.

Mr Watkins: It is not something that we, as operators of health care, would like to get into here or in other places.

THE CHAIR: Thank you, Mr Hanson. I have got a supplementary before I go to Mr Smyth. Just in relation to the line of questioning Mr Hanson was getting at, the current agreement that is in place between the government and Calvary hospital, or the Little Company of Mary, has obligations on both parties, I should imagine. The government has offered four options. Do any of those four options have an impact on the current agreement that is in place?

Mr Watkins: Certainly the second one does, I understand—proceed with the network agreement in its current form. We believe it does have an impact on the current arrangement. I suppose the fourth option would as well.

THE CHAIR: By "impact" I mean that you have to abide by the agreement. The government, I should imagine, has to abide by the agreement as well.

Mr Watkins: Yes.

THE CHAIR: So where does that leave the government in terms of the options that are being offered?

Mr Kmet: I think at the heart of any change to the current agreement there needs to be a mutual agreement to make a change. I think that once we see what specifically is being proposed more broadly we can work in with a number of options, and we have indicated our willingness to do that. I think that, at the end of the day, the heart of the current agreement is that, if it is to be changed, there needs to be a mutual agreement to change it. That is, I think, at the heart of any change.

Mr Watkins: Which is based on the mutual respect between both parties that has always existed for the last 31 years and will continue, I presume.

THE CHAIR: So, in other words, for anything to change, there would need to be a new agreement put in place. Is that the crux of it?

Mr Watkins: Pretty much.

Mr Doran: The network agreement goes to the heart of the agreement and

fundamentally changes it, which is why we do not particularly like that option. If the government thought that operating a 300-bed hospital at north Canberra and building another one made sense then it is a decision for government. We do not believe that that is a viable option.

THE CHAIR: Mr Smyth?

MR SMYTH: Thank you, Mr Chair. Gentlemen, thank you for your time. I know you answered some questions on the financial arrangements earlier—I have been listening upstairs—but I was just intrigued as to when the government brought it to your attention that they were going to use interpretation 12 to list the asset that is Calvary hospital on their books.

Mr Kmet: We will probably have to take it on notice as to specifically when that happened. It happened earlier this year. As to an exact date, we would have to provide it.

Mr Watkins: We are happy to provide that—when we became aware of it.

MR SMYTH: I would be happy to receive it, Mr Watkins, particularly given your—and the government's—financial arrangements. The territory each year produces consolidated annual financial reports that are audited by the Auditor-General, which is standard practice for governments. I have a copy of the 2008 financial year reports. As is required, it does list changes to accounting standards. It is interesting that in this document the changes to principles start on page 40, but on page 50 of the document it refers to the impact of accounting standards issued but yet to be applied, and it lists interpretation 12 on the service concession arrangements. The Treasurer and the Under Treasurer have signed off on this document saying, "It is estimated that the effect of adopting the below pronouncements when applicable will have no material financial impact on future reporting periods."

So it would appear that in late 2009 the territory accepted accounting standard 12 as having no impact and that it would not lead to a change to the finances as reported, but suddenly in 2010 they changed their view. The importance of the question is: when did they tell you that they had come to this opinion, so that we can compare what the Treasurer said in the Assembly—that something will have absolutely no impact on the finances—with when they got that message to you?

Mr Watkins: We will get to you as soon as we can as to when we were made aware of that change.

MR SMYTH: All right. You obviously as an organisation, and perhaps it pre-dates your time, Mr Watkins—perhaps it is for Mr Kmet and Mr Doran—in your reporting take into account changes in accounting standards, I assume, and report as such? Your interpretation of interpretation 12 leaves you in no doubt that the assets should be recorded on your books?

Mr Doran: Yes.

MR SMYTH: Have you advice to confirm that?

Mr Doran: Yes.

MR SMYTH: Is it possible for the committee to have that advice?

Mr Doran: We have provided that advice as attachments to the submissions.

MR SMYTH: That is the Deloitte advice and it is currently in your submission?

Mr Doran: And the Young advice. Really, that is the crux.

MR SMYTH: And Neil Young is?

Mr Doran: Neil Young QC.

MR SMYTH: You sought advice after the territory informed you or you had that advice from—

Mr Doran: We were seeking that advice anyway—whether 12 had implications for our group, because we run other public hospitals. As you know, it is about service concessions. We are trying to make the point that there is a fundamental and very big difference between a joint venture and a service concession, and 12 is not meant to capture the arrangement that we have with the territory.

MR SMYTH: Do you believe that you are currently in a service concession arrangement with the territory?

Mr Doran: No.

MR SMYTH: Again, the Deloitte and the Neil Young advice confirm that?

Mr Doran: Correct.

THE CHAIR: On the same area of interest, with the interaction that you have had with the government, you say, for the last 31 years, there have been good relationships between both parties. Have the current discussions broken down the trust in that relationship and is there a need for a more formalised agreement to strengthen the relationship or to rehabilitate the relationship, if you like, for want of a better word?

Mr Watkins: At a governance level, no. I will allow Walter or Mark to talk about the relationship perhaps at the departmental level. At a governance level, no; we enjoy an open and positive relationship with the government.

Mr Doran: At times, like in any relationship between a provider and a funder, they can be robust. That is part of the benefit. We have those same robust relationships with other funders, whether it be the Department of Veterans' Affairs or Medibank Private. In fact, we got a letter of support for a project we are doing today from ACT Health. We get on. There is no breakdown in the relationship, which is good.

Mr Kmet: I think it has been operating very well. Let us not forget that within the

context of our relationship we do have a performance agreement which we work to and that outlines the government's desires in respect of how much volume we should produce and what our targets should be. In respect of those, we are comfortable we are meeting not only our targets but also the desire of the territory in some areas to increase the work. For example, this year we have taken on an extra 20 per cent of elective surgery at Calvary hospital. Our relationships have to be good for us to be able to deal with that kind of change to volume because it requires a lot of interaction between us and ACT Health in respect of how those services are delivered and, indeed, to give them the confidence they can be delivered. There is a very strong structure in which we deal with the relationship, but I also think that relationship works well.

MS BRESNAN: One of the things we have talked about this morning—there has been an ongoing discussion about it throughout the whole debate—is the lease, which was done under a federal government before self-government. There was a statement that it may have been an ideal arrangement back at that time. The issue you brought up was around autonomy, about you being able to act autonomously in the service you provide. I am just wondering how that actually ensures that the government or the community, I guess, are getting the service that they need and that what you do is working in terms of the way the rest of the system works in providing health care, particularly public health care.

Mr Doran: The performance agreement is the obvious one.

Mr Kmet: I think we need to separate the role of Calvary and, indeed, the role of the Canberra Hospital from the role of the ACT government and ACT Health. The role of ACT Health is to determine what healthcare needs the community requires over time. It undertakes strategic planning; it undertakes analysis; it obviously ensures that it has the future funding to deliver services. The role of both Canberra Hospital and Calvary is to deliver those services. So we are responding to the needs of the government, as are other public providers, as are other providers in the system. In that respect, as we have said earlier, we believe that we are meeting those requirements, we are meeting those needs, across an annual performance agreement.

MS BRESNAN: I guess this is what I am trying to get at: over time, the needs do change in terms of what we need to provide as a community and as a health system. We have talked about this. You said that it is good to have different players in there providing services. But one thing that has been discussed recently by various organisations is that need to have an across-the-system approach—working together—so that one hospital might do this and another might provide another service so that they are working together.

Obviously, you have the service agreement and that is one part of it. But there are also the other things. As times change, what a government needs to provide as a government is health care to the rest of the community.

Mr Kmet: Yes.

MS BRESNAN: That is an issue. How does that impact on what the government needs to provide over time if we have this lease arrangement that was in place before we actually had a government?

Mr Kmet: In respect of all of the documents that we have put in our submission, the planning documents that really go to the heart of what the government wants to do in health care, I can confirm that we have had an involvement in all of those plans. There has been good consultation between us and the government and, indeed, between the government and other providers in the system, whether they be other hospitals or other healthcare services.

So there has been involvement by us in all of those plans. As has been more recently the case with "your health—our priority", that particular process, we were certainly participating in the capital asset development plan associated with that. I do not think that the lease at Calvary is at the heart of health care and service delivery in Canberra. I think what is at the heart is the documents that the government has taken the time rigorously to put in place over the last eight to 10 years and for all healthcare providers to be able to have participation in those documents, as well as then participating in delivering what those documents plan to do.

So I would rely on that work and I would rely on that work in the context of not only it being the right way to plan health services, but also on the basis that we have been involved in them, as have a number of other healthcare providers.

MS BRESNAN: But the lease probably does have some impact. If we had a situation where the government did want to purchase a hospital, did want to do anything with that site, the lease does actually have an impact as such, doesn't it?

Mr Kmet: We have outlined in our submission that if we are talking about capital asset development and capital funding, there are a number of ways in which we could deal with that—a number of options that are available to deal with it. In our view, they could take place to the mutual benefit of us and the government.

MS BRESNAN: I want to check something and I have another quick question on it. If Calvary in its operations made decisions, say, to close beds or to close wards—for whatever particular reason that might be—is that something you would consult on with the government first before that happens?

Mr Kmet: Absolutely. In the context of our operation within the system, there is constant dialogue between, for example, the CEO of the hospital or the medical director of the hospital and, for that matter, what happens at Canberra Hospital and a number of people there. We had the example during your visit where the accident and emergency physician and the accident and emergency manager had stated very clearly that they have almost daily conversations with the people at the Canberra Hospital, and you would expect that to happen. You would expect that to be the case, whether it be public hospitals, whether it be even a large private hospital in the system with an impact on the system.

