LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Calvary Public Hospital Options)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 16 MARCH 2011

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 7.31 am.

GALLAGHER, MS KATY, Deputy Chief Minister, Treasurer, Minister for Health and Minister for Industrial Relations
SMITHIES, MS MEGAN, Under Treasurer, Department of Treasury
AHMED, MR KHALID, Executive Director, Policy Coordination and Development Division, Department of Treasury

THE CHAIR (Mr Doszpot): Good morning everyone. We might get proceedings underway after an interesting start to the morning. Welcome to the fourth public hearing of the Standing Committee on Health, Community and Social Services inquiring into the Calvary Public Hospital options. I presume that our colleagues Ms Smithies and Mr Ahmed have had an opportunity to read the privilege statement? You have done this often enough.

Ms Smithies: Yes.

THE CHAIR: So you are comfortable with the proceedings on that. We have a slightly unusual situation this morning. We have got Ms Porter via the telephone; so would you mind speaking up a little more than perhaps usual? We will look forward to hearing from you, Ms Porter, whenever you would like to indicate that you would like to say something during the proceedings.

MS PORTER: Thank you, chair. Good morning everybody. Good morning minister, good morning officials.

THE CHAIR: Before we get to questions from the committee, minister, would you like to make an opening statement?

Ms Gallagher: No, thank you, chair. I think I have made a number of statements around this in the Assembly or in previous hearings; so I am happy just to proceed to questions.

THE CHAIR: Thank you for coming in for this second stint before the committee. Obviously with the new papers that have been released there are some questions that we would like to ask you. The first one I would like to start with relates to the options analysis paper. It indicates that construction costs were calculated on the basis of the hospital capital planning module developed by the Victorian Department of Human Services. Why was this model chosen to calculate the construction costs?

Mr Ahmed: This is typically used as almost a standard module. We actually went looking for what would be a general standard. This was a module chosen by the consultants themselves. They were aware of it; they sourced it from the Victorian government and used it. What I understand is that it is a widely used module.

THE CHAIR: Was the Western Australian plan that was recently announced with somewhat different costings considered at all?

Mr Ahmed: Not by us. No, we left it to the consultants to choose an appropriate module.

THE CHAIR: Okay. Are you aware whether the consultants would have looked at the Western Australian option?

Mr Ahmed: We have not certainly asked them, but I would tend to think that they would certainly be aware of it. These are consultants who have done work in this area quite widely.

THE CHAIR: Are you in a position to check with them at some stage?

Mr Ahmed: We can certainly do that.

THE CHAIR: Thank you.

MS BRESNAN: I wish to follow up on Mr Doszpot's question. Obviously there is the issue around the costings and the Victorian model. The model that Mr Doszpot mentions I think is the one you refer to as the public-private partnership. Is that something that has actually been investigated as a possible option? I mean, there are also examples of it in other states. Probably a slightly different one is where the government retains ownership or control over the provision of services and the provider actually does the building. WA is slightly different in that it is actually a provider doing that model. Is that something that has been investigated for this?

Mr Ahmed: Not as part of this analysis, Ms Bresnan. That would be the financing mechanism and how you actually deliver the project and we have not gone that far.

MS BRESNAN: Sure.

Mr Ahmed: At this stage of analysis, we have restricted ourselves to the costs. How those costs are financed or funded or the actual projects, are delivered is a matter for later consideration.

MS BRESNAN: So basically the work that is being done is just about actually outlining what the costs would be of each of the options. How that actually is carried forward would be something which is determined at a later stage.

Ms Gallagher: Exactly. When we have looked at the most effective way of estimating the costs—I think the papers go to this where they say this is high level costings at this point in time—we have used the work that we have done in terms of the capital asset development plan in planning and understanding the types of beds and the numbers of beds. Then we have used a generic costing model for that—overlaid that with the Victorian model. This is just the pure construct costs at this point in time. Obviously, if we made a decision to pursue any one of these options, that option would then be subject to detailed design and subsequent consideration of financing options.

MS BRESNAN: One further follow up question, and this might be more a health-related issue: in terms of the bed configurations and the cost of each bed, would that vary at all at any point if there were particular high-level beds or depending on what care you are actually going to provide for each of those beds as

part of any of those options?

Mr Ahmed: The capital costs estimated do capture the nature of the bed. They do have regard to what would be required to deliver, let us say, for example, a subacute bed. It would require wider spaces, it could require spaces for rehabilitation, hydrotherapy pools and so on. This costing does have regard to that in each of the options.

MS BRESNAN: Okay.

Ms Gallagher: And, for example, if you have 20 acute beds, then you are going to need one intensive care bed. They take that into consideration as well—the other support services that go around.

MR HANSON: I have a supplementary question on that. Does that include all of the fit-out? So if you are talking about a hospital bed—acute, subacute; whatever size—it includes all the fit-outs, all the actual technology that goes in there to run it or is it just the shell to receive the technology that comes in there?

Mr Ahmed: It does have regard to the fit-out requirements as well, Mr Hanson. It is not a costing which is based on final sketch plans, of course. We do not have those, but it does have regard to the technologies that go in. For example, as the minister said, if you need a high-care bed, what goes with the high-care bed is—

MR HANSON: So it includes basically everything other than, let us say, wages, which are a recurrent cost. But it is basically ready to receive patients and staff and—

Ms Gallagher: Yes.

Mr Ahmed: That is right.

MR HANSON: Okay.

Mr Ahmed: The spaces that are created, they need to be functional and operational, and it does have regard to that.

MR HANSON: Yes, but it has got all the machines that go beep, for want of another word.

THE CHAIR: Ms Porter?

MS PORTER: I refer to option analysis 4 on page 13 of the paper that you have given us, minister. I thank you very much for that. I am wondering how each option ramps up against being patient-centred. Being a patient myself—I guess I still am—I have been interested to watch how much we have been talking about in this whole debate the patients as being the centre of the issue. I wonder whether we actually have been talking about it. I think it has been a little bit missing in the debate so far. Anyway—

THE CHAIR: Excuse me, Ms Porter? Ms Porter, can I just interrupt you for a

moment?

MS PORTER: Yes.

THE CHAIR: This is the Treasury component.

MS PORTER: I know and I am talking about the analysis of the Treasury here.

THE CHAIR: Okay, that is fine.

Ms Gallagher: Yes, she is on page 13.

THE CHAIR: We just wanted you to be aware of that.

MS PORTER: I am just saying that I am interested to see that analysis there and to see how the different options are ramping up against being patient-centred. I was pleased to see that the Treasury did in fact put that in there. I note that options D and E are the two options where patients seem to be the most catered for. I wondered if you, Treasurer, have any comments on this particular analysis.

Ms Gallagher: What we have tried to do—I think it was picked up at the last hearing, but also in discussions that we have had with stakeholders throughout the last couple of years—has been not to just look at the financing, what is the cheapest option or what is the most expensive option but to look at a range of costs and benefits in the analysis. Treasury in this document have moved past just looking at what the construction costs may be and have looked at a range of other benefits which would impact on the efficient and effective nature of a new health system. Patient-centred is one of them. Accessibility is another one. Safety and quality care is another one.

MS PORTER: Yes.

Ms Gallagher: All of that, I think, in the end is going to feed into the government's consideration. When you look at the different costs between the options, it is in the order of $130 million, I think from memory, between the cheapest and the most expensive.

MS PORTER: Yes.

Ms Gallagher: Over a 10-year period, it sounds a lot of money, but it is not. The global cost should not be the most significant factor when we are making this decision. This is about providing a system that is going to work for the city for the next 40 years or so. Obviously a range of other factors are going to feed into the consideration and it shows that Treasury have a warm, fuzzy side as well.

MS PORTER: Thank you for that and I agree, obviously, in relation to the issue around the quality of care and it being able to be provided in a particular type of venue and a particular area and accessibility. I noticed that the analysis around transport and I thought that that was a pretty tall ask to be able to ask you to make those assumptions based on travelling and distance time. Anyway, I thought that it was a very good job done on a lot of assumptions.

THE CHAIR: Thank you. Anything else, Ms Porter?

MS PORTER: Not at this stage, thank you very much, chair.

MR HANSON: On the analysis that has been done for these five options, I was comparing it with the analysis that was done in September last year on the Calvary option and the option to build. Was the same methodology used, because that came up with a figure of $00 million? By my estimation, if we have got to build a Calvary, or an equivalent, it was going to be the original 222 beds plus 90. That is 310 beds. But you said back then that a new hospital, which I assume was going to be the equivalent of Calvary, which was 310 beds, was going to cost $300 million. Now we seem to have doubled that figure. I am just trying to—

Ms Gallagher: Yes, we knew that would excite you, Mr Hanson.

MR HANSON: I am just trying to understand it, to be honest minister.

