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Submission to the Calvary Consultation

Please find attached the submission from Health Care Consumers' Association ACT Inc (HCCA) to the consultation on the proposed possible transfer of ownership, governance and control of Calvary Public Hospital at Bruce to the ACT Government, with the ACT Government to transfer Clare Holland House Hospice to the Little Company of Mary Health Care.

HCCA has consulted extensively with consumers in the ACT on this issue through forums, meetings and the HCCA blog; we also listened to the issues expressed at consultations and forums run by ACT Health and ACT Palliative Care Society.

HCCA welcomes the opportunity to make a submission to the Future Ownership and Governance of Calvary and Clare Holland House consultation.

Yours sincerely

Darlene Cox
Executive Director

Submission to the Calvary Consultation

Background

Health Care Consumers' Association (HCCA) of the ACT was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

Summary of HCCA position

Having listened to the issues expressed at consultations and forums run by ACT Health, ACT Palliative Care Society (PCS) and HCCA, we:

1. **Support** the transfer of ownership, governance and control of Calvary Public Hospital at Bruce to the ACT Government;
2. **Oppose** the transfer of ownership of Clare Holland House (CHH) to the Little Company of Mary Health Care Limited (LCMHC); and
3. **Oppose** the offer of a contract for clinical service at Clare Holland House for a term of not less than 30 years.

The evidence presented regarding the transfer of Calvary Public Hospital is convincing and supported by a majority of consumers. However, the evidence for the transfer of the ownership, governance and control of CHH to LCMHC is not convincing.

HCCA does not support the nexus between the sale of Calvary and Clare Holland House and think that the issues need to be considered separately.

Transfer of ownership, governance and control of Calvary Public Hospital at Bruce to the ACT Government

HCCA has heard a wide range of views expressed by consumers. Many consumers see the transfer as a win - win situation: an opportunity for more efficient public hospital services and enhanced private sector services. Others expressed anger in asking how a fair value can be put on a building which has been built and maintained with public money. There is also a concern expressed that the sale will result in the loss of the Calvary ethos in the public health sector in the ACT.

The majority consumer view is however that the sale of Calvary Hospital should go ahead as the results will be improvements in integration of services, the effective use of public money and improved conditions for staff and better health outcomes

Integration of services

The potential for a seamless public system is improved with a single governance structure for both hospitals. The statement in the ACT Government Information Paper, *moving to a single point of accountability across the two hospital*

campuses will create opportunities for improved coordination of services points to a better health system for the consumer and HCCA supports this.

Effective use of public money

The current situation of having two management and governance structures in a small jurisdiction is an inefficient use of public money. The proposal for a single management and administrative structure will create a more efficient service. HCCA supports the ACT Government's careful management of public funds for the delivery of health care services.

The editorial in the Canberra Times on November 2nd 2009 provides two additional points, which we add in our support of the sale:

- *Calvary Public provides impressive services and pastoral care, but it is impossible to describe this as being fundamentally different from what is provided by secular hospitals*
- *The public funding arrangements… any public investment at Calvary Public becomes the property of the subcontractor …it is quite natural and reasonable that the ACT Government would want to re-examine arrangements when on the cusp of a major reinvestment in ACT hospitals*

HCCA contends that the ethos of caring is not only a result of the LCMHC ethos, but also due to the nature of the hospital as a level 2 smaller hospital and the sub acute care provided.

Transfer of ownership, governance and control of Clare Holland House to the Little Company of Mary Health Care Limited

Legal certainty, accountability and transparency

It is critical that the deed of contract between the ACT Government and Calvary Health Care (CHC) ensures that Clare Holland House facility and clinical services remain as a continuation of the public (not private) service to the ACT community. It must continue to be accessible to all in the community regardless of ability to pay and beliefs held.

HCCA remains unconvinced of the benefits of the transferring ownership of Clare Holland House and/or the land on which it sits, to the control of LCM. The transfer introduces some uncertainties over the continued provision of public hospice services at that site.

A 30 year contract is not good practice public policy practice. It is excessive and is seen as excluding other potential providers. Thirty years is a whole generation who are likely to have different viewpoints, education and experiences that will affect their response to palliative care services, no matter whether they are part of the LCM or the ACT community. It could be expected that over that period public sector health care will have changed substantially. This particularly applies to community based services and their links with residential and acute services. It should be noted that the LCM who established the Calvary Hospital thirty years ago at Bruce are now a radically different group today.