I think it is incumbent on all operators, whether they be public, private or community operators, as best as possible to integrate their self-care services. If there is something that they do that will impact on the rest of the system, I think we have a responsibility, let alone it being good common sense, to communicate and inform.

MS BRESNAN: This would be the case if TCH was going to do something that impacted on you—they would consult with you—and if there was something you were going to do that would impact on TCH. If feedback came back that that would have an impact that was going to be negative, would that be something that Calvary would then want to consider?

Mr Kmet: Absolutely. We have seen numerous examples of that even over the last 12 months where there have been movements, for example, in the number of obstetrics deliveries on the north side. We have had to have more deliveries planned for than were planned for in the original agreement. We have worked with the government in terms of our capacity to deliver, as I am sure the government do with TCH. And, of course, we work on all the issues around how those services are to be funded. Again, the same thing would apply with TCH, yes.

MS PORTER: Have there been other areas where you have had to adjust the service delivery based on demand? You talk about the demand on the maternity area. Have there been other areas where you have had to increase the amount of service delivery?

Mr Kmet: The most obvious one I think for the currency of the times is that we have agreed to increase our elective surgery throughput by over 20 per cent this year. Certainly, over the last 10 years there have been stepped increases in the number of presentations to A&E. So in respect of the accident and emergency presentations, we are now up to nearly 50,000 presentations a year on that site. That has increased enormously over the last number of years.

In terms of the introduction of new streamed services like older persons' mental health, the investment five years ago in the ability to deliver those services onsite—in rehab and in older persons' mental health—has seen a stepped increase in being able to respond to that.

Health care, and particularly public health care, is not an exact science. You can often plan over a long period what the community's health care needs are, but within that planning period there are lots of ups and downs. We are in a position where we would never deny anyone access at any immediate time to public services at Calvary. There would not be any situation, funded or unfunded, or regardless of the circumstances where someone comes into the hospital and needs a service we would not provide it. We operate in exactly the same way as every other public hospital in that regard.

MS PORTER: Has there been additional demand in the general area of mental health? You talked about older people's mental health but how about the general area of mental health? Has there been an increase?

Mr Kmet: Yes, there has been and from both the public and private point of view. We have seen the development of Hyson Green private mental health service. That is certainly something that has grown over the years and taken pressure off the public system. At the same time, it is an identified growth area. In Canberra, mental health is a growing area of need. It is a significant growing area of need, particularly in terms of bed days. That is something that these planning documents do identify. We as a provider in the system need to be able to respond to that over time.

MS PORTER: On another subject, you talked about electronic management before. You know that the government is very keen to introduce the seamless e-health system across the ACT. What work is being done to integrate the work that you are doing with the ACT government's work?

Mr Doran: It is a federal government initiative. The federal government is calling for submissions for tomorrow. What we are trying to do—we actually use the same software. We have to upgrade ours to match. We actually use that same vendor for the rest of our organisation. So it is quite useful. In fact, not only are we doing two public hospital submissions; we are doing a private one as well, partnering with the major vendor.

That vendor happens to provide 70 per cent of the software that manages our hospitals, public and private, in Australia. So if one of those three gets up, that is wonderful. We start working on various aspects of working out how all those inputs from general practice, pharmacies, those sorts of things, go into, let us call it, the black box and how they end up in the electronic medical record of the hospital and vice versa—on the patient's medical discharge, how it works its way back out. That is essentially a bird's eye view of what we are trying to do.

It is this black box at the moment that is the trick to the whole thing, how do you get all those different and diverse signals—languages, if you like—through a filter and get it out in a format that can be accepted by the major vendors. We are doing that on a number of counts. But it is obviously the way ahead. Australia is considerably behind the rest of the world in this. We think we have a role in it as well.

For example, medication errors are an iceberg. We know that. Generally, they do not lead to any harm but they are there. They are in every hospital. We would like to eliminate them. Obviously, getting IT to get a consistent approach to it across the whole system is one of the Australian quality commission's main aims. It is probably No 1 on their list, as I recall. That is where we are pitching a couple of bids—in that area.

MS PORTER: So transfers from one part of the system to another would be seamless?

Mr Doran: Seamless and inputs from general practice and reports back to general practice would be seamless.

Mr Kmet: The committee might be interested in an example where that already happens and where it happened last year in respect of the implementation of the territory-wide picture archiving and capture system in terms of radiology. We participated with the territory in that program and that has been fully rolled out. So we are able to take an x-ray at Calvary, put it on the PACS system as it is called and it has access across the territory. That is an example of where e-health has been translated into the local integrated health system, public health system, and, as Mark has mentioned, that example is the first of many examples that are going to be coming our way as a result of the various initiatives by the commonwealth government.

As Mark as mentioned, we think that is really exciting. We are participating with

ACT Health in a bid that ACT Health are making to the submissions for the e-health patient electronic health record process and we are also putting a submission in which, as Mark mentioned earlier, ACT Health are supporting us in, which is a more broadly based application across aged care and also interstate with our hospital in the Riverina.

MR HANSON: The My Hospital website looked at EDs and we have already touched on that, but it also looked at elective surgery, and the picture for elective surgery in the ACT is very grim. In actual fact, the results that we are getting, both at Calvary and at the Canberra Hospital, are the worst in the nation. I am just wondering why that is. Is it a lack of facilities—beds, operating theatres? Is it a lack of staff, be it specialists or nurses? Is it a lack of operating dollars to actually run the system? Is it a combination of those or is it something else? Why is it that we are doing so poorly when it comes to elective surgery?

Mr Kmet: I do not think it is for us to comment on elective surgery performance more broadly in the ACT.

MR HANSON: My Hospital is reported by hospital and it reported on Calvary and Calvary got some pretty good figures, so I suppose I am making the assumption that what happens at Calvary happens at the Canberra Hospital, the same sort of factors. But let me ask then very specifically about Calvary: why is it that at Calvary we are not meeting those targets?

Mr Kmet: In respect of Calvary I can comment clearly and provide a report this morning that indicates the number of procedures we have done. We are certainly meeting our target in the system to that. If that target then translated in a different result either for us or across the system, we are doing within the system what we are being funded for and being required to do. That is really as far as I can comment on that. The question of elective surgery—because what we have in the ACT is not just about Calvary; it is across the system—is really a matter for the government or ACT Health to manage.

MR HANSON: Let me frame it another way then. Assuming that there is a problem here in the ACT, and Calvary is one of the two hospitals that does the public list, if you were to do more, if one part of the solution was for Calvary to do more, is it an expansion of facilities you need, in staff or operating dollars in the shorter to medium term? Looking towards the future—I think 2020 is about the time that we peak—what is it that we need? Have you done a bit of a review of that, where you need to increase capacity? What sort of dollars, what sort of increase in size in terms of beds or operating theatres, what percentage of staff do we need additionally, both to meet the current demand and also to expand?

Mr Kmet: As we have demonstrated this year, we have a capacity to do more work and we are doing more work this year. We believe there is further capacity at Calvary to do more work. We also believe that there is a real opportunity in day surgery at Calvary, in particular the ability to clearly designate day surgery work with more acute, if you like, overnight work, and I think that in terms of both efficiency and patient care is an option and that will increase capacity as well. So there are a number of areas in which we believe that we can increase capacity should the government want us to.

MR HANSON: So it is just dollars essentially that are limiting it?

Mr Kmet: It is not just dollars; it is a question of government priorities and certainly where that work takes place. It could be a view that that work on planning by the government is better to take place at TCH than at Calvary.

MR HANSON: Sure. I suppose the point I am making, though, is that, if the government were to say, "Here are X dollars to increase the amount of work that you do," you would be able to turn that on reasonably quickly; that your constraints are not there because of a lack of beds, a lack of operating theatres or a lack of staff? You have the capacity.

Mr Doran: We have the capacity, and in the wider framework of our network we have capacity as well. What I am referring to is obviously the private sector. There have been initiatives to purchase elective surgery from them and that is not unique to this jurisdiction; it is quite common around Australia now.

MS BRESNAN: In terms of specialists, particularly for elective surgery, are you saying that that does not have an impact? I would imagine that would have an impact here in the ACT.

Mr Kmet: It is interesting that over the last 12 months with some of the commonwealth government initiatives around training of specialists, some of that is actually starting to filter through the system. For the first time, in our last round of applications for staff specialist anaesthetists we actually had more than one application. So I think some of the work around training and skilling is starting to filter through. Clearly, like anything you do in health care, the ideal situation is to be able to plan. We cannot literally, for want of a better word, turn the tap on tomorrow; nor can any other hospital. You need to be able to plan for the future. It is about staff and skills. It is about facilities. It is about the ways and models of care in which you do things.

One of the clear issues I am trying to get across in the day surgery issue is that I think there is an opportunity there to do things more effectively as well. Everyone can do things more effectively. So it is about people, facilities and models of care, and all of those things properly planned provide you with a better capacity. History stands for itself as far as we are concerned: Calvary has increased its capacity significantly over the years and has been able to do that in respect of both medical and professional staff.

MS BRESNAN: You said with the federal initiatives there is more a focus on the specialties that are required. That is something which does take time and something which government, or even you as a provider, cannot really control in terms of what specialists come out of the system as such, I guess.

Mr Kmet: Sure. That is true and that is one angle. Calvary, I think, has had the real benefit of not just using staff specialists but having a visiting medical officer model of care. Let us be clear: visiting medical officers up to probably 20 years ago were part of the public health system per se. Most public hospitals ran on that model of care. It is a more recent phenomenon that we have put in place staff specialist models of

medical practice.