Ms Gallagher: It is a completely different scenario. What we have done is that we have taken the opportunity of national health reform and the sort of questions around Calvary hospital and asked, "What is the ideal system?" We are not just thinking about necessarily what is needed on the north side, but throwing in extra ideas like the subacute facility, for example, which was not part of the consideration. What we are looking at is the delivery of 400 beds as opposed to the extra beds that were under the original document at Calvary and a new hospital which was smaller than some of the options presented here. I mean, you could try and draw the comparison if you wanted to, but I do not think you can because it is a different mix and it is a different number.

MR HANSON: Yes, it is a different number, but the number last year was 312, which essentially was the comparison that you provided. If you were going to rebuild Calvary, it was $200 million or so and if you were going to build a new hospital the equivalent of Calvary, which is 312 beds, then it was going to cost $300 million. Now we are saying that 400 beds is going to cost double that. The maths do not add up.

Mr Ahmed: Sure. There are probably two questions here. First going to the maths, at that time that analysis had 200 beds at around a tad over $300 million; so about $1.5 million per bed in capital construction cost. The cost of option D here is about $680-odd million—about $1.7 million per bed. In per-bed cost terms, it is not too far off, especially when you adjust it for the cost escalations that have occurred since that point—the 2008 costs. We will be looking at the 2011-12 costs. You have to escalate it for the normal cost rises and the construction period. We have assumed a five-year construction period in here as well. So it is pretty much a reasonably good reconciliation on a per unit cost basis.

MR HANSON: Basically, taking it back to September—I do not want to re-litigate some of this that we have already been over—when you were actually doing the comparison last September to compare a rebuild of Calvary to a new hospital, we were actually comparing a rebuild of Calvary, which was 312 beds, with a new hospital, which you were talking about being 200 beds. That is where the discrepancy is?

Mr Ahmed: No, the—

Ms Gallagher: Well—

MR HANSON: I am just trying to work out where the discrepancy is.

Ms Gallagher: No, you go Khalid.

Mr Ahmed: Sorry. That was the second question that you had. The first is whether on a per unit or per bed basis we have significantly deviated from the original cost, and the answer is no. The second question is: how does this analysis relate to that analysis? That question at that point was an entirely different question. The question was: if you had to invest in an asset, would you invest in an asset that you own—that was the question—or would you give a grant to a third party? The analysis was essentially around the impact on the financial statements but the framework was different and the question was different. The question in this case, Mr Hanson, is: how do you configure and deliver those 400 beds? It is a different question.

MR HANSON: All right.

THE CHAIR: I hark back briefly to my first question. I guess that some of the answers that have been given make me want to re-examine that a little further. The costings you have got are based on the Victorian model; correct? There is another option, Western Australia. In what they have announced, they had considerable difference in costings. I guess my question is simply, given there were so many variables in this, would it have been more appropriate to examine both extremes or both options to get a better indicative cost, because it is a complex situation? We all understand that.

Ms Gallagher: Mr Doszpot, I have not seen the Western Australian analysis, but listening to Ms Bresnan, if it is about financing options it is different to the costing of the construct.

THE CHAIR: No, the costings themselves are different as well.

MR HANSON: No, I think it is about cost per bed that that came up with. I think is quite a variation from the Victorian model.

Ms Gallagher: We can have a look at it.

THE CHAIR: That is fine.

Ms Gallagher: I think that we have done some review of the work of the consultants. Our understanding and advice to Treasury is that these are reasonable and rigorous analyses used by a standard tool to provide a global cost, a strategic high level cost of this. If, for example, we choose option A, B, C, D or E, then it would go to a much more detailed costings analysis.

Mr Ahmed: We have scrutinised the cost in detail. You check the math and that is

normal. But we have also checked the reasonableness and the logic and whether they hold together or not. So we have done that internally and we have had three consultants look at it as well. Ernst & Young looked at it, Dr Lesley Russell at the Menzies Centre for Health Policy looked at it, and KPMG had a look at it as well. We have certainly undertaken to ask the consultants about the Western Australian costing model.

One would tend to think that the Victorians would be—they are a larger state; they do more hospitals. It is simply the scale question as well and the amount of work that they do in this area. That is probably the reason that that has not been taken as a standard. But we can certainly look at the differences between the two and see whether there is anything which could materially change these options.

MS BRESNAN: I am interested in getting a little more information—it is discussed to some extent in the options paper—about the benefits of actually having that fully networked hospital system. Has there been any further analysis done with it? When you think about it, it makes sense that it would actually have efficiencies in terms of not just economics but also other things. I know that there is some of that information in the paper, but is there anything on actually putting an economic cost on what you actually save by having that networked hospital across the system? I should say across TCH and then if you were to have another new acute hospital, what the actual economic benefits of that are?

Mr Ahmed: Yes, I think in a narrow sense you could calculate the financial benefits once you got the actual configuration really nailed down. Then you could figure out what the benefits are. But perhaps, if I could suggest this to the committee, the most significant benefits are around efficiency of care and quality of service. I think we have tried to draw that out in this analysis as well. I just have in front of me one of the references that is in the paper here.

This is Professor John Dwyer. He does talk about really significant benefits coming from the quality and safety of service when hospitals have got delineated rules, they are networked and the patients are transferred at appropriate times. The paper is in there and I can certainly provide a copy to the committee as well. What we have suggested is that that is where most of the benefits lie. As I said, it is possible, once you have got the actual shape and form of the configuration settled, to compare those options as well on that basis.

MS BRESNAN: Thank you.

THE CHAIR: Ms Porter?

MS PORTER: No, I do not have anything at the moment, thank you, chair.

MR HANSON: I am just wondering what the process is in terms of—does this go into this year's budget? I am referring to the decision time for when we are going to start expending funds, because as I understand it, there is some pressure on to do work at Calvary. That is what is driving this decision. So I am assuming it has to be made before this budget. Can you give us an explanation of how this is going to roll out, please minister?

Ms Gallagher: We will have to wait and see what is in the budget, but I think I have been pretty up-front that we need to make a decision to do some detailed work, because it will take a year to do a detailed design and costings, I imagine, of the preferred option. That will take some funding. But we also have some needs at Calvary; so I expect that we will need to manage both those pressures in the budget. If the decision is taken to stay at Calvary and upgrade Calvary, you will probably see some movement there in the budget. I cannot speculate, but we do need to move on this, because whatever happens it is a five to eight year construction time and we need to have it ready by 2020 at the latest, I think.

MR HANSON: So you anticipate selecting one of these options essentially before the budget so that it then allows for the seed funding for the—

Ms Gallagher: I think so, and I do not think that is unreasonable. We have been talking about it, as you point out regularly Mr Hanson, for a couple of years now. We have had lots of consultation. I think everybody is aware of the issues. So I do not think it is unreasonable to try to put a line in the sand by mid to late April this year.

MR HANSON: All right. Will the decision that is made actually include the location, because it is—

Ms Gallagher: No, because that would be subject presumably to the next detailed design. We have not gone out shopping for land because we are still looking through all the options. I think people would be quite rightly a little annoyed if we were out putting markers in land. We know areas of land that would be large enough for a facility like this and land where there are not restrictions, but that would be subject to the next step.

MR HANSON: Sure. The problem is, though, that if you are looking at any of these options, until you actually know what that location is, it is difficult to do that analysis. Some of the options that have been discussed have been from Gungahlin down to the Monaro. They are wildly different.

It is a bit like being asked to sign up to a republican model. People like the idea of it, but when they actually see the detail of what it is going to be they steer away. I just fear that if we do not actually know, if the decision is to build a third hospital somewhere—if it is a different location from Calvary or the Canberra Hospital—the decision of where that should be is a major part of actually lending support to that option, because otherwise you are basically signing off on a concept rather than something that is a concrete model. If it is a third hospital in Gungahlin, that is going to have very different community support, for example, than, let us say, a third hospital at the Monaro or one of the other locations that have been speculated on.

I am just trying to work out the time frame for that decision also. That also has a cost impact, because depending on where you select—obviously if it is Calvary, there are negotiations that would be require purchase of land. Other areas might require purchase of land which does have an impact on the cost but also on the whole consultation process and the ability to do an evaluation of that as an option.

Ms Gallagher: It is not unusual, though. If you take Bimberi, for example, we made the decision to build a new juvenile detention facility when Quamby had reached a point of its life. The decision was taken. We then went out and consulted with the community over five different sites and the site was selected. We did the same thing with the secure unit. We have made the decision to build it. This is the expected cost. Now we are identifying four sites, I think from memory, and we are going to go out and consult over that. So it is not an unusual way of progressing a decision. I think it is safe to say, as we have focused on the north side of Canberra, that a decision for a new building will be on the north side of Canberra.

MR HANSON: Sure.

Ms Gallagher: It will not be stretching down to Yarramundi Reach or the Monaro Highway. There is a whole methodology that goes into selecting what are the options for that to be the best place. For example, it will need to be accessible, it will need to be near major transport routes, it will need to have a good distance from Canberra Hospital for transfer of patients; so all of those will restrict a number of sites, I expect.