As consumers commented at a forum held during HCCA discussions on this issue:

> *Changes in the type and delivery of health services have been so great in the past 15 years I am very concerned*
>
> *A 30 year exclusive contract will be designed to keep other providers out and I consider it to be bad public policy*
>
> *Most absurd public policy option ever thought of*

There is concern that a single provider will not keep pace with changes in community values and beliefs. Voluntary euthanasia is a case in point. The majority of people in the community support voluntary euthanasia. For example in 1994 a Time Morgan Poll found that 71% of Australian supported voluntary euthanasia and in October 2009 a poll conducted by Newspoll on behalf of Dying with Dignity NSW showed that 85% of Australians were in support. In the next 30 years (the terms that are proposed in the agreement) it is possible that voluntary euthanasia will be legalised in the ACT. With the opposition of the Catholic Church to voluntary euthanasia, what options does that leave people in the hospice who see this as their preferred course of action, and who may have advance care directives, enduring power of attorney and other legal agreements which specify use of voluntary euthanasia?

Volunteers and staffing

It is critical that the volunteer service provided by the ACT Palliative Care Society (PCS) continue being supported and allowance is made for expansion of services to meet the needs for palliative care as the ACT grows. Volunteers are an essential part of this service delivery model. They should not be cut out of the service delivery or feel that they have been. They will continue to need education and debriefing and the other support services that they currently access and should continue to meet with the management of CHH.

Since home based palliative care management transferred to LCM nursing staff the resources available to provide palliative care in the community appear to be considerably less than when home based palliative care was part of ACT Health. Consumers are expressing concerns about these reductions in available resources while the need is growing and the population increasing.

It is acknowledged that there are currently expert and dedicated staff working in palliative care. HCCA want them to continue to be well supported and remunerated for their expertise so that they can perform their duties and provide quality care to consumers and their families. If they decide to leave CHHand palliative care generally, it will be difficult to replace them with staff with a similar depth of expereince.

The other concern is that while exisintng employees will remain employed uner Public Sector conditions, all newly appointed staff will be employed under LCM

conditions. Our experience is that this creates inequities and division amongst staff.

Another consideration is ageing of the nursing workforce. This phemonema is being experienced in all jurisdictions in Australia which are having difficulties in attracting trained and experienced nurses. Any perception that nursing pay and conditions have deteriorated, will compromise the ability of CHH to recruit the best staff. If they decide to leave the CHH and palliative care generally it will be take some time to replace them with staff with the depth of experience that these staff have. Consumers only receive good care when we have well trained and supported staff.

Home based palliative care and respite

Many consumers reject the current support and consultancy model of home based palliative care service in the ACT, and want a best practice home based service that is socially inclusive. This includes hands-on services, not consultancy advice. For families who are managing the care of person who requires palliative care do not have the experience to negotiate the system or the necessary spirit to undertake such work.

There is a need to recognise that some members of the community may have a strong wish to receive care in their own home, if at all possible, rather than entering a hospice. This may include those with chemical sensitivities.

There is increasing desire for people to die at home rather than in any type of facility no matter how well it is set up or the quality of the services offered. This leads to a need for increased funding for home based palliative care, which need to be integrated with local community health services, so that there can be a seamless service between the home and the community health service.

HCCA requests transparency about the perceived need. We will be asking the government and CHC to release publicly the figures for usage, unmet need etc.

Integration of services

Concerns have been raised that the proposed sale of Clare Holland House will create a private monopoly in ACT palliative care. At present the service is a tri-partite one, involving ACT Health, LCM, and the Palliative Care Society, which provides checks and balances on the quality of the services provided. There is a one view of some consumers that the interface between services when they are under different auspices creates significant issues for consumers. There is another view that a splitting of services would be a positive for consumers. Some consumers believe that home based palliative care and respite should be provided by ACT Health.

We urge a re-entry of ACT Health into the provision of non hospice based palliative care services that complement those provided by the LCM at Clare Holland House.

There is a strong view that a second secular hospice should be an option in the community. This is because of a concern that the only hospice is run by a

religious organisation, which has moral and spiritual principles which means that it cannot cater for all. There is also a view that a palliative care service should be provided which is not by an organisation that is operating for profit. Further the current location of CHH disadvantages people who don't drive or do not live within a reasonable distance.

It is important to note that we recognise that many consumers are satisfied with the support and care provided by LCM, however, as consumers we must have choices in the provision of palliative care support to us in the ACT.

There is a minority consumer view expressed that, as the hospice is publicly funded, there are in existence already a range of key performance and quality indicators and accreditation processes that will ensure that there will be no changes in the provision of services.