One of the great benefits of Calvary is that it has a mix of both. It has great support, longstanding support, from visiting medical officers as well as having a growing base of staff specialists. So what we can do really well is flex up and down in terms of our capacity. Our visiting medical officers, as you have seen from the submissions, and some of the longstanding ones, are very supportive of Calvary and very supportive of the notion that Calvary can increase its capacity.

MS PORTER: In terms of nursing staff, what are your feelings about going into the future?

Mr Kmet: I am also fairly positive. In saying that, there are clearly stresses with a skill shortage in that area, as there are in many areas of health, but Calvary has a very strong relationship in the teaching and training of nursing staff with the University of Canberra. We take large numbers of nurses for training every year. We believe that is one way in which we can assure future resourcing of the hospital and also benefit the system more generally. That is part of what we do. I think that is one angle. That commitment is something that we have had for a long time and it helps us deal with some of the pressures we have on what is obviously a skill shortage in nursing right across Australia.

Mr Doran: Likewise in aged care, we are doing the same in Canberra, because that has been a forgotten area.

THE CHAIR: Option 4 put forward by the government is that the ACT government build a new acute public hospital on Canberra's north side. You have already indicated you do not believe there is a need for a third hospital in Canberra. Should the government pursue that option, what impact would it have on the government being able to staff that hospital, for starters, and what impact would it have on your ability to retain or recruit staff?

Mr Kmet: I think what we have said here and in the submission is that we believe it is logical for there to be an investment in Calvary, both from a value-for-money proposition point of view and from a risk point of view. Being able to add to existing infrastructure and existing systems, in our view, will provide the system with the best way to increase capacity. Presumably, if you build a third hospital, the intention and the reason for doing that is to build capacity. We are building capacity in the system. We believe that the way in which you can do that at Calvary provides value for money and a good risk-management approach to that process. I think it is really as simple as that as far as we are concerned.

THE CHAIR: My question related to the situation in Canberra. We have a problem with GPs. You indicated we cannot automatically turn on the tap. We are talking about a third hospital and additional specialist staff required. Does Canberra have the capacity to attract the numbers that would be needed for a third hospital? That was my question. What impact would that have on your hospital?

Mr Kmet: It would depend on the planning. At the end of the day what does a third hospital mean? Does it mean a duplication of services? Does it mean additionality?

What is the time frame? Building a new hospital and providing a new health service is fraught with a high level of complexity and challenge at the best of times. I agree with you that in Canberra we have challenges in recruiting skills in all areas, not just in health care. It will be a challenge whichever way you look at it. Our perspective on it is that we believe investing in Calvary provides us with the best value-for-money and low-risk option in achieving an increase in capacity, if that is what the government wants to achieve in doing that.

Mr Doran: I think it would be fair to add that the medical fraternity share the view that building a hospital is not the best option either. They can see fragmentation in training. They can see the problems of not having a clear view of what you are trying to achieve when you say that you should build another hospital.

THE CHAIR: When you say "the medical fraternity"—

Mr Doran: The VMOs and the specialists at Calvary hospital see it as a great risk to the clinical network they have set up for training and teaching. You will see their submission is supporting that view.

THE CHAIR: Ms Bresnan?

MS BRESNAN: Following on from that, there are a number of organisations that are in favour of it. The AMA were very much in favour of it. When they appeared before us, they were very much in favour of it in that they see there is capacity there. Organisations such as the Health Care Consumers Association also are in favour of it. I just note that.

One of the things discussed with the government in terms of looking at that third hospital option was whether there would be a focus on subacute beds at that facility or at another facility. Organisations like the Australian Institute of Health and Welfare recently said that is where we do need to invest more. The AMA have mentioned having subacute and preventative-type care.

If we are to continue with Calvary as it is, as a major public hospital, as is TCH, how are we as a community to build up those subacute services? That is something that we are going to need to do. We still have the acute focus. The subacute is something that everyone knows we do need to start focusing on more. How do you then see we are able to proceed with that? If we do not have a third hospital option, we will potentially have to focus subacute at another site. If we continue as we are, how are we going to account for that need in the community as well?

Mr Watkins: Walter can perhaps talk about how we deliver subacute needs beds. On the issue of submissions arguing for a third hospital, I think there is a bit of confusion as to what that actually means. Some suggest it should be a brand-new hospital that replicates what we do at Calvary generally and that Calvary either evaporates or does something else. Some other submissions suggest there should be a third hospital but are silent as to what a third hospital will do. If it became the second acute hospital, what would you do with Calvary? In the submissions that have come through, there is a lot of confusion over just what a third hospital means.

THE CHAIR: On that, the government option is quite descriptive. The submission says that the ACT government will build a new acute public hospital.

Mr Watkins: Yes. In the submissions that have come through, there are different interpretations of what a third hospital may be.

MS BRESNAN: To be fair, a couple of organisations have appeared and there was a lot of discussion about what would be the best option to proceed, rather than confusion.

Mr Watkins: Sure, discussion.

Mr Kmet: If I could respond to the subacute issue, the territory plan is fairly clear on that. The priority which we outline in our report is the need to invest in the Bruce campus to provide a subacute services precinct. On the basis of where we are right now, we are working to it, to the extent that there will be additional subacute services provided on that campus. That does not mean that should change or that it should not be revisited or that there should not be other options looked at. I would encourage that to take place.

I am aware that the government is going through processes to look at aged care in Canberra. That is all very positive. That has been linked with subacute care. It is absolutely critical that we do not look at subacute care on its own, without then looking at aged care and chronic disease management. There is a tripartite approach that requires a lot of planning and coordination. But insofar as the existing plans are concerned, as outlined by the government, the proposal is to increase those acute beds on the Calvary campus. Because of the landholding there, we would have the capacity to do that.

Mr Doran: You also need to look to the industry to see value for money. If you look at both other jurisdictions and the private sector, most of the investment is in brownfields, not in greenfields. In other words, do not build a new hospital; build on what you have got. It is much more effective. If you look at the private sector—for example, Ramsay Health Care—all are doing brownfields. There are very few new hospitals being built.

It is the cost of capital. The cost to start from scratch is enormous. The difficulties in getting a hospital up and the things that fall through the cracks are well known to those operators in other jurisdictions and in the public sector. Know what you have got. That is a very good maxim.

Mr Watkins: We are very conscious of the cost to the ACT government of building a brand-new greenfields-site hospital. It is an extraordinary cost that would burden the community. That is a judgement the government has to make, whether or not it seeks to do that. I suppose the decision is going to be determined by issues such as the planning needs going forward. There is that awful phrase again.

Over the next 20 or 30 years the efficiency of developing a new hospital as opposed to building on one that is already there, the budget impost, the quality of care that will be provided, these things change. These are qualities the government will need to address.

There is the sheer burden of building a brand-new hospital in the north of Canberra. You need to be aware of the impact it will have on the ACT budget.

MS BRESNAN: It is true that you have to acknowledge what happens in 10 or 20 years time in terms of health care and the health budget. It is big. It is a growing budget. It is about acknowledging that as well and thinking about what the community is going to expect or carry as a burden in 10 or 20 years time in terms of health care.

Mr Watkins: We are very aware of that. We know there is going to be a huge demand for more services in Canberra. A lot of those services, we believe, can also be delivered outside the hospital. It is increasing as people age and get chronic illness as they age. The best place to deliver those services is in their home and keep people out of acute-care facilities. With some conditions, for example, dementia, it is the worst possible place to have someone. I think that is going to be a developing trend we are going to see over the next 20 to 30 years as well. There will be a huge increase in dementia services in the ACT. That is why you are here today, trying to work your way through that.

THE CHAIR: I have a supplementary on what you mentioned before about the cost of a new third hospital. If option 4 were to be undertaken, with the number of hospitals that your organisation is involved with, would you be able to give some estimate of what a new hospital today would cost?

Mr Doran: Probably the most recent one is in Adelaide. It is off the Richter scale, to be quite frank. It is well over millions per bed. Per bed, it is somewhere between $1½ million and $2 million. So, if it is a 300-bed hospital, that is $400 million or $500 million.

MR HANSON: Is it the same sort of cost for a private hospital?

Mr Doran: No, and there is a reason for that. They are nowhere near as large and they tend to understand the cost of capital. We sometimes refer to it as the effect that everybody is a winner in making a hospital in the public sector large. It is not so in the private sector. It is completely the reverse.

MR HANSON: I was thinking about if we were to look at option 3, which is building the private hospital and what the cost of that would be.

Mr Kmet: We went on record last year when we looked at building—we phased out what we thought a private hospital development on that site would look like. We looked at a five-year development of $45 million to $50 million, at that time.

MR HANSON: How many beds was that? Was it about 90 beds?

Mr Kmet: Ninety beds; that is right.

MS PORTER: I have a supplementary on the comments you were making before about the cost. You were talking about what the government was prepared to pay for the cost of care. I am sure you are not suggesting that the government or you would decide that you could deliver a cheaper level of care. You were not suggesting that the

government would ever contemplate that at any stage?

Mr Watkins: No, I would not suggest that at all. I would not suggest what the government of the ACT should do or could do.

MS PORTER: You said it was dependent on what kind of care you are prepared to pay for. I thought that was what you said. I need to check the *Hansard* later.

Mr Watkins: I probably was referring to the type of care that might be delivered in a particular hospital with the design. Also, there was my reference to care in the community, which is so much cheaper than care in a—

MS PORTER: Right, so you were referring to whether it is delivered in the hospital or delivered at home. That makes sense. Do you see Calvary as having the capacity or having an interest in expanding the services into the home? You particularly talked about the area of dementia. That also creates a huge burden on the carers. How would you see responding to that?