MR HANSON: Sure. If I could expand on my point, though. Particularly when you are talking about the medical fraternity, if you were to say, "We are going to build a new 400-bed hospital and it is going to be adjacent to Calvary"—for example—I am sure you could get reasonable support from the medical professionals at Calvary. It has different implications in terms of how you network and operate the hospital system. It is completely different than if you were going to build a new hospital on a greenfield site out at Gungahlin, for example. There are very different considerations that would take place, I would have thought.

Ms Gallagher: That is why it would need to be subject to a fairly extensive consultation process. But you would not be sitting here consulting over: "Should we build a super hospital? Should we invest in Calvary? Should we build a north side hospital? And, by the way, we have got five selected sites which we will consult on with you as well." That just would not work because then everyone would quite rightly say, "You're not genuinely consulting on A, D and E, or whatever. You've already chosen the land. You've already made your mind up." That would cause a whole range of other problems. So I think it is quite a reasonable progression to say, "These are the options. Government, in partnership with the community, makes a decision about what is the preferred option. We've got the preferred option. These are the sites that we've identified as being the right kinds of sites. Let's consult on that."

I have to say that that is the way we have done it in a number of areas in health that I am aware of. We did the same with the Belconnen health centre and the Gungahlin health centre. We said, "Yes, we're going to build one. What is the land available that we can use?" Then we have consulted with the community. It seems to be a completely acceptable way of doing things. I have not had any concerns raised with me. I take your point about the doctors. They are a key stakeholder group in this discussion. I think that if you were looking at sites that were going to result in doctors saying, "Well, I refuse to work there in five to eight years time," which is what the situation would be, we would have to consider that in terms of selecting the preferred site.

MR HANSON: As you go through the consultation, people in Belconnen might be thinking that a new hospital looks good—and it does on the analysis paper—but if they were told that the new hospital was going to be 30 kilometres away from them or that it was going to be away from Calvary—it was going to be over in Gungahlin—all of a sudden they might not think it was such a good option. I think it does have an impact.

Ms Gallagher: It does, but that is subject to another process. When we made a decision we would then go through a site selection process and discuss that with the community. I think it is important that the community have a say about where their hospitals is going to be. I am not going to say that I think everyone will agree with it in the end. If you put it out in Gungahlin then the people of Belconnen, I think, will say, "Where's our hospital going?" If you put it in Belconnen, people in Gungahlin will say, "Well, we got gypped. We need a hospital out here." I do not think it is an easy decision, but I think it is subject to another process—and should be, and will be in this sense—because we do not have the sites and we are not consulting on them.

MR HANSON: Thank you.

THE CHAIR: Just looking at the assumptions that have been made on these costings, I think $1.3 million is the figure you have mentioned per bed, or $1.7 million.

Ms Gallagher: 1.7, I think—1.65.

Mr Ahmed: This is not the assumption. These are the numbers, the unit costs, that emerged out of a detailed costing exercise. They vary between 1.7 million and in excess of two million per bed.

THE CHAIR: Do these costings take into account the manpower required as well—the doctors and the initial—

Ms Gallagher: The recurrent costs?

THE CHAIR: Yes.

Ms Gallagher: That is not built into the capital costs, but in a sense that is how we manage health. That is what is built into the operating costs. The health budget is over a billion dollars this year. The majority of that goes into acute care, or a large part of that goes into acute care. We are running 200-odd beds at Calvary. The recurrent costs will have to be delivered through whatever the health budget is at the time, which will be growing as we bring on more beds.

THE CHAIR: My question, I guess, is more aimed at the planning required. Currently there are doctor shortages.

Ms Gallagher: Yes.

THE CHAIR: Especially with the critical skills that are needed, do we have the time frame to ensure that there will be adequate doctors available for the additional beds that we are talking about?

Ms Gallagher: This is probably subject to another extensive hearing. Health Workforce is right across the board. The jurisdictions have set up Health Workforce Australia precisely for this reason—to better map and plan our health workforce. It will be a challenge. In two years time, I think, we are expecting more junior doctors than places to employ them in the hospitals, with the extra graduates coming through, but it takes time to get those junior doctors to become the senior clinicians. The doctors are coming through the system. But it is everything—it is nursing, it is assistants in nursing, it is allied health, it is a new type of worker, which will be the IT health worker to manage all the new IT systems that will be put in place in these new hospitals.

That is the subject of a much bigger piece of work. When you look at what we have done over the past six years or so, we have brought on about 240 beds. So it is achievable. Those beds are staffed; those beds are open. So 400 beds over a five to eight-year period is what we are going to have to do. Staffing will remain a challenge, but we have been doing it every year and we will continue to do it incrementally.

THE CHAIR: Thank you. Ms Bresnan?

MS BRESNAN: Thank you, chair. I have a question in terms of the budgetary impacts of Calvary continuing—or needing to continue—to operate, regardless of what option is pursued. Even if it is decided to build another new acute hospital, Calvary is going to have to continue to operate and will potentially require some upgrades as well. Obviously you have got the costs here for each option. How have the ongoing costs and work that are going to be required at Calvary, regardless of what option is finalised or pursued, been factored into future budgets?

Mr Ahmed: Into budgets or into the analysis, I am sorry, just to clarify?

MS BRESNAN: If it has been factored into this analysis. Calvary has currently got a budget bid in for a car park, plus other work which has been identified through capital development as well.

Ms Gallagher: Yes.

MS BRESNAN: Regardless of what is pursued here, Calvary is going to have to continue to operate for possibly a considerable time and will require some work. How has that been factored into everything which is going forward?

Mr Ahmed: I can certainly answer the technical part of it which relates to the analysis, and what we have assumed in the analysis, and then the budgetary policy question. The analysis assumes that in all the five options the level of service remains the same. That is the first thing. In each case, we have got 400 beds, and it is just about configuration. So the overall level of service largely remains the same. That means that there are no differences in actual service delivery levels. That is why you can see a difference in recurrent costs. There might be some efficiencies, but they will be relatively minor. That is one thing.

The other thing is the analysis assumes that in all the options Calvary is there in one

shape or form. We have not assumed any significant change in Calvary. Option D, in fact, configures Calvary as a centre of excellence for subacute services. But, with 200 beds, it is still a public hospital. In those options the Calvary hospital is there and the services are there.

Ms Gallagher: Within that there are the refurbishment costs of creating a subacute capacity under option D. Option A would have the components of Calvary in there, of upgrading Calvary. If the decision is to go with A, those costs are within that figure. If you go with D or E, building a new facility, there are some costs for refurbishment of Calvary built in there, but there may be some additional things that we have to do in the interim.

If, for example, you went with option D, so you had a changed role for Calvary into a subacute facility, which meant we went off and built a new acute facility, acknowledging that they have got to remain as an acute facility for the next five to eight years—five years to build a hospital, probably three years to transition—that is probably more than enough time. But just for the purpose of this argument's sake, having a time where you would wean services out of Calvary into a new system then there may be additional things that we need to do.

The areas that they are keen on at the moment—because we have done the intensive care unit; the aged care unit is there—are around the emergency departments and work there and a car park. They are probably the two projects we would have to look at some response in the immediate future.

MS BRESNAN: So if option D was pursued, you are saying that any upgrade costs that might be required for Calvary to continue operating as a public acute hospital, until that new hospital was ready to start taking patients—any costs that are required to upgrade Calvary in that period—are factored into that particular cost?

Mr Ahmed: Those are common to all options. In a differential analysis, they would be taken out because they are common to all options. You have to do something at Calvary as part of the capital asset development plan.

MS BRESNAN: So that is factored into that cost?

Mr Ahmed: In these costings, no.

MS BRESNAN: It is not factored into the costs?

Mr Ahmed: No—only to the extent that you need to configure.

Ms Gallagher: Yes, of delivering that.

MS BRESNAN: That is what I was just wondering. So there are going to be costs outside of this process. You have identified three particular areas.

Ms Gallagher: Yes.

MS BRESNAN: If that option is pursued, they will have to continue to operate as the

second—

Ms Gallagher: Yes. There are the standard building and maintenance costs that we fund every year. I really think that if a decision is made to build a new facility, whatever the shape of that is, then we will need a response around the car park, because nothing can happen at Calvary without the car parking being brought into line. That is even refurbishment in a sense because it would be a major refurbishment. We need a response to that. When I look at the hospital, I think it is probably the emergency department that is gaining—as the population grows, it is becoming increasingly busy.

MS BRESNAN: Just for argument's sake, if we went for option D, the three main areas so far that have been identified are the emergency department, the car park and, I think you said, the aged care—

Ms Gallagher: No. It is really the car park and the emergency department.

MS BRESNAN: So that is beyond any further consideration of what might be needed? They have been the main ones which have been identified.

Ms Gallagher: Yes.

THE CHAIR: Mr Hanson?

