

TRANSCRIPT

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Subcommittee

Inquiry into infrastructure projects

Melbourne — 19 October 2016

Members

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Witness

Professor Andrew Way, chief executive officer, Alfred Health.

The CHAIR — I will begin by declaring open the Standing Committee on the Economy and Infrastructure public hearing. Thank you very much for your attendance today and for providing testimony to the committee. Today we are hearing evidence in relation to our infrastructure inquiry, and the evidence today is being recorded. This hearing is to inform the third of at least six reports into infrastructure projects, and witnesses present may well be asked to attend future hearings as the inquiry continues. All evidence taken today is protected by parliamentary privilege, therefore you are protected for what you say in here today, but if you go outside and repeat those same things, those comments may not be protected by this privilege.

Once again, thank you, Professor Way, for your presence here today. I might hand over to you at this point. You might introduce yourself, state your role with your organisation and then move into any introductory comments, and we will follow with some questions from the committee.

Prof. WAY — Thank you very much, Chair. I am Andrew Way. I am chief executive of Alfred Health, the organisation that is responsible for the provision of services out of the Alfred in Prahran. I have been there seven years, having had an extensive NHS career before that. I started out as a nurse — I am not a physician — and have had a wide variety of academic management posts. Most of my career has been about organising and delivering clinical academic services, which was one of the attractions to the role at Alfred Health.

I thought it might be helpful for the committee just to get a sense of the Alfred and its role in cardiac services in the State as it stands at the moment. I am happy to go from there in terms of how you want to pursue the conversation. The Alfred has been the centre of the State's cardiology and cardiac system for a very long time. It goes back to 1948 when the first right-heart catheterisation was performed. In the late 1940s and early 1950s, more than 200 operations for congenital heart disease — something that was not done anywhere else in Australia — were performed, and the first mitral valvotomy was performed in 1951, the first in Australia. There is a whole series of successes around coronary care units; it was the first in Australia. There is a whole range of service innovations. The first non-invasive and invasive laboratory was opened at the Alfred in 1981.

Presently the Alfred is the sole provider in the State of highly specialist, or some people call quaternary, services. So we are the only provider that does a range of services not only for Victoria but for Tasmania and South Australia. We do about 25 to 30 heart transplants a year. We provide something called ventricular assist devices, so these are devices that are surgically implanted onto the heart to deal with heart failure. In our service at the moment this is only used as a bridge to transplant, but the technology is changing, and it is likely that over time will become a destination therapy — so, a treatment for very severe heart failure. Many other jurisdictions are already doing that, but that decision has not yet been made in Victoria.

And we are the centre of what is called the ECMO, the extracorporeal membrane oxygenation service, for the State, and we deal with about 60 or 70 patients a year needing that sort of transfer, where we go out to other hospitals and retrieve patients who are in extreme distress by basically putting them on a bypass system that allows their heart and lungs to not need to work while they are brought to the Alfred and put into our intensive care unit and treatment is otherwise provided.

So in addition to those highly specialist things, of course we are the second largest and fastest growing interventional service, so we do more in that space than almost anywhere else. We have the largest what is called structural heart program — so dealing with heart valves. We do 70 to 80 cases a year, and that is growing rapidly to this year; we are expecting in this financial year to go to about 100 cases, which will be the largest program in the country. We have the largest implantable device program, so these are things that make your heart go at a regular rhythm — so, defibrillators and pacemakers. We run the largest implantable defibrillator service in the country and the only one in the State. We were set up by the State to be the cardiac imaging service for the state in the early 2000s, and we now do about 1000 patients a year for cardiac imaging. It is a very large research program that runs with the Baker, which I will mention in a moment. And we have the fourth largest cardiac surgery service in the State, so we are the state's dominant cardiac provider.

We provide about 40 per cent of the activity from outside of our immediate catchment. So responding to your earlier question, a lot of our patients come from the west and the east of the state. They bypass other centres to get to us because of our very specialist nature. We have a lot of patients from Gippsland, from Hume, and we have systems in place to cope with patients that come long distances, particularly those in our very specialist programs, because they end up being with us for very long periods of time and their families of course need a lot of extra support.

Because we have all of that, there is a very large infrastructure and, of course, a very large research program. We work very closely with Baker IDI, which is the state's only cardiac medical research institute, and with Monash University, which has a large academic presence on our site. Our main research interest is in the basic science and clinical science space, not the technology space. So we are not particularly a device innovator. We are much more in the science, in the laboratory, in the molecule and in the cell. We have about 70 or 80 combined clinical academics doing research on the site. We publish widely with other partners. We are a major provider of education to postgraduate trainees both in medicine and in other specialist professions.

All of that requires a very substantial infrastructure, so because we do not only the cardiac service but the trauma service and we are also the major provider of lung services, we have a very significant infrastructure that is pretty much impossible to replace, because each service supports the others' infrastructure and makes the depth and availability of that infrastructure more affordable. And because many of these patients get into distress, the multidisciplinary, multispecialty nature of what we do — meaning that we have specialties ranging from immunology; pathology; other pathology base specialties; endocrinology; interestingly oncology, because a lot of our transplant patients get into cancer difficulties because of the treatments they are receiving; respiratory medicine; neurology; pharmacology and so on — means there is a whole interconnectedness around those very, very complex programs.