Mr Kmet: We have a significant role in Australia, not the least here in the ACT, in providing care in the home, through some level of community services. For example, when we look at palliative care home-based services, we have long experience in that. We work with a number of physicians at Calvary Public Hospital on the hospital in the home concept. So that is where we have exposure to that. Of course, we always try to link up through what we see in the A&Es, particularly with people coming in with chronic diseases. We try to better manage those. We have a long way to go in all of that; so has everybody. I would agree wholeheartedly with the Health Care Consumers submission in this respect. The focus around an affordable and best-placed healthcare system in the future is around being able to deal with some of the issues that you are referring to, absolutely, and being able to provide capacity and quality in those systems.

Mr Watkins: You have clearly identified one of the great burdens on our healthcare system over the next 20 or 30 years, which is that of private carers. An Access Economics report commissioned last year suggested a shortage of about 150,000 carers within 20 years, just in dementia, let alone other chronic diseases of ageing. That is only going to be resolved with forceful, forward-thinking action by the federal government with the cooperation of states and territories. If it is left, the end result is going to be literally tens of thousands of Australians living at home without care when they most desperately need it. That needs concerted action. Hopefully, the Productivity Commission report that we are currently awaiting in aged care and dementia care will point towards that problem and an answer to it.

MS PORTER: I think an interim report is due in January.

THE CHAIR: We might move on to a last question. Mr Hanson?

MR HANSON: I am good, thanks. Given the time, I think I have got everything I need. It has been very helpful.

THE CHAIR: We have obviously covered a whole range of questions. In the time

remaining, is there any question that you would have liked us to ask that we have not asked you?

Mr Watkins: I think you have covered it, chair. You are very clear on what we are arguing?

THE CHAIR: Yes.

Mr Watkins: I do not need to repeat that.

THE CHAIR: No. We are well aware of option 1 and—

Mr Watkins: If we are coming to a close I would like to thank the committee for its attention and intelligent questions about a critical issue for the future of the ACT. We stand willing and able to assist in the continuing care of ACT citizens.

THE CHAIR: We thank all three of you for coming along and giving us your time and the information that you provided. If there is anything further that comes to mind that you feel we should have been made aware of, you are obviously welcome to present that information to us in the interim. A copy of the transcript of today's hearing will be sent to you. Thank you once again for appearing.

Meeting adjourned from to 11.25 to 11.47 am.

GUNNING, MR ROBERT, President, Save Calvary group
HORNE, MS RACHEL, Publicity Officer, Save Calvary group

THE CHAIR: Good afternoon, Mr Gunning and Ms Horne. Thank you very much for attending this second public hearing of the Standing Committee on Health, Community and Social Services inquiring into the Calvary Public Hospital options. We have already had a session this morning with Little Company of Mary Health Care people here, so we welcome you now as the Save Calvary group.

Before we get underway, have you had an opportunity to read the privilege statement that we provided and are you comfortable with it and its implications?

Ms Horne: Yes, thank you.

Mr Gunning: Yes.

THE CHAIR: Would either of you like to make an opening statement?

Ms Horne: Thank you for seeing the Save Calvary group this morning. We are very pleased that the ACT Legislative Assembly has decided to hold this inquiry. In our view far too much about what the government proposes for Calvary in delivering health services in northern Canberra remains a complete mystery. In our view there is much that needs to be revealed. Save Calvary is a grassroots community organisation formed when a number of people who live in north Canberra realised over a year ago that it looked as if we were on the verge of losing the unique and well-valued health services of Calvary hospital and it seemed this could happen without any grassroots community group, everyday members of the community and users of Calvary hospital raising their voice in public.

So we formed a group to represent that voice—the voice of ordinary, everyday people in the community who wanted to retain Calvary as it is. It is not by accident that all of us have a direct and long association with Calvary as do our family members. We know from personal experience that Calvary delivers an unparalleled level of quality, caring services. We simply do not want to lose that. We simply see no reason to fix something that is not broken.

As we joined the debate and followed the various twists and turns, we became more and more convinced that we were not getting the true story. For a long time the government's public position said that somehow the government had to take over Calvary so as to maintain the ACT's credit rating. It was a complex argument, one we did not find very credible, and now at this moment that argument seems to have been completely dropped, yet the government is still talking about this issue effectively in option 4 and the debate goes on.

The longer the debate has gone on, all the more concerned we have become that it is very obvious that the north Canberra community is seeing much needed health investment withheld. We think it is high time the government took the necessary decisions to move forward and to make these investments in health which are continually talked about but which are not really happening in north Canberra.

Perhaps now I will turn to the apparent options which the government has said are the options that ought to be examined. I will go through each option in turn, but the first and most obvious point to make is that the options are not clearly independent. They range from options 1 and 2, which seem to be some variation of saying that Calvary will continue, to option 4, which envisages the government bypassing the Calvary campus to apparently try and create a duplicate north side hospital on another less well situated site.

I will hand over to Robert now.

Mr Gunning: I have come along really, I guess, prepared to talk through the four options that the government had mentioned a couple of months ago as being the relevant options. I have taken the opportunity to read some of the transcript of what has already happened before the committee, so maybe I am just covering ground that you have already gone through, but it certainly seemed to us that there are apparently four options but really they come down to two options. One is: do something generically where we work with Calvary, with Little Company of Mary, in some way. That is some version of options 1, 2 and 3. The other option seems to be: do not work with Calvary; go and do our own thing. That is option 4.

So the four options become two in reality. There is a great confusion as we see it between what the first three are actually saying. They operate at different levels. They drop to different levels. They call up things that really from our point of view are complete black boxes. For example, they call up the network agreement in its current form. So far, we from a small community organisation point of view have not been very effective at getting hold of any of these essential items.

For example, we are asked to comment on the network agreement in its current form. We have looked at the *Hansard.* We are told that is under a confidentiality cloud. Our experience suggests that is rather the case and it sort of leaves us with that kind of sense, in terms of the options at the end, that there is something clearly driving the debate. It is hard sometimes to know what it is. Different reasons get erected. Those reasons come and go. Underneath it all there seems to be something else going on, which is probably reflected in that notion of trying to work with Calvary, which the government seems to have difficulty doing—and we look across Australia and ask: why can every other government in Australia find some way of working with non-government organisations? But it seems to be beyond the capability of government in the ACT. The other option just seems to be some sense of "We'll do our own thing," which is not something we are at all in favour of.

Just to go back to our theme, what brought us together was the fact that we have all had personal experience of Calvary. We have all been there. Some of us have worked there. My own involvement, for example, is a family involvement—rushing off to emergency with the kids from time to time, going there myself from time to time, having friends go there and so on. We are absolutely sure that we have got an unparalleled, wonderful facility service there and we really do not want to see that affected. As we have tried to follow the debate, we have got more and more bemused about what it is that is really going on.

So I guess our final point is that we like Calvary as it is. We would like to see that

tradition of service continue and we would like to have some hospital services on the north side of Canberra.

THE CHAIR: Thank you. Obviously, as you know, the terms of reference for this committee are to look into the four options and to look at the people who have been given the option of putting submissions in. We have had, I think, 18 submissions now, and all of these submissions, by the way, are available for you to view. I am sure you are aware of that; I hope you are.

Mr Gunning: Yes, we have looked at some of those submissions and one is continually struck by the fact that we are having a debate—I am at least, and I think our group is—which is missing the core. The core was this idea that it was somehow connected with the credit rating—something we did not accept. Now it seems that core has gone, although from time to time it seems to bubble up.

Another thing that gets mentioned from time to time is that the government seems to have some difficulty dealing with a system where it does not own and control everything, and that seems to be unique to the ACT. Other governments in Australia do not have that problem. Sometimes we are told that it is about efficiency, yet when we have asked for efficiency numbers in the ACT we get the cloak of confidentiality. The figures that are produced on efficiency are really sufficiently aggregated not to mean anything. And there are all sorts of issues that are pulled across the path that we look at and we think: is that real?

We keep thinking: "We have got a great facility. It is a great place to go. We know people go there by preference. We know staff go there by preference. We know patients go there by preference. We know it provides a defined range of services and within that defined range it does a great job."

THE CHAIR: Thank you. I just wanted to make sure that you are aware of the other submissions.

Mr Gunning: Yes. We are sort of going through them.

THE CHAIR: Obviously that is important, to have access to those.

I will pass over to my colleagues as well, as they have some questions to ask, and then we can develop some of the things that you want to get across.

MS BRESNAN: Noting your submission—and I am guessing you have looked at the Little Company of Mary's submission as well—

Mr Gunning: We have looked at the majority of submissions that are available, yes.

MS BRESNAN: Obviously the Little Company of Mary appeared before the committee this morning—

Mr Gunning: So we understand, yes.

MS BRESNAN: In terms of their support for the various options that have been put

forward, option 1 I think is one that has come through from Little Company of Mary themselves to government and option 2 is one that they have noted this morning they do not support. They are mostly supportive of options 1 or 3. That is what they are quite supportive of and that has been laid out in their submission as well.

In terms of your submission, I note that you have said there are some connections, particularly probably between options 1 and 2, although LCM have said that they do not support option 2; they support option 1. You have mentioned maintaining Calvary as it is. Is that your preferred option? Do you want to see other services provided there on the LCM site in terms of subacute-type facilities? What is it that the Save Calvary group want to see happen on that site?

Ms Horne: Certainly there is a need for a greater range of services to be available to people at Calvary hospital, especially since we have a very expanding population in the north, in Gungahlin and other areas. So that would be our preferred option—that the Calvary hospital be given funds to improve the facility there and to be able to service the population in north Canberra.