MR HANSON: Just following on from Ms Bresnan's question, this is obviously a lot of money and my question is: where does it come from? If you look at the capital expenditure over the next 10 years or so and then you look at the end state in terms of the amount of recurrent expenditure that is going to be required, it seems to go quite a bit beyond the CADP as it was first envisaged. I am just wondering where that money comes from. Have you looked at the budgetary impacts to say, "Well, this is actually going to see an expansion of the health budget in comparison to other areas of the budget"? Are we anticipating additional revenue to pay for this?

Ms Gallagher: What are you talking about? Are you talking about the capital or the recurrent?

MR HANSON: I am talking principally about the recurrent, but obviously you have got to find the capital expenditure. You have got to pay for that somehow as well. But by the time we get to 2018 when this is mature, or whatever time frame we actually get it built by, have we looked forward to that point and said, "Can we actually afford this in the ongoing territory budget?" If we are talking about a nine per cent increase per year—I know that we have got the federal agreement to meet half of that cost—it seems like an extraordinary amount of money. Is this going to impact on—

Ms Gallagher: We meet 70 per cent of that cost at the moment.

MR HANSON: That is right. Are we going to be able to afford this on an ongoing basis?

Ms Gallagher: Can we afford not to, would be my response, as a community?

MR HANSON: Sure, but the question is: have we done the analysis to say that by the time this is mature, the additional salaries, which are a significant component of the health budget—it is adding about a third to the salaries of whatever it is going to be—and spending all that money on capital infrastructure—I am just wondering what impact this is going to have as a project to the entire budget. Does this mean that we are going to have to squeeze elsewhere or are we anticipating that additional revenue by that time will actually be able to fund this sort of project?

Ms Gallagher: As you know, the health budget grows and is budget funded to grow in the order of about 6½ per cent a year. That is built into our forward estimates. I have to say that if we did not budget like that our budget bottom line would be looking a lot healthier than it is. We have factored that in and we took that decision in 2006. That is a lot of money every year. When you look at new initiatives in the budget, which we usually try to contain to about $30 million a year, the health budget is growing in the order of $60 million a year, on top of—

MR HANSON: Can I just quickly interrupt? Does it not normally grow by about nine per cent in real terms, though? I know that you factor in 6.5 per cent, but—

Ms Gallagher: In terms of the growth factor that we have factored into the forward estimates, if we need to supplement that baseline activity we do that. I think on average it comes out at about the high eights—8.9.

MR HANSON: It is about nine per cent.

Ms Gallagher: Yes. We are reviewing the growth formula at the moment. It was designed in 2006. Within that 6.4 per cent there is a component for growth in acute care, subacute care. They are different components, but they add up to be about 6.2, I think—6.2 to 6.4 per cent.

Mr Ahmed: Yes.

Ms Gallagher: If, based on activity, the hospital was busier, as it has been for a number of years, then we supplement, based on that activity, the difference. That is how you get to the 8½ to nine per cent. We have funded two-thirds of that growth essentially through our forward estimates. In a sense, that growth does not hit the bottom line; it does not deteriorate the bottom line. Anything above that has an impact.

In terms of projecting forward, these matters are all before cabinet at the moment as we determine the next stages of the CADP, but, in a sense, the capital costs are the easy part. Trying to contain the recurrent costs is the more difficult challenge. But I can certainly sit here and say that health costs are going to continue to grow. There are ways you can manage that. You can only plan to meet a certain level of your known need and those recurrent costs look a lot better. But I am uncomfortable with that approach.

The question is—and I cannot think of another area of government where we have done this level of work—this is what it is going to cost, recurrent. These are the capital costs and these are subject to budget consideration at the moment—how do we

get there and what efficiencies are we looking for in containing some of those costs?

MR HANSON: I am not asking what the detailed efficiencies are, but it just strikes me that whichever option we go with, by the time we add the capital and the recurrent, it is going to be well beyond the 6.5 per cent that has been built into the budget. I am just wondering—

Ms Gallagher: That is compounding. You understand that, do you?

MR HANSON: Yes, but what is it? What is that delta going to stretch out to—the difference between 6.5 per cent and 8.9 per cent at the moment? It seems that, once you factor all this in, that gap, in terms of what you have to then find, is going to be much larger. What is the impact of that going to be on the budget?

Ms Gallagher: We expect health growth to continue in the order of eight to 8½ per cent a year.

MR HANSON: With this factored in?

Ms Gallagher: That is as far as you can predict out. We believe that is a reasonable assumption. That is certainly what the commonwealth believe in the work that they have done. Every year we see growth upon growth. In a sense, we are trying to manage the majority of that through our forward estimates. Anything on top of that requires top-up, and then you do have to start looking at what else you are going to do to meet your needs.

But at the same time, in the next 10 years, our community will be growing as well, so the budget overall will be growing. Perhaps the most attractive side of the networked integrated system is that there is plenty of evidence that shows you that that is a much more efficient way to run your hospital as well. At the same time that we are looking at what is the best way to run the hospital, we are also looking at the most efficient way to manage those costs into the future.

MR HANSON: So you have done analysis, then, that shows you that the capital and the recurrent combined over the next 10 years or so will stay within that 8.5 per cent anticipated growth?

Ms Gallagher: That is a lot of growth in there—8½ every year.

MR HANSON: Yes, I am just asking if you have done the analysis that shows you—

Ms Gallagher: We think that is a pretty realistic figure. Barring some major catastrophe that nobody has seen—

MR HANSON: Sure. What I am asking for is: have you got the analysis that shows that you have done that work, or are you just thinking it? Have you done that analysis that shows that?

Ms Gallagher: Yes. We have done the analysis based on the demographic data that we have—the size of our community, the ageing of our community. We look at all

different sources of information—the Chief Health Officer's report about the growing prevalence of chronic disease—

MR HANSON: Could you provide me or the committee with that analysis that just shows that with the anticipated expansion in the budget, because of population growth and this project as well, that it will stay within that 8.5 per cent growth? That is my concern. That is my question.

Ms Gallagher: Well, what—

MR HANSON: You said you have done the analysis—

Ms Gallagher: It is an assumption. Yes, we have done—

MR HANSON: Can you show it to us?

Ms Gallagher: It is based on the last 10 years of knowledge as well—feeding in and looking at all that change. I can look at what we can provide to you, Mr Hanson, to assist you, but I do not think it is an unreasonable assumption that health costs will continue to grow in this order.

MR HANSON: Of course they will, but I just want to see the evidence that this project—when you add all the recurrent costs on and the capital costs—is within that 8.5 per cent growth over the next 10 years or so.

Mr Ahmed: If I may add that the project puts beds in there, and the beds will be filled by patients who will be treated and so on. The building blocks of the growth rate can be built from a microscopic analysis of individuals in each suburb, what their health status is and what they will consume. Or you can look, as the minister suggested, at the past trend and see how health costs have evolved, if the price has escalated, if health CPI has tracked above the normal CPI. So there is a cost component and, typically, it is run at about four per cent—in excess of four per cent—per annum.

The population has grown, and, all else being equal, if you assume the same utilisation rate from the demographic factors, they will add another 1½ per cent. Then there is a non-demographic utilisation factor, which is due to ageing and things like technology. Typically, another 2½ to three per cent is added there. These are well-known growth factors. Combined, they add up to something like around eight to 8½ per cent. Those are the general planning parameters that are used by all levels of government.

The recent COAG negotiations and discussions, which are quite public, assumed a similar set of parameters. In terms of growth rates, those are the parameters that are well-established and well-understood at this time. What happens in future, whether there are significant changes in technology that reduce the growth rate or, on the other hand, actually increase the utilisation and increase the growth rate, is yet to be known. Those are difficult things to predict. As a planning parameter, I would suggest, Mr Hanson, that it is a reasonable parameter.

MR HANSON: I think it is good. I am just wondering whether building a new

hospital and increasing the size of your workforce significantly has an impact on that. That is what I am trying to follow up.

Ms Gallagher: Well, it does not.

Mr Ahmed: Mr Chairman, can I just clarify an earlier question from Ms Bresnan. This was about the car park and about the assumptions that we have in the various options. I have just taken advice. The assumptions that put extra beds in Calvary do have the car park built in, because that is what a bigger Calvary would mean, to make that option work. So that assumption is in there.

THE CHAIR: Thank you. Minister, with your Treasurer's hat on, having looked at all the options so far—you have four, and then, of course, this late inclusion of a fifth option—do you have a preference, as Treasurer, out of all these options at this point?

Ms Gallagher: I can answer with both my hats on, because I think I have been clear about it. I would prefer one manager of the acute system. I believe that in terms of financial efficiencies but I also believe it from a health service delivery point of view. I have been clear about that with Little Company of Mary and with other stakeholders that I have been discussing these options with. I think, from a patient safety point of view and potentially from financial efficiencies, which we go to a little bit on page 19 of the Treasury analysis, it will set the service up for the future. Again, this is not going to be something that I benefit from as health minister in five to eight years. I honestly believe it is the right thing for the community as a whole.

THE CHAIR: Thank you. Ms Bresnan?

MS BRESNAN: I think we are out of time for Treasury. Let us move on to Health.