Cultural insensitivity is a significant issue in the ACT from the perspective of a representative of the Canberra multicultural community. There is a concern about cultural and religious practices, and respect for the wishes of the patient, their family and carers. Part of the issue is about cultural sensitivity training of staff and improvements to the currently inadequate interpreter service. Progress could also be made through a review of staff recruitment practices to ensure a diverse clinical and administrative workforce, although this could prove difficult as all new employees under the LCM would have to sign up to LMC valves..

Consumers express the clear right of refusal of pastoral care.

A more socially-inclusive model of palliative care

The ACT community is often celebrated for the diversity of its population and yet, this is not reflected in the model of palliative care that either exists, or is being proposed, with a continuing Catholic-centric model. Whilst a Catholic model satisfies the desires of some members of the community, other members of the ACT community find a Catholic palliative care model deeply spiritually offensive and call for a secular palliative care service.

In 'Respecting Patient Choices', it is envisaged that this would develop as an ACT Government initiative, along with an increase in the resources currently directed to the existing home-based palliative service. This would also help to appease some other members of ACT community who are concerned about the increasing medicalisation of the dying process – and providing that their pain management is not compromised – want the opportunity to die at home.

Future of CHH Beds

ACT Consumers oppose the transfer of ownership of Clare Holland House (CHH) to the Little Company of Mary Health Care Limited (LCMHC). However, if the sale does go ahead it is critical that the contract is predicated on an outcome basis. For example, if 19 beds are to be available for public patients, then there must be a clause in the contract that ensures that a reasonable percentage of

patient days are available to public patients. There must also be transparency of the assessment process for admission and performance reporting, regardless of who owns and runs it. Further the contract should also ensure that ACT Health reimburses the LCM on bed usage and level of care, not on total beds.

The provision of palliative care services should be put up for tender periodically and ACT Health could tender for this, at least for market testing. Consumers expressed concern that there had not been a tender or market testing for the provision of palliative care services in the ACT for around 15 years. HCCA calls for a testing of the service providers who would be interested in this service provision.

Palliative care in aged care facilities

In discussing palliative care options with consumers it became evident that there was a need to consider the integration of palliative care services with residential aged care facilities.

An initiative was introduced in 2007 as part of the ACT Palliative Care Strategy 2007- 2011 that provided support and training in palliative care for staff in aged residential accommodation and volunteers. This program recognises the need for this type of service as many people who go into residential aged accommodation are now older and frailer than in previous years. The provision of such services will also reduce the need to transfer older people to ACT hospitals in the last stage of their lives and further add to the confusion of these people and their families.

Due to the high staff turnover and associated staffing problems in aged care facilities, there is some concern that training by itself will not result in a satisfactory improved outcome unless this training is done on an ongoing basis. The recognition of this relatively new and it should not be forgotten or overlooked with the current community focus on the CHH and its future requirements.

Outcomes desired

1. There must be evaluation built in, with consumer and carer feedback on service provision strengthened.
2. Family and carer wishes should be a high priority.
3. *'Respecting Patient Choices'* should be built into all contracts for provision of palliative care services.
4. An advisory group should be formed, to improve communication and understanding of palliative care between the key stakeholders.
5. Admission to CHH must be based on clinical need and not on the capacity to pay.

The future of Palliative Care in the ACT

The proposal for the transfer of ownership, governance and control of CHH to LCMHC has led to much debate and discussion for consumers. Consumers do not want the transfer of ownership and governance of CHH to go ahead until the issues are thought through more solidly without the confusion of being linked with the transfer of ownership of Calvary Hospital. We believe that the ACT Government has the opportunity, with key stakeholders, to rethink the needs of the community for Palliative Care. At a time when there is considerable community interest in palliative care, HCCA calls for:

1) A comprehensive independent review of the unmet need for palliative care

In order to plan for the short term and long term future, an independent review team made up of individuals with expertise would provide informed advice on the implications of demographic changes such as the increasing number of older people as a proportion of the total population, an increase in the number of people living alone. This would include a broadly scoped terms of reference incorporating both expert and community views and possibly including a number of community focus groups. The aim would be to chart future directions for quality delivery of palliative care in the ACT into the future, with opportunity for a periodic review 5 years hence.

2) The integration of home based palliative care into the capital asset program planning and development

With the rebuilding of the health system infrastructure, consideration should be given to the inclusion of a home based palliative care service and respite care within the medi-hotels and/or Enhanced Community Health Centres. Consideration should also be given to the funding of a community hospice in the near future. The National Health and Hospital Reform recommendations (54-57) relating to palliative care reinforce this integrated approach.