MS BRESNAN: As a group that has formed around Calvary, what sort of services would you actually like to see there? Something which has been noted by the government and LCM is that the population of the whole of the ACT and the need for health services are growing and there is a need to work between TCH and Calvary, or whatever the health facility would be. What do you think are the sorts of services that we need to see at Calvary?

Ms Horne: The emergency department needs more funding, for more staff and more facilities there. It is not often that you walk into the emergency department in Calvary—and I understand it is the same at Canberra too—and not have a six or seven-hour wait for non-urgent cases. I have spoken to staff there and they are quite frustrated by the lack of beds and being unable to provide the services that they need to provide for the people that come into the Calvary emergency department.

With respect to some of the things that need to be done as a whole, we need to have reduced theatre waiting lists. If Calvary could be expanded then those waiting times would be reduced. It is not necessarily particular to Calvary hospital but certainly it is particular to northern Canberra. Obviously our option would be that LCM would maintain the service and ethos that are there but have an ability to expand the services that they currently provide.

MS BRESNAN: As a group, is your outlook in terms of maintaining LCM's management or ownership of the hospital based on the ethos that they apply to the hospital?

Ms Horne: Absolutely.

MS BRESNAN: Is that the primary issue for you as a group?

Ms Horne: Absolutely.

Mr Gunning: Our core issue starts with the notion that we have got something very

valuable which we see as being threatened. That is our core issue. As a group, we have talked about how expansive we get about other sorts of issues that we have in mind. In a way, we have debated the sort of issue you are raising. We have gone back to our core issue. Obviously, as consumers of health services in the ACT we want the full range of services. As to whether a particular service is better provided at Calvary or at the Canberra Hospital or at the new hospital that is emerging, we have deliberately steered away from being too prescriptive about that.

In the end, we think there is a mix of things that needs to be done. We are not health professionals; we are just people who go there, who use Calvary, know it is special, know that people who have been at Canberra Hospital are often seeking to transfer to Calvary, make that choice ourselves and think, "Why would you take away this valuable community asset, delivered in this special, unique atmosphere at Calvary?" As I say, when we have asked that question—why take it away?—we do not feel at all satisfied with the sort of arguments that get thrown up.

To us, it seems that a sensible future has Calvary or something like Calvary in the mix, that continues that kind of ethos of caring, that has a structure you can deal with, as we find it. And that is our essence. So, from that base, when you think about Canberra expanding and the north side expanding and you see all the activity happening at the Canberra Hospital site, I, for example, have friends who go there quite routinely. I sometimes say to myself: "Why are they having to go to that site? Aren't there some things that should be appropriately provided on that campus?" I think our generic answer is yes. As to particularly what should be provided, I do not know that we would necessarily jump in with strong views. We would like to have a mix that works, and we would like to see Calvary part of that mix. And we do not understand why the ACT government, unlike any other government in Australia, cannot deal with a body like Calvary.

MS BRESNAN: LCM did say this morning when they appeared before the committee that they do have a very good working relationship with the ACT government. It was interesting to hear their view about that.

Mr Gunning: Part of the problem is the debate that happens in public and the things we know happen behind the scenes or the things we imagine happen behind the scenes. So there is a kind of debate of shadows that goes on. The ACT government, for example, has said that the ACT is unique in the way that the non-government sector has an involvement in health supply—unique in the ACT and unique in the world. We know that is not the case. We are a group of Canberrans; we have lived in other states. We have been to other places. We are familiar with the generality of what happens in Australia. Some of us are familiar with the generality of what happens overseas. It is not unique for a hospital system to have a variety of providers within it.

MS BRESNAN: One thing which I did ask LCM about this morning and which is unique in the ACT is that the percentage of care which Calvary provides in terms of public services is actually much higher than in other states and territories.

Mr Gunning: Yes, that is factually true, but every other state has a percentage, and we seem to hear the ACT government saying all the time that the only percentage we can deal with at the first blush is zero per cent. We think: "Why zero?" It is not an

argument as we see it about relative balance. In its fiercest form, the argument is: "We in the ACT need total ownership and control of this whole system; otherwise we can't make it work, and we want, in essence, zero." Then there are the add-ons and caveats which go on for quite some time. We are people who use Calvary. We think it delivers great services and we think: "Why can't you accommodate this thing?"

One of the issues we pursued was this question of efficiency which people occasionally say they care about. It is very difficult to get efficiency measures, but we suspect that in the range of services that is provided, case weighted and all those qualifications you can make, Calvary is an efficient institution. We also think, "Why would you destroy this thing that delivers this quality of service that we like?" We know that governments inevitably get limited by the amount of expenditure they have. Why would you not maximise the health services you can produce for the amount you are spending? To us, that is just another question mark. Why would you not do that?

MS PORTER: I have not read anywhere, and maybe you can read in these documents something that I have not seen, an intent by the government to destroy Calvary, I need to say. To "destroy" Calvary: you have used that word a number of times, I think. You talk in your submission about the activity-based funding being under a cloud of secrecy. I think they were the words—

Mr Gunning: This is option 2, the network agreement?

MS PORTER: No, in your submission you said the matter of the activity-based funding seemed to be something that the government is intent on hiding or something like that.

Mr Gunning: You can infer intent. What we know is we have difficulty getting to the core of what is happening.

MS PORTER: I asked the question of the previous witnesses about the need to have this new activity-based funding and they said that really this is dependent on the national agreements; when we finally get our national agreements then we can go forward with those kinds of agreements. At the moment this is being prevented by the larger question of what is going to happen nationally rather than the relationship between the government and Calvary hospital. It is only a subset of what might be happening nationally. That is my understanding of what they said but you can check the *Hansard* later on when it becomes available as to what they said about that.

One of the things that the Australian Nursing Federation raised was the difficulty that we are having at the moment between the different standard operating procedures between the hospitals. So critical incidents and occupational health and safety incidents are dealt with differently in both hospitals. Therefore, it makes it difficult for them to get them resolved at Calvary. They are not saying that Calvary has more than anywhere else and they are not saying that Canberra Hospital is better than Calvary in terms of what incidents might occur in either category. They are just saying that it is more difficult for them to resolve them.

We did ask some questions about that of the previous witnesses and they assured us that this matter is being attended to and is in the process of being harmonised so that it

is easier to work across the two systems. When you are talking about efficiencies, this might be one of the concerns. When you have two different standard operating procedures across two different hospitals, obviously it does make it difficult. With records, for instance, we were talking about e-health and how that will be implemented around Australia. They are the kinds of things that you are looking at to get some efficiencies around the ways that the different hospitals operate. They were some of the things they were talking about. What would your comments be about your sense of how the operating procedures could happen? I do not think there is an unwillingness for the two hospitals to work together. I get a general sense that they want to have a seamless system between both hospitals. What would your comments be about that problem we have at the moment?

Ms Horne: Whatever is going to work for bringing about a better outcome for the population of Canberra health-wise, we are going to be in favour of. If, as at present, beds are put in place—that happens across the board between Canberra and Calvary—it would be absolutely fantastic. I am now trying to get an understanding of why the ACT government wants to take over Calvary hospital if these things have been put in place that allow Calvary and Canberra to work together but independently of each other.

Mr Gunning: *Hansard* might show I used the words "destroy Calvary". When you contemplate issues like option 4 and you read the *Hansard* of what has occurred here, it is this search for the elusive. I would not say my view of the elusive is absolutely irrefutable. When you get comments in essence saying, "We find it difficult to manage a system with multiple providers; we want a seamless system where everything is owned and controlled by the one entity," and you think you have an entity that, in a structured framework, is a subsidiary that has degrees of autonomy, it seems to me there is a very clear arrow saying, "We do not want that kind of autonomy; we do not want that kind of separate arrangement."

That is a conclusion, I guess, I draw and is a conclusion we collectively tend to draw, especially after we have had the advantage of consulting with some people behind some of the closed doors and getting some sense of what is happening. Again, one keeps going back to: "Can you actually prove it?" No. Just look at the tendencies and think this is the way we are heading. We are trying our best as a community group to understand option 4.

I read with great interest the ACT government's submission to this committee. I hoped to see some elucidation. I thought I was going to come along and say: "Try to work hard. Think about it." It is very hard to make any real meaning of these four options. They seem to fall into two. The ACT government submission, I thought, was singularly unhelpful for a community group trying to come to grips with what is the real intent of option 4. Is it intended that the government goes alone and builds a new acute public hospital on Canberra's north side and then lets Calvary wither and die? That is what I fear. That is what we are here to try to argue against.

If the government—and they have had plenty of opportunities—were to say, "No, we see a flourishing Calvary and for some reason, against the territory health plans that have existed to date, we suddenly think the north side should go from one major campus to two," we would be interested in that. That might, arguably, be the response.

That is the question. What is really intended? Why the perpetual elusiveness?

As to the other question you asked which I regarded, from our perspective at least, as a fairly detailed question, about a new activity funding agreement, a network agreement and all the different provisions that have existed, we, as a community group, generically see that as the government somehow working with the Little Company of Mary. Whatever names you call it, however you structure it, we see it as working together.

When you drop down many levels—and the Little Company of Mary is an independent organisation, to a degree—they will have views about particular provisions. The government will have views about particular provisions. As a community group, we would, in the first instance, not get too involved in that process other than simply to say that we hope you sort that out. Clearly, if there are things that are absolutely unsolvable, issues of principle, then the community group might have some expertise to comment on it.