THE CHAIR: It is 8.35 and the end of our Treasury session. Thank you very much, minister. Thank you very much, Mr Ahmed and Ms Smithies.

The committee adjourned from 8.23 to 8.34 am.

THOMPSON, MR IAN, Deputy Chief Executive, ACT Health

THE CHAIR: Good morning and welcome back to this reconvened meeting of the fourth public hearing of the Standing Committee on Health, Community and Social Services inquiring into the Calvary Public Hospital options. Welcome to our new members assisting the minister, Mr Thompson and Dr Brown. I guess you would also be pretty familiar with all the requirements of these hearings. The privilege statement is okay by both of you? Thank you. Minister, I asked you at the beginning of the previous session whether you wanted to make a statement.

Ms Gallagher: I am happy just to proceed, chair.

THE CHAIR: Thank you. Minister, can you explain how the figure of 400 beds was calculated?

Ms Gallagher: This is work that is being done through the capital asset development plan, so essentially our planning unit about what our acute bed needs are. I think it is fair to say 400 is perhaps at the lower end of what we need to get to at the end of this project. I am not saying that there would not be additional beds on top of this 400 by the time the whole capital asset development plan has finished, but, in terms of looking at configuring the system on the north and south of Canberra, 400 beds is a reasonable planning tool, in a sense.

THE CHAIR: And the mix of acute and subacute beds was part of the same calculation?

Ms Gallagher: That was part of that work. Within beds, I guess, you have your subacute beds, you have your acute beds and around that you have a level of higher capacity beds—intensive care and high dependency beds. All of that has been looked at unit by unit across Health. It is a component of cancer beds, renal capacity—I think they are increasingly using chairs in renal. We have gone to each unit, in a sense, to try and predict what the level of bed needs will be.

It is a hard job, in a sense, because the health system is changing all the time. If you look at renal as an example, in the past we have, and we still do, run in a sense a ward situation for some renal patients. In the Belconnen enhanced community health centre that is going to commence construction soon we are building capacity for renal to be provided in that environment in chairs. We are looking at another opportunity for patients to go and perform dialysis themselves in a secure setting at a time of their choosing. That is just giving you one example.

It is difficult to predict, but based on our population—some of the factors that Khalid Ahmed was going to before: our known level of need, watching what has happened over the past 10 years and extrapolating that forward across different units—again, it is a reasonable position to be working from.

THE CHAIR: A supplementary, Ms Bresnan?

MS BRESNAN: Yes, just to follow up on that. It is an issue which we discussed earlier with Treasury around the original numbers that were put forward. Obviously

we have moved on to different options with this paper, but there were around 90 beds that were going to be picked up from Calvary if that asset was purchased. There are already around 200 or so beds that they have provided there. So that is an increase in around 100 beds, approximately.

Ms Gallagher: Yes.

MS BRESNAN: In terms of the work that was originally done about what would be needed and purchasing that asset—and now we have got to a figure of 400 beds—how has that changed in that time period to that increase?

Ms Gallagher: Like Khalid said before, it is a different question. What we are asking in this paper is different to the Calvary options analysis, which was done really around: what is the most effective from a balance sheet—on our financial statements, what is the best way to manage a redevelopment on the north side of Canberra? In a sense, we have flipped that up and said, "Let's just not restrict it to a future about what we are currently doing at Calvary but look at what opportunity we have to configure the health system of our future in the best possible way."

What this brings in is less growth at Canberra hospital, for example. That is a scenario that we are looking at on the north side of Canberra. It varies under each option. If we build a new subacute centre on the north side of Canberra, obviously there will be fewer subacute beds being required at Canberra than we had factored into the Canberra rebuild. So, in a sense, they are different questions. We have said, "Look, we know we need 400 beds, under the current system, spread across two hospitals or we can look at 400 beds spread across three different sites and the configuration of those sites could change." It is a different question than what we were originally posing under the Calvary options analysis.

MS BRESNAN: I understand that. It is around another 100 beds. It is a fairly significant number. I take your point: you were looking at that as an asset—what we can do there and if there is going to be potential growth well perhaps we do it at TCH. It was basically in the original calculations. Obviously it is a different question now and we are looking at a different set of circumstances. Was that originally factored in in terms of what would be the actual numbers we would need in that original assumption?

Ms Gallagher: So have our numbers changed, in a sense? Are we planning more beds than we had planned?

MS BRESNAN: I guess in the original planning process—

Ms Gallagher: The answer to that would be no. As to what was being planned at Calvary, it is difficult to take a snapshot in time. Yes, we expected over time that it would be a doubling of services at Calvary. I have said that publicly. There are 200-odd beds there now. But over time you would not have necessarily said that is going to be a 300-bed hospital. For the purposes of the analysis in the options paper it was, but that would not have excluded further growth should you have been required to do it. Under that scenario, the majority of beds were going to be delivered at Canberra.

THE CHAIR: Mr Hanson, do you have a supplementary?

MR HANSON: Yes, to wrap up both of those. Essentially, you have defined the destination in 2018-20, that sort of time frame, and the options present the way of getting to that final destination, which is a number of beds. The options paper defines that as a number and it talks about the number of subacute versus acute. You were talking about the fact that you have actually refined that in more detail down to renal beds, high dependency beds and a whole bunch of bed categories, saying that you need 20 of these and 100 of those and so on. Could you provide that to the committee, please?

Ms Gallagher: I think at the moment that is subject to cabinet processes. In a way, I have tried to deal with that because these are subject to government decisions through identifying them as acute or subacute beds. So within that—

MR HANSON: This goes back to Mr Doszpot's question in terms of how you define the 400. This comes up with a total number of beds for our community. You said that you have done the analysis, and I assume Health—

Ms Gallagher: We have done the analysis. I have not just said that we have done it; we have done it.

MR HANSON: You have done the analysis that shows you what category of beds will be required by this community in 2020. I do not understand why that is subject to cabinet process, because you have said that you are going to provide 400 additional beds. That is the destination. We are just looking at the way to get there through the options.

Ms Gallagher: At the moment we are going through budget cabinet and a lot of that information is subject to budget cabinet processes. I think it is fair to allow the cabinet to consider that.

MR HANSON: Are you going to change the number of beds from 400 to a lesser number, Minister, because otherwise surely you have defined that those are the community's needs? Why can't we get access to that? This is work that is done by ACT Health to define the community's needs by bed category. I do not understand why that information cannot be provided to this committee.

Ms Gallagher: Because it is currently before the cabinet for consideration, Mr Hanson. If at a point in time that cabinet has considered it then there may be the opportunity to make that information public, but at the moment that is subject to budget cabinet processes. I do not think it makes a huge amount of difference to the purpose of this process to go to that level of detail. I accept that once you make a decision, people are going to want to know how many of this, this and this are going to be in a new hospital. If you go to a new hospital you will need to consult on all of that, as we do with every new facility we are building. But for the purposes of this discussion and the future, it is at a much higher level, which is: there are 400 acute beds; how best do we deliver them?

MR HANSON: I disagree, because you are asking us to sign up there. This committee has been asked to consider the options. You are making this statement that there are 400 additional beds required and when you actually add that to the current beds it gets to the 1,200 figure. I cannot quite remember exactly what it is, but it is a lot of beds. You are saying that you have done the analysis that explains why you need that additional number of beds, because you need a certain number of renal beds, a certain number of subacute and so on. I just do not understand why this committee cannot have access to that information so it can assure itself that 400 is the right number and can understand where that 400 comes from. I simply do not understand, if you are saying to us, "It's going to be 400; trust me," why we cannot see the analysis behind that that has been done by ACT Health.

Ms Gallagher: I think you have got pretty detailed information before the committee. We are not really asking the committee, and I am not sure the committee is actually in a position where you are, with all due respect, expert enough to decide whether 400 hospital beds is—I am not trying to be rude here, but there is a lot of work that goes into designing and predicting that. I think we have put in the discussion paper, in a global sense, some of the levels of demand, some of the drivers of demand. I guess the committee is being asked to assist in the government's consideration of a preferred option.

MR HANSON: Yes, but I do not see why the committee cannot see the analysis behind it to gain a better understanding. You are saying that it is 400 beds. Why can the committee not have an understanding of what beds they are and how they all fit into the bigger system, which is what we are being asked to look at here and then to refer back to the Assembly? It is a very big project. This goes, as you say, for 10 years and will have implications for Health for probably 30 years. You are saying it is 400 beds. You are saying you have done the analysis that says that it is a certain number of beds by category. I am not sure why this committee cannot see that. I cannot see why that should be subject to budget cabinet. Ultimately, the decision of which option is—

Ms Gallagher: Okay. We have got 50 minutes. I think you have made your point about 17 times. I understand it and I have told you it is before budget cabinet. There is a breakdown of the subacute beds. Anyone with a level of understanding about what subacute provides would be able to extrapolate from that those numbers of beds that are detailed in the paper on page 6 and the same for the balance of the acute beds.

I think that at page 5 we go to what makes up an acute bed, what makes up outpatient services and the other support beds. I do not know if you have seen page 5, but it does go to what we have currently got and the difference in what will make up an acute bed. I guess all you are missing is, next to each one of those, exactly how many beds.

MR HANSON: That is right.

Ms Gallagher: I do not know that for the purposes of the discussion we are having today that that is necessarily the relevant bit of information. I think it is. Subsequently when we consult on whatever the preferred option is—

MR HANSON: Sure. So will you release it at that stage, minister?

Ms Gallagher: If the government decides to go to a new facility, there will be extensive consultations around that, as we have just gone through if you take Gungahlin community health centre, Belconnen enhanced community health centre, the new mental health unit or the women's and children. Once we have made the decision you would then go through a year-long process about what is the model of care, what is the makeup of the spaces, how do they configure them, how many in women's and children's are going to be NICU, how many are going to be female gynaecology beds, how many are going to be outpatients, how many are going to be labour, delivery and birthing suites, how many are going to be just birthing suites. All of that work is all public and clear and consulted upon.

THE CHAIR: We will have to move on, Mr Hanson. Ms Bresnan, your second—

MS BRESNAN: No, I am happy to go to Ms Porter.

THE CHAIR: Okay.

MS PORTER: What about me, Mr Doszpot? I'm still here.

THE CHAIR: We have not forgotten about you, Ms Porter. We are simply—

Ms Gallagher: We keep forgetting about you, Mary. You are in a smaller package.

THE CHAIR: These are all supplementary questions. We have not forgotten about you at all.

MS PORTER: I beg your pardon. I do actually have a supplementary, but never mind.

THE CHAIR: You have got the floor.

MS PORTER: My supplementary was really a comment about what you said at the beginning of the discussion about the configuration of the beds, the rapid changes in health care and the fact that, of course, we will obviously be taking this into consideration when we start to do that further analysis. How much of this care will be happening in the community as well as in the subacute area and in the chronic area? I guess that will be part of the discussion when we go into that further discussion. That was just my sort of supplementary on this collection of how many beds and what they would look like.

I was just wondering whether you could talk about something else. Would the option of building a new acute system provide for better role delineation in our elective and emergency surgeries? This seems to be where the delays are caused and a great deal of angst to get these lists managed effectively. How do we deal with those people on the list versus the emergency surgery, which inevitably happens? Could you talk about that, minister, please?

Ms Gallagher: This is a component of my belief that one management of the acute system would deliver I think a better service to the community. That is not to say that the current services are not delivering good services. But as demand continues to

grow, the pressure comes on and Canberra Hospital continues to grow as the regional tertiary referral hospital, I do not think we can ignore some of the pressures, particularly around emergency surgery, that are presenting a challenge to the system as a whole.

In the past year or two years, the emergency surgery work at Canberra Hospital has increased by 20 per cent. That is because our region is growing and we are a large provider of emergency care. That does put pressure on the elective lists at Canberra and in an ideal world I think an elective surgery centre would be fantastic for the ACT. The problem we have had in the past is delivering an elective surgery centre as a stand-alone facility, which other jurisdictions do as a way of reducing cancellations and effectively managing the lists as efficiently as possible. They have these stand-alone centres.

The reason we have not been able to proceed down that path is that an elective surgery centre would require an intensive care unit and there is no way we can staff three intensive care units across the ACT. So some of the challenges I think at Calvary—and they are still having them—are balancing the private and public needs of their elective lists. Since the Auditor-General's report where they have had to change the way they operate their lists in order to accommodate the transparent delivery of public services, their list management has become more inefficient because doctors have had to separate their public and private lists. That has put pressure on Calvary as well.

In an integrated system if there was one manager of the acute system, certainly I think there could be better coordination and management of elective surgery. I would hope that if you went down that path you would be able to reduce the elective work at Canberra to allow Canberra in a sense to just deal with the emergency work that they are seeing every day. I think that would bring some benefits to the system as a whole.

Role delineation is an area of frustration I think for both Canberra and Calvary hospitals at the moment. Calvary, quite rightly as a hospital, wants to do a range of activities. Canberra has to do a range of things as well; so at the moment I think effective role delineation has not been achieved, but that is not to say that we do not work together very well and try to manage the lists. Indeed, I think that Calvary is doing an extra 800 procedures for us this year.

There is a lot of goodwill there, but whilst there are two managers of two lists with two loads of patients, with systems that do not talk to each other, I think that there is frustration around the potential to deliver a good, effective role delineation across the hospitals. I have to say that certainly from my point of view that would be alleviated if there was one manager of the acute system.

MS PORTER: So minister, just to clarify, when you say systems that do not talk to one another, we are talking about the—

Ms Gallagher: IT.

MS PORTER: The IT. We are not talking about—

Ms Gallagher: Yes, sorry. The people talk to each other.

MS PORTER: You guys talk to one another.

Ms Gallagher: Yes, yes.

MS PORTER: It is the actual IT systems that do not marry with one another, which causes the problems, yes?

Ms Gallagher: That is right. We do not have a patient administration system that talks to each other, although that is changing. By 2012 at Calvary will have ACTPAS. That will allow those systems to talk. But even if you look at outpatients data, we do not have necessarily the data around outpatients and demand for outpatient services that are managed by Calvary at the moment.

I think that is frustrating for patients in the one city where doctors work across both hospitals often to have that level of fragmentation. But we can fix all that. It just will take a little time. But in terms of pure, true role delineation—this is what this hospital does; you do not do a lot of emergency work; the emergency work will be done at Canberra and the majority of the elective work will be done in a new facility—they are some of the opportunities that I think at the moment we do not have.

MS PORTER: All right.

Ms Gallagher: To the greatest extent possible, anyway.

MS PORTER: Okay, thank you.

THE CHAIR: Ms Bresnan has a supplementary on that.

MS BRESNAN: Just to follow up, you have mentioned the electronic systems and obviously that is a problem when you have different technologies. I think you briefly mentioned that it is also about probably having two different hospitals with two different systems. It is one thing which has been raised by the ANF, and I think they have probably already raised it in previous hearings. Also, when the committee went out to TCH, the management processes that are put in place was also raised, not just around staffing but around procedural issues as well. That too cause some issues. Are there other issues on top of your technological issues that do cause some issues across the two hospitals?

Ms Gallagher: I think there are and they just come from having two managers of the services. Calvary Health Care is part of Little Company of Mary Health Care; so they have policies and procedures that are sort of developed for that organisation. We have, as the ACT Health, systems, processes and arrangements that are developed for ACT Health. I am certainly aware of the ANF's concerns. They cc me into all their correspondence to Calvary. There is a level of frustration I think when you are the Minister for Health that you are not able to intervene in any way on some of those issues that are constantly brought to your attention around what happens at Calvary Health Care.

That is not to say that Calvary do not manage those and deal with that relationship with the ANF, but as the public health minister, certainly that management arrangement pretty much keeps the government out of being involved in anything. I think that on the day-to-day level, staff work across the hospitals, but it is not just IT systems. I think the Auditor-General's review into the elective surgery waiting lists again points to two lists being managed across what should be one elective surgery system. There are differences about how they are managed—patients being on one list not necessarily being able to be linked up across the hospitals and things like that.

I just think that in a two-hospital town we have got to get better organised around that. That is not to say you could not fix all that without building a new hospital. You could. But I think our experience has shown that it takes a long time to negotiate that.

MR HANSON: Yes, the discussions with Calvary hospital around these options has them changing their role to subacute in some of the options. Are they comfortable with that? Are they agreeable? Or do you anticipate that if you did choose that as an option there would be the sort of more complex negotiations and discussions that we have seen over the last couple of years?

Ms Gallagher: I think Little Company of Mary would know that I believe one manager of the acute system is the preferred way forward. When I first spoke to them about different options, they were very keen to make it clear to me that they wanted to manage an acute service, which was, of course, a different position to what was taken when these discussions started when they said that they did not want to manage an acute service.

There has been a change over the last two years and I am trying to accommodate that change, in a sense, but I am asking them to consider changing, just like I am asking everybody in the health system to consider changing. For example, I am asking doctors at Canberra Hospital to go and work in community health centres doing things that they have never done in community health centres before. We are starting nurse-led clinics. The Medicare locals will come on board. We are going to have a local hospital network.

Everything in a sense is changing and I do not know that it is fair—and I do not think this is Little Company of Mary's position—that one very important element of your health system can just say, "We do not want to change because we like it the way it is." I do not think that they are saying that to me. I know they have some concerns around a changed role, but I have met with them recently. We are just having ongoing discussions. They are going to provide a response to this paper and they are going to make that public when they have formulated it. I think it will be clear from that submission what they are prepared to consider.

MR HANSON: Yes, because the concern is, obviously, that they would say that you think option D is the preferred option and certainly that is the way that the ticks are going at the moment. But if they have a different view to that and were to then—

Ms Gallagher: Yes. What does that mean?