To go back to your point, in essence we would rather stay a little bit away from that. What we see is incredible interest. The fact that the health process is now apparently overtaken by yet another process which is going on, where the commonwealth is going to have some yet undefined role, yes it makes it more complicated. It does not explain to us why we have had so little real information about what has happened in the past. Presumably the past still exists. Some new arrangement of some unknown kind is coming on. One would think, as a community group, you would get a bit more guidance.

THE CHAIR: Mr Hanson?

MR HANSON: I do not want to ask any questions that have already been asked. I will read the *Hansard*.

THE CHAIR: You have articulated your support for Calvary quite strongly in your submission, which is very detailed. In terms of our getting a feeling about your organisation as such, how many people does Save Calvary Group represent?

Mr Gunning: We have 30 people who are active members of our group. Some of those people belong on the basis that they will consult with others. Some of the people who belong made the point that they would rather the world did not know who the others are that they consult. We think we have got about 20 activists that we talk to all the time. Some of those activists are bringing views and expressions of interest from others.

THE CHAIR: On that question of whether you are representing yourselves or a group of people, we have submissions from individuals. That has not got a weight.

Mr Gunning: We try to be very straightforward. We represent people who have used Calvary and who want to save Calvary. Other people have other interests. We do not purport to represent everyone. We just represent that community group who have that common interest. From our point of view, at one stage we thought it was fixed. This was just a short time ago. Then the issue came back again. We find public interest

waxes and wanes amongst the people beyond our group, whether they think it is a live issue or it has gone dead again. For our part, we really do not know.

THE CHAIR: To answer some of the rhetorical questions that you have thrown up, we have had the opportunity to talk to the Minister for Health. If you read the transcript, some of those questions that you posed may be answered. There are always additional questions that are available. If you feel there are questions that have not been answered, you are welcome to submit those questions to us in writing and the committee will consider them in light of our deliberations. Are there any other questions? I make the offer again. I think you have articulated your case very well. Thank you, and thank you for your submission. Are there any closing remarks that either of you would like to make?

Mr Gunning: One thing that struck me, reading the *Hansard*, is that I notice the minister committed herself to making a decision within five months. I found that rather interesting. I thought: "That is news to me. The government is going to announce within five months what it is going to do." As a committee, that might be something you might like to take up, I imagine. On the track record, I would not necessarily expect anything. Frankly, we would rather have a decision to continue Calvary rather than have a decision within five months that was to the opposite effect.

THE CHAIR: The committee will report in March. We presume there will be no decision before this committee reports. That will fall roughly within that time frame. Thank you again for coming in. A full transcript of this session will be available to you and you will be able to see yourself in *Hansard*.

COLLIGNON, DR PETER, President, ACT branch, Australian Salaried Medical Officers Federation

THE CHAIR: Dr Collignon, welcome to this committee hearing. The ACT Legislative Assembly's Standing Committee on Health, Community and Social Services is inquiring into the report of the four new options for future ownership and management arrangements for Calvary hospital put forward by the Minister for Health in August. We are here to consider all the views and we thank you for agreeing to come. I believe you have not put in a formal submission at this point.

Dr Collignon: No.

THE CHAIR: We very much look forward to hearing your submission. Just before we get to that, you have a privilege statement that has been, I presume, given to you. You are aware of the implications and otherwise and are comfortable with that?

Dr Collignon: Yes.

THE CHAIR: First of all, could you just tell us the positions you represent this afternoon? We then invite you to make an opening statement.

Dr Collignon: I am the president of the ACT branch of ASMOF. I am also the federal secretary of ASMOF. ASMOF is the Australian Salaried Medical Officers Federation. I guess, in basic terms, we are the trade union for the salaried doctors invariably in government service. When I say "salaried" it is salaried doctors who work for government. We do not represent salaried doctors in the private sector.

From my perspective and from that of most of my members, both here and nationally, we have a vested interest in making sure that the public hospital system works appropriately. That actually means it is organised properly, appropriately financed and efficiently run. We have an interest in this and in how moneys are going to be spent because our basic feeling is that if you spend $100 million or $80 million a year there is somewhere else where that money is not going to be spent. You want to make sure you get value for money and that it is productive.

At the end of the day, we want a system that works. We need a system that delivers health care in a reasonable way. Health care will always be rationed. We figure that we will be lobbying to get more of the rations, I suppose. But it has got to be done sensibly, with as much wastage avoided as possible, and by delivering services in a timely fashion, because a lot of times that does not happen. I guess we get irritated because we think we have much less influence on the system sometimes than we would like.

The Calvary issue is very important for us. Delivering healthcare services on the north side, of which Calvary is a major component now, and I presume in future, is important. To us, how it is actually done and whether you have subacute services or acute services is a matter of how it is done efficiently and how you deliver the service. What we think is really important is that there is an integrated health service. That does not mean the private sector cannot deliver some of it—or the Little Company of Mary or whatever—but it has to be coordinated.

My experience here in the last 23 years has been that we have had opposing camps at times all wanting to be their own thing with, I think, duplication and waste, and sometimes personalities wanting to set up services, I think, inappropriately. At the end of the day, there is a certain level of service, and I think most health departments around Australia have got this.

I will start with Canberra Hospital. If we wanted to do heart transplants I think that would be entirely inappropriate because I do not think we have the population to justify that in Canberra. Equally, if we wanted to do cardiac surgery at Calvary because somebody thought it was a great idea, that would be inappropriate. You just do not have the population to support two services. There is a certain number of people that you need to support one unit at a certain level. By the same token, to say that Calvary should not do general surgery would be equally ridiculous—to say that all of it should be done at Canberra Hospital, or to say that you could do not it in the private sector. I am being equally extreme.

There has to be some high-level decision as to what services are going to be offered in the community and how many of those you can offer on how many sites. I think you can even argue that having three obstetric sites in Canberra—I know this is controversial—is one more than we need and, for instance, having an emergency department open 24 hours a day at two sites when it is only 20 minutes drive. They have all got issues with providing pathology services, radiology services and anaesthetists. Once you get to a certain population you can do that, otherwise you find there are holes and nobody is there at Christmas. All of those issues become quite important. I do not say I have got the answer to this, and I am not sure anybody has, but often the politics overtakes it so the appropriate decisions do not always get made. We want a good service in the ACT.

One of the other things—I guess I am a salaried specialist so I am biased, you could argue—is that we think you need a certain number of salaried doctors. I guess it is because we are onsite all the time. That has been one of the issues about Calvary. It has been a VMO-run hospital. It is not that that is a bad idea, but I think you need a mix. I think of some of the politics that have come out of this. In fact, I almost did not come to Canberra when this place had a reputation for the VMOs and staff specialists hating each other. I heard of one episode where somebody's tyres were slashed.

There was a lot of animosity—so much so that when I was still a registrar I took advice from somebody that left Canberra who worked at Westmead where I was at. I said: "Should I go there? I want to be a staff specialist. The sorts of things I want to do, which is teaching research, you can't do as a VMO very easily." He told me, "Yes, when I was there it was a problem that had gone." I must say that is the case. I think the problem with that was mainly people over the age of 60 now, I would think. But you start seeing indications of that a bit.

I might say that all these things are complicated, but even with this obstetrics issue, the bullying stuff at Canberra—not that there is not behaviour that needs to improve—some of it is this VMO-staff specialist business, not having staff specialists running the units and having VMOs running them again. I think it is quite appropriate for VMOs to run some units. My bias most of the time is that it is likely to be staff

specialists because you are just there all the time and it is difficult. But there are all these other things that sometimes go under this. Something is set up here but there are other little political agendas going.

I guess the point I make is that the only other public statement we have made, which was probably a year ago now, is that what we did feel was really unreasonable, in respect of both the ACT government and Calvary, was the $80 million that was going to change hands for Little Company of Mary to leave Calvary.

Our view was that it was inappropriate for Little Company of Mary to get any money if they did not put it in. I mean, if they built buildings with their money, they should get it back with interest. But my understanding is that they did not put any of that money in. So for them to get $78 million we thought was ridiculous. We thought it was ridiculous for the government to offer it because we could not actually see why they had to do that. At the end of the day, there was all this argument that it would not come out of health, but it comes out of somewhere—education, health—you know, we pay for it.

That money was going to be used to build a private hospital on site, which is fine for the private hospital. But ACT government money, taxpayer money, should not be used to provide a private hospital. Most of it was going to go to Victoria, South Australia and Sydney, anyway. They were talking about leaving $40 million here. The rest was going to go who knows where. So we all had a strong view that that was inappropriate.

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

I guess, getting to the nuts of this thing, that we think we need a good service on the north side. It cannot be at the same level as Canberra Hospital. But the majority of stuff done in the health system is not at level 6. You can do that in community-type hospitals. In fact, you can do it more efficiently if you have a place that does not have really sick people blocking up the beds for too long.

We think it is very good to do something on the north side with elective orthopaedic surgery, which is effectively done now. A large proportion is done at Calvary. It is also a good place to have people who have acute medical and surgery problems, provided they are not too complicated. I actually think that if you are really sick, you should not be in Calvary hospital. That is one of the issues—making sure we have protocols to move the really sick people out to where there should be more support to look after them. That does not always happen because of these ownership issues as well. So they are really important protocols.

By the same token, do we care if it is at Calvary run by Little Company of Mary or a new greenfields site? There are advantages for a new greenfields site in that you can usually build the hospital better and cheaper. Calvary has a real problem. It is a bunch of rabbit warrens. It is all higgledy-piggledy all over the place when you go there.

There are not enough beds at Calvary for acute medical and surgical care now.