MR HANSON: What does that mean and what does it mean legally? I mean, they

might not like it, but legally can you say, in essence, "Bad luck. This is the way we are going"? Going back, have you looked at the current agreement to work out what actually you can do? The agreement, as I understand it, is that they have got to run a hospital on the north side of Canberra, but it does not express whether that is acute or subacute as far as I am aware.

Ms Gallagher: Yes.

MR HANSON: I mean, just legally what can you do? Have you looked at that?

Ms Gallagher: I have to say that the legal avenues would be my last—I would do anything to avoid 30 per cent of our health system being dragged through the courts. I just think that would be a disaster. It is something that I do not want to even consider and I have said that to Little Company of Mary as well. Whether you would have legal standing I think is a question that is very difficult to answer. I cannot see any reason why, if Little Company of Mary felt so aggrieved that they wanted to pursue legal action, the courts would not allow that case to be heard, in a sense, because I do not know how many contracts there are dating back 30 years. I think there would be enough there for the court to be interested.

MR HANSON: All right, so we will essentially wait for Little Company of Mary to put in their submission and then take it from there.

Ms Gallagher: I think so. Look, all I can say is that John Watkins and I have had a couple of very good meetings. He certainly said to me, "We want to work with the government; we want to deliver the outcome that is best for the community." I have said the same thing to him. So I think my preferred end point of this again is not to fight with Little Company of Mary Health Care.

MR HANSON: Yes, certainly. Have they expressed why they want to run an acute service rather than a subacute?

Ms Gallagher: I think some of the—look, in the past and we have not gone to it in any detail and perhaps this is a better question for them rather than me because I do not really want to speak on their behalf. But my sense from meeting with the doctors at Calvary and the board is that there is some concern that it would be seen to be a reduction in their role. Now, under national health reform I think it is pretty clear that the area of growth that needs to be managed in the best way is subacute care and I think there is acknowledgement from Little Company of Mary and the government that they already do it very well.

They do the Keeney building; so they do subacute aged care. They also do 2n as subacute mental health, they do palliative care to a very high standard and in other jurisdictions they are specialists in subacute care. But they have been running an acute hospital here and I think for them as an organisation and for the doctors that work there, a changed role is confronting. So we just need to continue talking with them and I will be interested when we get their submission.

THE CHAIR: Ms Bresnan has got a supplementary?

MS BRESNAN: It is just a supplementary. If the options analysis D and E come out sort of across the board as being probably the preferred options across a number of different areas, because of the current arrangement with LCM and obviously, as you said, it is quite complex in terms of the existing contracts and the lease and everything is related in that respect, will their feedback and their preferred way to provide future health care impact on the sort of options that might get finalised in terms of what they are then prepared to go for, given that there is that complexity in the relationship to the lease as well?

Ms Gallagher: I think they are a very significant stakeholder in this. I guess I am trying to not put their preference above, say, the consumers association, the Health Care Consumers Association, the ANF or any number of other organisations who have been talking with me about it. But realistically to move unilaterally without at least conditional support of LCM I think is risky. So my preference again, and the energy I am putting in, is talking to them about what potentially a Calvary in five to eight years time could look like.

MS BRESNAN: And if it was that subacute option, that could still be a public service?

Ms Gallagher: Yes, and I think that is important for other elements of the Catholic healthcare organisation. Having a continued public role is perhaps the most important element of the future of Calvary. Not necessarily Little Company of Mary Health Care but other interested people are very keen to have that public role maintained and to not just become a private facility.

MS BRESNAN: Sure. Thank you.

THE CHAIR: Minister, according to consultation guidelines set by your government, major decisions like this should be open to community consultation for 12 weeks. Why has the consultation period been halved to six in regard to this issue?

Ms Gallagher: My view is we have been consulting on this for two years and variations on it. All of the interested stakeholders are very well across the issues and have been to a number of different consultation sessions with me over the last two years. This is really drawing all of that together. In terms of the next stage, post-decision, then I expect another lengthy consultation process over that as well.

THE CHAIR: I take your point about consultation with the major players, but the community itself has not had a sense of consultation.

Ms Gallagher: To be honest, outside of stakeholders—and I do not know whether the committee is any different—apart from emails from the Gungahlin community, I have not had any interested individual members of the community approach me around this paper, but I expect that some will be coming in. Again, usually they are linked to another organisation—whether it be the Catholic Church—or they are involved in the consumers association or they are a recognised stakeholder in this.

If there was a huge outpouring of grief that we needed to extend this for another six weeks, we could certainly look at how we deal with that, but the pressure on me—

let's be honest about where this has come from. In a way, the timetabling has not been set by me. We have had a number of different iterations of this and changes that have occurred along the way. By the time, I guess, the accounting advice issue had been settled and once the proposal to buy Calvary had fallen over, once the proposal to buy Calvary had become complex and the parties had disagreed, this was the third stage of trying to pull a reasonable way forward together. Then the detailed costings and things like that took a period of time. In fact, we worked right over Christmas and New Year to get this done so that we could provide it in time for some level of consultation before the budget.

THE CHAIR: The point I am coming from is that community groups like the community councils obviously meet once a month, and six weeks does not really the give them time to consider these with their members and have an opportunity to come back. There was a fair bit of criticism with the schools closures about the length of time. According to your government guidelines, is the consultation guideline meant to be more mandatory or is this simply a guideline that can be utilised or under-utilised as seen fit?

Ms Gallagher: As I would say, we have been consulting on this, Mr Doszpot, for a number of years. I have not had any complaints at all about the consultation process or the time line. In fact, I am booking meetings in to meet with a whole range of stakeholders in the next week. I am very happy to write to the community councils—I have not written to them with this paper—drawing it to their attention. I am sure Gungahlin Community Council know, and Belconnen—because it is particularly them, I think, in terms of the north side. I am happy to draw it to their attention and to provide them with an avenue to provide the government with feedback in that time if that is needed. I certainly have not had any approaches about it.

THE CHAIR: Ms Bresnan, your substantive question?

MS BRESNAN: Thank you. One of the key issues that have come up—and this is through going to TCH and also through some of the evidence given to the committee by Dr Peter Collignon, particularly about infection control and how that is having an impact on the design of hospitals now and into the future—is that obviously there are a lot of considerations in the options analysis. Is that one of the primary considerations about what is then going to be the best option? Obviously if it is to reconfigure Calvary to have more acute beds, that sort of work could be required. Is that going to be a primary consideration?

Ms Gallagher: Certainly it is and it would be factored somewhat into the construction costs. We have set ourselves, through the CADP, I think a target of about 80 per cent single rooms, which is the biggest change you can make to your hospital to reduce the risk of infection, and that would be factored in. Indeed, it goes to some of those issues about a refurbishment versus a new build. I think people have raised the question that it is much easier to just refurbish an existing building. That is certainly the view of some of the doctors at Calvary—you have got a hospital here, just refurbish it and make it good.

When you look at the refurbishment costs per unit, it is actually around $2 million as opposed to a greenfields construction of a new facility which sits at about $1.7 million.

I think that is because you are not dealing with the costs of basically the old buildings that were never built with the intention of being single rooms, making use of light and the use of IT that essentially will control a number of those infection control measures within the room. Those older buildings have to be significantly redone and that adds to the cost.

MS BRESNAN: Also at the moment—this is an unrelated issue, but it is related in a way, I guess—obviously with the experience of TCH where you are dealing with providing the majority of the acute services in the ACT, plus dealing with the construction site, is that also a consideration, given what option will then be pursued as well? If it was going to be the Calvary site, you would potentially have the same situation with your services provider, but you have also got construction going on.

Ms Gallagher: That will factor in, believe me.

MS BRESNAN: It is not the primary concern, but I guess it is a lesson learned from what is happening at TCH.

Ms Gallagher: It is. It will very much factor in. We have had probably 18 months now of a heightened level of activity on the Canberra Hospital site. I have to say on every day it is a challenge—whether it be a contractor hitting a gas bottle, fumes going into places they should not go or bits of construction material falling off a building, not hitting anybody but it had to be reviewed from a safety point of view for pedestrians. Because it is a large area where lots of the public are coming and going, to actually have a full-on construction site and maintain 24/7 services and not reduce any services has been a huge task and is a huge stress to staff, I have to say, both to the people that are working on the site but also staff in the hospital that are having to deal with that. It is very much at the forefront of my mind in terms of having both of our public hospitals under significant construction for the next five to eight years. I think it will be a very big challenge and I have said that as well. I have said that to LCM.

THE CHAIR: Ms Porter?

MS PORTER: Yes. My question was around infection control, the difference between trying to refurb the hospital and build a new one and all the modern technology that we need for acute care now. I guess that question has been fairly well answered, but I also had a question around community feedback on what the government has put forward so far. You have answered that question too, but I just had a comment about the community councils in response to what the chair said. I know that the Belconnen Community Council, for instance, minister, at the drop of a hat will call a meeting if you put something forward and say you want to have a meeting with them. They frequently have meetings between meetings for special subjects. I am sure that if you were to contact the Belconnen Community Council—

Ms Gallagher: Yes, we will.