Their rooms, even though it was built after Canberra Hospital, are less adequate for infection control purposes—the toilets and there not being enough single rooms; all that sort of stuff. So if you are going to actually have a Calvary site, in my view, it is going to require a fairly massive rebuild. The recovery wards are inadequate. I guess you can refurbish anything with money, but it actually becomes very disruptive. One way or another, even on the current Calvary site you could probably put up a new building that is designed rather than trying to redo the rabbit warrens there.

Alternatively, if it moves down the road, we do not have an objection either. We think the proposal that we heard also seems sensible. What I think Calvary and Little Company of Mary would do much better than the government sector is psychiatry and rehab—all those slow stream things that are very untrendy and nobody wants to know about. I refer to the people that are caught between hospital and home where they have social problems or whatever. I have heard that one proposal was to turn it into a slow stream hospital to do those sorts of things, providing it had adequate backup as well, of course. We do not have a problem with that as well.

There is currently a problem in getting staff at the medical level across both hospitals. I actually go there once every week—usually on Wednesdays—to do infection control and infectious diseases control. I am one of the few people who go across both sides. There have recently been some in oncology. I think that is a problem. We need a better integrated service and a better way of working. We need to get the patients out who are sick but equally we need the specialists and specialities to go out there so that the patient does not have to move needlessly and you can have it done there but in an efficient way.

One of the problems is that if you only go over there once a week, that may mean that somebody is twiddling their thumbs and taking up a bed for five days while they are waiting for me or somebody to get there. I have probably confused this by throwing too many things into the equation, but it is difficult to integrate this and make it efficient and run in an appropriate way. I think I have mentioned all the things that I had down on my piece of paper.

THE CHAIR: Thank you, Dr Collignon. That is a very instructive opening statement and thank you for bringing a lot of matters to our attention. We will examine those in more detail in the transcript. You mentioned current areas of duplication and waste. We are looking at the four options that the government has put before the community or the Assembly. Option 4 is that the ACT government build a new acute public hospital on Canberra's north side. Taking into account that we already have Canberra Hospital and Calvary hospital, does Canberra need a third hospital at the moment, and is that a duplication and waste in the terms that you have described?

Dr Collignon: My view is that if we had three acute care hospitals in the public sector, yes, we would not have the population to do that. If it were moved from the Calvary Bruce site to—I have heard the proposal—maybe Canberra University, the major waste in my view, depending on the function, would be the new ICU that was built there. It is quite a good ICU. It is new. If Calvary became a subacute slow stream hospital, their psychiatry would still be there, a lot of their Keaney building would

still be used, I presume in continuation as it is now, because they are subacute services that I presume would continue there.

It is the acute medical stuff that is an issue, which is mainly their ICU. I would argue that their current wards are atrocious anyway. So they would have to be rebuilt even if it stayed there—the medical and surgical ones. Even their X-ray facilities I do not think are that flash. The ICU for me would be the major building waste.

To me it is a case of somebody doing the sums. I hear repeatedly that building a greenfields hospital is more efficient. Whether you move Calvary to run the new greenfields hospital is another possibility too. We do not have a strong view one way or the other, other than we need it as an integrated service with levels of service being decided beforehand, a good mix of staff specialists and VMOs from a medical point of view and all those sort of integrated services.

From the waste point of view, that is the main waste that I see. I do not know how much they paid for that ICU. I think it was about $10 million or $12 million.

MR HANSON: That is correct.

Dr Collignon: Admittedly, somebody else can do the depreciation. You still get five years. It will not happen overnight, anyway. A hospital lasts 20 years before you have to do it again. That is my understanding. So if it is used for five years, you have only wasted three-quarters of the money.

MS BRESNAN: You have already talked about whether or not Calvary would be best to offer slow stream types of services and whether they could be sited there if you were to design a greenfields hospital. We have had a submission from some of the VMOs from Calvary and had various views expressed about how you should be siting services. When the committee went out to Calvary, the view expressed was that it is best to have the acute and subacute together rather than separate. We heard all those arguments about that. What are your views on what is actually best in terms of not just the siting of services but how you locate them in terms of what is going to be best to provide them to people?

Dr Collignon: If we take psychiatry, for instance—and I must admit I am not a psychiatrist—it is probably a disadvantage to have them sited together. I would have thought that if you were into subacute psychiatry it would be better if you were separated from the noise and clutter.

There is the argument about the Keaney building, and I have been involved in there from an infection control point of view. This is where there are not enough beds and people try and compromise principles. Our view is that if you are in a subacute area you have different levels of infection control. The reason is that if you or I are in an acute hospital having our gallbladder out or something we do not want to pick up MRSA or a superbug.

The way we do that is by isolating the people who have got the superbugs and wearing gowns and gloves. That actually means that those people have their medical care interfered with a bit. They cannot wander around everywhere. They may not be

able to access all the facilities as easily because effectively they are quarantined, if you like. What we have tried to do in what we call subacute spots is make sure those people can do everything that they need to do. The main risk of these superbugs is if you have got an open wound or an IV cannula after surgery. Provided we do not let them have patients of that type in a subacute area, our view is that we do not have to take all the infection control precautions because there is not the same risk to that individual.

Perversely, when you have acute and subacute close together, people are always trying to break the rules because there is a bed in subacute and they try to turn that into an acute care area, which has been a recent problem. The other way of looking at it is this: what if somebody gets sick in the subacute area? What if somebody is developing pneumonia and needs acute care? My view is at the moment they have got to be transferred from that subacute care to an acute point anyway because the nursing staff ratios and expertise are not there to look after acute.

I guess the difference is that you would probably have to call an ambulance to move them rather than use a trolley, but I can tell you that the problem at the moment is the lack of beds. You may actually get quicker service by doing that because you will at least be in the emergency department rather than languishing in the subacute area. There will always be black and white both ways. I personally do not think that is an issue.

To some degree in that subacute area, at least a couple of years ago, there were acute physicians there, geriatricians. They were not allowed to treat acute people up in the wards. There was this demarcation between the VMOs and staff specialists. The staff specialists from Woden were not allowed to treat their own patients in the acute wards. They had to be transferred or not sent up there. There has been a lot of politics, in my view, to entrench some physicians rather than necessarily what is in the best interests of patients.

There is an argument that some people might come to grief. That is exactly the same argument that you have when you say that all of your nursing homes should be next to your acute hospital. It is a question of degree. There is, I suppose, some advantage in having all your medical facilities together, but if that was an argument we should put everything at the Canberra site together. There are practicalities of people moving and parking. There is some nicety to having a smaller hospital. Going to a big institution that is overwhelming causes problems for a lot of people—visitors and patients. I think you can argue it both ways.

MR HANSON: If I can ask a supplementary to that, when you build a hospital it is not just the hospital; it is the whole campus that goes with it, be it VMO rooms, pathology and so on. Is there not an advantage, regardless of who is running it and what is subacute and what is acute, in having things located on that campus? If we were to build another hospital, be it subacute or acute, you would need to duplicate all of those additional bits and pieces—VMOs rooms, pathology et cetera.

Dr Collignon: I think that is a factor. The reason I think staff specialists are a good idea in public hospitals is that their offices are in the hospital and they live there, so in theory they should be able to go and see the patient fairly quickly without having to

get in a car. Having the set-up at Calvary, where they have got the Calvary clinic, which is where most of the VMOs are, actually means they should be able to walk over and see people if they have to and do procedures. So there is an advantage.

I guess my view would be that if you built another hospital up the road, you would not want to build some facilities for outpatients as well. I would think the mix of people who were at the Calvary clinic and went to the new one would change. If you were a psychiatrist or rehab doctor you may set yourself up at Calvary clinic and if you were an acute surgeon you may set yourself up. But, by the same token, there are a lot of VMOs who work at both Canberra and Calvary who have got rooms at John James. Not many VMOs are just at one hospital.

That argument that you have to be within walking distance does not hold because if they really believed that they should only be at one hospital. I think there are conveniences. The question will then be: who pays for it? At the moment you are in a convenient place at Calvary clinic. You probably own it or whatever and to some degree that real estate will be devalued if it is no longer an acute care hospital. That is an issue that might have to be addressed. Because I am a staff specialist and we do not pay for our rooms, you can argue that I am biased the other way—it is not my money. I think it is an issue, but as long as VMOs service multiple hospitals it is always going to be an issue.

MS PORTER: My question is around that infection control that you were talking about before. You have obviously read the ANF submission. It talks about the different standard operating procedures in the different hospitals and that they are having some difficulty in resolving the issues—up until we heard witnesses from the Little Company of Mary say that these problems are being resolved. However, at the time of the submission they said that they had not been resolved. The question is about the operating procedures being different at both hospitals around infection control, and critical instances in relation to that, and occupational health and safety. Am I hearing you say that it is not necessarily about the standard operating procedures being different; it is to do with the structure of the wards?

Dr Collignon: I think it is all of the above. I actually believe very strongly that we need the same standard operating procedures, as much as possible, across the facilities and across the private sector, I might add, as well. There is nothing worse than going to every institution and finding that they have different rules. It is the same issue with National Capital Private at the Canberra site.

We in infection control have managed to get this together better, I think, than a lot of the others because the nursing staff talk to each other and we have got one set of things. What I find surprising is that Calvary got a group up from Victoria to accredit and look at their infection control because they are part of the national service. Their views are different to ours because in Victoria, at least five or six years ago, they had so much MRSA they could not cope so they had laxer rules. You find that laxer rules are being put in place—it was National Capital Private too—because we achieve a better result here than those places do. Because they cannot cope, the "I don't cope" standards can be put in place.

I think it is really important that we have standard operating procedures. You have got

to be a little bit adaptable about it because the facilities might be different. Absolutely saying that what goes at Canberra Hospital has to go at Calvary may be ridiculous. I cannot think of an example, but you can imagine there are some. You have got to have some sensibility. What I find really not acceptable is interstate protocols being placed into hospitals in the ACT that are driven by circumstances that are different in New South Wales or Victoria. To some degree that happens with Calvary because it is part of a national organisation of which this is a minor bit.

I guess I agree with the ANF that we need, as much as possible, standard operating procedures across the public sector and, I would think, as much as possible, for infection control and occupational health and safety across the private sector health as well. That obviously is a political negotiating position to achieve that, particularly with the private sector.

One of the problems is that if you have different procedures at John James, National Capital, Calvary and Canberra it is no wonder everybody gets it wrong. There is the same issue with patient safety. You can have 10 surgeons all doing something slightly different, all of which are right, but you get more mistakes in your organisations. You are much better having a standard way you do antibiotics and operations because you decrease your risk of getting mistakes made.

I guess I have a philosophical view about it across Australia. I think the safety quality commission is trying to get Australian standards or standard operating procedures to try and minimise the rare risks that happen but the rare events that occur. What it does then is facilitate the ability of staff to move between states but within institutions, because people do go across the private—nurses in particular—and public sectors and across hospitals. We really do need, as much as possible, people doing the same things with their hands and the way they do stuff to minimise the patient risk part of it.

MR HANSON: Dr Collignon, you talked about the shortage of beds. Can you expand on that and talk about what you think that number might be, as it currently sits, and where that shortage is? Is it a shortage in acute beds or subacute? Where is that playing out?

Dr Collignon: I think it is mainly acute medical and surgical beds. I guess we have been saying this for 20 years. We have half the number of beds per head of population than we had 25 years ago in the ACT. There are not enough beds. As much as I see all the stuff come out, "It is inefficiency," if a GP rings me and says, "I have got Joe Bloggs who has a fever and is looking unwell; he needs to come into hospital," I say, "Send him to the emergency department," because I know I will never get a bed. I will waste an hour or two of my time for a bed that will never be there. I presume my colleagues do the same. It is just a waste of time trying to find a bed that is never there.

All the data I have seen says that if you want to be efficient you should aim to have 85 per cent occupancy. To me, that makes sense because you can actually get a patient in. There is a bed there. You do not have to put him through emergency. You have assessed him. But the beds are not there.

It also means that people are moving all around the hospital all the time because they

come to the emergency department. They need to be under the gastroenterologist but they go down to the geriatric ward and then to another ward. They make four or five moves before they get to the place where they have got the nursing staff and the medics who have got the expertise.

This is an Australia-wide problem, I might say. I cannot single out the ACT. There is the same problem in Sydney and Melbourne.

Every time I think there is not a problem, I go down to the emergency department and often see five or six people on stretchers in the corridor because there is nowhere to move them to. They are not people who are just trying to not go to their GP. These are people who are sick and need to be admitted. They spend atrocious times in atrocious conditions.

If you look at the complaints of patients, some people get the wrong things done to them and things like that but the majority complaint is: "I could not get access to what I needed. I had to wait too long in the emergency department. I was not admitted," or, "I could not access some service." A lot of it is to do with beds.

The real problem is that you cannot expand the beds overnight. You need nurses and everybody else to man them. When I am talking about beds, I am talking about adequately staffed beds. That includes the ratio of nurses and doctors.

To some degree, this is used as an excuse, in my view, by governments of all flavours to not spend the money. What they then need to do is say, "How many nurses will we need in five years time to do this?" We are going to have to put the training in so that they come out at the end. There are issues around retention and all the rest of it but my understanding is that nurses have a really high attrition rate. Fifty per cent are not working after five years. I am not positive about that number but that is what I have been told.

MR HANSON: It is pretty close.

Dr Collignon: For doctors, it is about a two per cent attrition rate. It is not because they are having children. There is something fundamentally different with the training and what is happening that we are having a retention problem which affects, then, the beds.

Look at Calvary. There are a whole lot of medical and surgical wards that have been turned over to office areas and stuff. They used to have six floors of beds. Now they do not. Canberra was the same. One of my bugbears is, when they are looking for more office space, it is usually the single rooms that get turned into office space and patients get four-bed rooms. I have a view about that.

The new building recommends 80 per cent single beds, which I think is a good idea. There are privacy issues, smell issues, everything else. When you are sick in hospital you need the ability to actually be separated from other people, for infection control, for a whole lot of things.

I have no trouble with the ratios they are putting up but there have to be adequate

numbers of those beds too. There is no point in having every bed a single bed at Canberra Hospital and there are only 200 of them.

MS BRESNAN: Do bed blockage and those issues have any impact on bed availability?

Dr Collignon: I think it does. I think you become less efficient. For instance, if you have got patients in another ward, you do not see them as often if it is not where you go. Decisions may get delayed for another day or two. I think it was Menadue who came up with this 85 per cent number. To me, it makes intrinsic sense. To have a hospital half-empty is ridiculous too. A hundred per cent is too. Most of the time we have 100 per cent occupancy in the acute medical and surgical beds. I think the figures are fudged because they put some of the other beds in so that it looks better. To me, acute medical and surgical is what you want to know.

MR HANSON: Wards that close over Christmas will probably be counted as well.

Dr Collignon: I think you can have some beds close over Christmas because you do not do elective surgery, but nowhere near as often as they do. I am in a non-elective profession. Nobody has an elective serious infection. In fact, we end up getting more work over Christmas because some other people find us to take over their people. We even look after people who should be surgical at times and treat them with antibiotics.

People who are really sick come to hospital because they are really sick. I would think at least two-thirds of the patients who come to hospital are coming with nothing remotely elective or semi-elective. They are coming through the front door because they are crook.

MR HANSON: To summarise it, you are not really concerned about who runs it or where it is but you want some help sooner rather than later. You want to see more beds and you want to see it integrated.

Dr Collignon: "More beds" means we need the staff to run it.

MR HANSON: Of course, yes.

Dr Collignon: I actually think we are markedly short of beds. We could probably increase our beds by 20 per cent. There is an infinite demand for health—everybody wants to live forever—and how you adjust that is difficult for health ministers and bureaucracies. But at the end of the day I think it is patently obvious now that we do not have enough beds. But, having said that, nobody in medical administration believes that; nor do any of the people I have spoken to in federal health or any health department. They actually believe, with their hands on their hearts, that us being inefficient in the hospital is the reason we have got bed block.

I, with equal passion, believe that is not true. There are factors like getting people into nursing. But the end result is that we have all these people banking up in emergency departments who justify being in hospital but we do not have a bed for them. They have got the average length of stay down from, I think, seven days to about 3½ for the non-day-onlys. It is hard to see how you can get much lower.

One of the other issues with beds, and New South Wales is a good example, is: is it reasonable to send somebody out in the street who really does need a bit more recuperation, particularly if you have got to send them down to Bega? That is why they have longer length of stays, because it is the logistics of getting them down there, and they are often more frail. This is heresy, I guess, but if you keep a little old lady in hospital for another day or two and you are just taking their blood pressure once a day and saying hello, how much extra cost is that? The marginal cost must be zip. The bed is already there. You should not staff that bed in the same way with nurses or doctors. There is something to be said for not kicking people out in the street too early from a social point of view—not just: "Here's the factory. Here are your pills. Get out of here." Equally, people can exploit that by using it as a hotel, so I fully agree with that.

But we can be too hard nosed about this business and not take into account people's true recuperative efforts. If you do it properly in hospital and say, "Look, you are no longer a category 1 patient" or a category 6—that means you get some food and somebody comes and checks you twice a day—that to me cannot be hugely expensive. You are not doing any tests on them. You are not doing any surgery. You are basically letting them recuperate a little bit.

THE CHAIR: Time is about to beat us but I have one final question I would like to pose. You mentioned at the outset that you were concerned about any money that would have gone into the purchase of Calvary hospital, because there is a great need within the Canberra Hospital system, I would imagine. The building of a brand-new hospital: would that not impact on what sort of money could come into Canberra Hospital?

Dr Collignon: I think we need to make sure that we spend the money where it is appropriate to deliver the service, and if that means a bit more gets on the north side and less in Canberra, so be it—providing that is a rational decision of where we are going to put the services. By the same token, in my view Calvary cannot continue the way it is now. It is a rabbit warren with not enough beds. So, even if you are going to leave it where it is now, whoever runs that site, be it the government, Calvary or some third party, there has to be a reasonable amount of money spent on redoing the buildings and making them efficient. Whether that is cheaper than building a kilometre up the road—and there is nothing to say that Calvary cannot run the new hospital up the road either. These are all political decisions. Providing all the rules are set down and it is integrated, we do not have any objection to the Little Company of Mary running one up the road. But that is a political decision.

Option 4, a subacute hospital on that site, I think has merit too, because they are the services that are not done very well and it may actually free up some beds, because maybe that is where you get some of these people out of the hospital beds into somewhere else. But, again, whether it is ACT Health that runs it, or Little Company of Mary, or even the private sector for that matter—although I do not think the private sector would do it very well because they are the sort of patients that do not make money, but that aside—somebody needs to do it under a certain set of standards with a certain set of expectations.

THE CHAIR: Thank you so much for coming in. Obviously the transcript of this

session will be available to you, and if there is anything else that comes to mind that you have not mentioned to us we would love to hear from you.

Dr Collignon: We have obviously got a lot of interests that affect public hospitals in general, not just this. We do not have an infrastructure—we have a couple of industrial officers—but if anybody of any political party wants to talk to us and get another angle, which I guess might be different from the AMA's, we are happy to give it. We have about 200 members in the ACT so we have a reasonable representation.

The committee adjourned at 12.56 pm.