MS PORTER: they would be very happy to rally the troops for a meeting. The other comment I just had when we were talking about—

THE CHAIR: Have you got a question, Ms Porter?

MS PORTER: I am sorry?

THE CHAIR: Have you got a question?

MS PORTER: No, I have got some comments to make. I said that two of my questions I was about to ask had been substantially answered and I just wanted to make a final comment; thank you, chair. That is with regard to the rehab. You did not mention rehab, I do not think, minister, when you were going through the list. It was subacute and acute. I guess that part of that mix of the subacute and chronic is the rehab facility. That would also be a part of that, at whatever site it would be put. I was just trying to clarify that.

Ms Gallagher: I am sorry, Ms Porter, I did not quite grab the question.

MS PORTER: You talked about chronic care and you talked about subacute care. You talked about all those different aspects, but I cannot recall you talking about the rehabilitation function.

Ms Gallagher: One of the options—actually it is covered in two of the options—is a subacute centre and rehabilitation centre. I have to say that I think it is one of the areas that we need to develop further. I think it has grown up in a bit of a piecemeal fashion, which I can understand in the sense of the smallness of our community. We have not had necessarily any centre that specialises in rehabilitation and subacute. Rehabilitation occurs in a number of different units, and occurs very well, but I think evidence of any sort of reading of contemporary publications at the moment will again reinforce the measure that, from a patient's safety and quality of care point of view, areas that specialise in particular streams deliver a higher quality and safer service.

We have a number of different services. We have RILU, we have aged care, which fits within aged care and rehab. We have a number of subacute areas across TCH and Calvary that I believe could be pulled together. They could be brought together in a very expert way to continue to attract expert staff to specialise in this area.

MS PORTER: That, I guess, has savings ongoing for the community in that you do not have readmissions back to hospital so quickly if a person is able to use those facilities.

Ms Gallagher: That is right. I guess you get that integration between in-patient and outpatient services as well. From a patient journey point of view, your experience in that subacute setting should be seamless, whether you are stepping down from the acute into subacute or from subacute to the community.

MS PORTER: Thank you.

THE CHAIR: Thank you, Ms Porter. Mr Hanson, do you have any questions?

MR HANSON: Yes. Minister, are these the last options that we will see, because we have seen a number of different iterations of the plan for the purchase of Calvary and

then the four options now—the final options. I assume that one of these—

Ms Gallagher: I added the fifth option in response to the Health Care Consumers Association submission to this inquiry actually asking that the new centre be subacute. That is how option E came about.

MR HANSON: Is this the sort of last iteration then? It will be one of these that a decision is made on—

Ms Gallagher: Yes.

MR HANSON: or if you decide for something else, you will come back to this process? We are not going to see something—

Ms Gallagher: Subject to further discussions with LCM and the outcomes of this committee. This committee might come up with a preferred option that does not fit within these options. I cannot predict that. But based on the consultation feedback we get, particularly the feedback from LCM health care and the outcomes of this committee, I would be hoping that we would be able to—my preference is that we actually reach agreement across parties and across the service.

MR HANSON: Who knows, we may do.

Ms Gallagher: Hey?

MR HANSON: We may do that.

Ms Gallagher: I mean, that would sincerely be my preference. Whether we can do that is another question.

MR HANSON: Can I just follow up on a question I was asking earlier about the land, the site selection?

Ms Gallagher: Yes.

MR HANSON: Can you clarify when that decision will be made? You take the decision for the option in this budget. You then do the work to do the site selection, I assume.

Ms Gallagher: Yes.

MR HANSON: When do you make that decision? Have you worked out a decision time line for that?

Ms Gallagher: We have not at this point in time. I think those decisions will flow from the final decision on the options. We would then, based on that—I am not putting too much effort into progressing any of the options whilst we are at this point. I just think it is a waste of people's time and resources.

MR HANSON: All right.

Ms Gallagher: But, say, we wanted a new facility. Obviously the first piece of work would be to find the location. I think we have identified in terms of just some rough work a number of sites across the north side of Canberra. I think that what would happen would be that fairly quickly once we have made the decision to move to a new facility, if that was the decision, we would put those sites out and start another process on those. I imagine that people will have mixed views on those.

MR HANSON: I have got another one if I can keep rolling?

THE CHAIR: Is it a supplementary?

MR HANSON: No, it is a new question.

THE CHAIR: Minister, will any of the options that we are considering require variations to the territory plan?

Ms Gallagher: That would feed into the site selection process potentially. My preference again would be not to, because I just think it lengthens the time again.

THE CHAIR: Sure, yes.

Ms Gallagher: If the decision was to look for another site, my instructions to the departments would be, whether it be LAPS or Health, to find a large enough site in an accessible location that meets all those accessibility tests for hospitals that do not require a variation to the territory plan. But whether we can deliver that again—probably if you could not and you did need a variation to the territory plan, I think this is probably one project that you could try and move that process through very quickly, if there was agreement that this was the right thing to do. It could be one of those projects of significance that—

THE CHAIR: You know the planning minister too, don't you?

Ms Gallagher: Yes.

THE CHAIR: Thank you. Ms Bresnan.

MS BRESNAN: I think this is a quick question. In terms of considerations as well about what is going to be the best way to progress, I imagine workforce has been a part of what will actually be able to be delivered as well?

Ms Gallagher: Yes, yes. It is—

MS BRESNAN: Yes. And so is that just—

Ms Gallagher: I am happy to come back and do another—

MS BRESNAN: Sure.

Ms Gallagher: It is a long answer to that—the work that is going on about workforce.

MS BRESNAN: Basically, you have got that work going on, which I understand.

Ms Gallagher: It runs alongside it, yes.

MS BRESNAN: But that will be going alongside that process?

Ms Gallagher: Yes, very much. Indeed, we are working with Health Workforce Australia on that.

MS BRESNAN: Yes. Thank you.

THE CHAIR: Ms Porter?

MS PORTER: Nothing, thank you, chair.

THE CHAIR: Mr Hanson.

MR HANSON: Thank you. Hospital in the home, obviously that is an area that has been expanding incrementally. Have you considered that in terms of the total number of hospital beds? I am referring to page 5. Have you looked at that as part of this equation when you are looking at the total number of beds and have you looked at an expansion by the end state in 2018 of what number of hospital in the home beds we would anticipate running?

Mr Thompson: We have. Within the overall planning, we have looked at a range of different service models that have been demonstrated to reduce demand for acute beds. Part of what we are doing, of course, within the enhanced community health centre work that is already underway is looking at the capacity to provide expanded community health centres, with a view, one, to getting services off the hospital campus but, two, to reduce demand for acute beds.

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

MR HANSON: That sort of allows you to have 400—

Mr Thompson: Yes.

MR HANSON: That is good. Likewise, did you look at Queanbeyan Hospital? I know there has been some discussion with Queanbeyan Hospital. Going beyond that perhaps the integration with New South Wales, if we were to go that direction, to form local network. Has that had any impact on this plan?

Ms Gallagher: We have not set in any capacity around Queanbeyan. Certainly at government level there is agreement that we should be able to use Queanbeyan,

particularly for elective surgery. Making that something that we can deliver in reality is proving a bit challenging. That is essentially around how you would get that model to work and how you would staff it with staff that are prepared to deliver those services there. We just keep continuing to work on that. But it is not factored into the—in a sense, this is about capacity for our system. We are not really worrying about trying to utilise Queanbeyan as part of that. We would like to use Queanbeyan as part of it, but there are some doctor issues essentially that we are working through.

MR HANSON: Yes, understood. Then in terms of Clare Holland House and QE2, now that they are included, or will be, I assume, in the network—

Ms Gallagher: Yes.

MR HANSON: do you see any growth in those areas or do you see them being incorporated? If you build a new hospital, does part of that get incorporated or what happens if you make Calvary a subacute centre and palliative care centre? I am just wondering what their role would be, whether there would be a change in role, an expansion or a contraction in either of those facilities?

Ms Gallagher: Certainly, palliative care will grow, because demand for palliative care is going to grow. However, the big driving area of demand for palliative care is home-based care. If people have their choice and can be supported in that choice, their preference is to die at home. I think we have not factored in a huge growth at Clare Holland House as part of that, just essentially around patient choice.

The same around QE2. The way that the women's and children's hospital will work across with QE2 will deal with that. Certainly, QE2 is not a big area of growth. Palliative care is, but not in a hospice setting. But we have not considered changing—LCM health care have made it very clear to us that they want to continue to be the provider of services at Clare Holland House.

THE CHAIR: That brings us to the end of our current time frame. Minister, I thank you, Dr Brown and Mr Thompson for this record-setting early start.

Ms Gallagher: Thank you very much. We look forward to your report.

THE CHAIR: Thank you.

The committee adjourned at 9.28 am.