Because you are an infrastructure committee, I thought I should say something about our infrastructure. Most of the accommodation where all of that is done was built about 40 years ago, and it is still in its original buildings. The State has put support in for various upgrades, but most of our upgrades are funded through philanthropy. So as with most of our ward upgrades, the most recent one we have done was funded through fundraising activities from the Alfred Foundation and large gifts. However, the re-provision and redevelopment of our cardiac catheter labs was funded by the state.

The CHAIR — Wonderful. Thank you for that presentation. I am hoping to just talk initially about the opportunity for new facilities. I understand that Infrastructure Victoria identified that the Alfred should be looking to consider a major refurbishment or new facility construction within the 10 to 15-year range. I am wondering, is that also a priority for you?

Prof. WAY — Yes, so our two service challenges around buildings are that our operating theatres are still in the main operating suite that was built 40-plus years ago. We do have four theatres that have been mothballed, so when the Alfred Centre opened about 10 years ago, four theatres were closed and another number were opened in the Alfred Centre, but they are at the end of their useful life. We know that some of the infrastructure that feeds them — whilst we have refurbished internally, some of the things that run underground, so the pipes connect the oxygen tanks to the rest of hospital have been underground for 40 years, they need replacing. So there is a lot of that sort of infrastructure stuff that is hidden. It is safe, but it is coming to the end of its useful life. That does need to be tackled.

The CHAIR — I am wondering what work has been done with DHHS to investigate options for a total refurbishment or redevelopment.

Prof. WAY — So we have had discussions over the last four or five years with DHHS about the driver to reprovide our operating rooms, as I have just mentioned, and our mental health facility, which is the other facility that is in most need of a refresh. We have got to the point where we have done our preliminary piece of work that says we now need to do a fuller business case, and we are working with the department to ascertain the priority that government want to give to that piece of work.

The CHAIR — I know it is obviously very early stages but do you have any idea of the cost of a total redevelopment?

Prof. WAY — Not a total redevelopment but a redevelopment of the wards and the operating suites has a tag on it of about \$750 million.

The CHAIR — Would you call that perhaps stage 1 of a total refurbishment?

Prof. WAY — My experience is that hospitals do not do well if you do a total refurbishment. What you try and do is logically sequenced wings. We have a master plan that is a 60-year master plan, and that would be the first significant stage. The next stage after that is to refurbish the main ward block, so what you would end up

with is a new building that you would decant half of our current ward block into. That would give you the ability to deal with a building that is really getting to the end of its first life. To have a complete refresh it needs all the walls taking out. There is substantial asbestos in the building, so all of that needs to be done in a way that has the patients and public excluded from it whilst it happens. You do the first half, decant into the first half, then you do the second half and at the end of that, which is probably about 10 years, you end up with additional capacity.

The CHAIR — In terms of what would need to happen in the short term to achieve the outcomes that you have described what are the first steps to get there?

Prof. WAY — We have identified where the build can happen, and there are two options for it. In both options we decant out of old buildings that are no longer used. So the old Baker building, which Baker gave up some years ago to move into their new facilities, we use as offices, and the old Monash building, which Monash have moved out of, we also have completely empty; it is not used. Those buildings need to be brought down at a cost of about \$5 million each. There is a bit of decanting, so about another \$5 million to sort out that decanting and then a case to do it.

There is an option that if we were to be really aggressive about how big we wanted this to be, you would buy four properties of St Kilda Road and expand the footprint of the Alfred onto the St Kilda Road frontage. Two of those happen to be up for sale at the moment. The Singaporean company that went bust is looking for \$115 million for them. So it is not an easy thing for governments to commit to — to buy land with buildings on them and to demolish the buildings when they are that sort of value. It is a pie in the sky thing that would be nice to do but in reality I suspect it is not a sensible thing to do.

Mr LEANE — Thanks for helping our committee today. I was interested in your comprehensive overview of what you do at the Alfred, and I was interested that you mentioned heart transplants and certain procedures. I am not too sure if you were here to hear the previous witness talk about the new heart hospital. Would there be interaction between the Alfred and the new heart hospital when that is in place?

Prof. WAY — That is a very interesting question. In the cardiac services plan, which is the document I think that Professor Meredith was referring to, which is this one, it leaves the Alfred as the centre for all of those things. But what it does not set out is how it then connects to what is proposed at the Victorian Heart Hospital. We are not involved in the development of the heart hospital business case, so my straight answer to your question is that I do not know. One would have to assume that that would be the case. It is a public system. We would all expect to work together. But at the moment it is not clear how that would work.

Mr LEANE — You did mention that there are some service upgrades that need to be done. Have any been done recently? I know there was some money in the last budget for fire services. Is that going well?

Prof. WAY — That program is really to deal with the fact that large parts of our main ward block have no fire alarm system and no sprinkler system. They are not compartmentalised in any way that the current fire codes require. And because large parts of that building still have significant asbestos in them, they have to be managed in a very particular way. So it is a lot of money to do something that really does not improve anything for anybody other than in an emergency — it will make it safer.

Mr LEANE — The buildings have been like that for 40 years, so I think it is a good thing that it is getting better as far as fire services are concerned, I would imagine, if it has been like that for 40 years.

Prof. WAY — Yes. My general view is that a building like the Alfred's main ward block should last 60 years, but in years 30 to 35 you have to spend a lot of money doing a refresh to get it to the next 30. Of course, that does not give you a new building; it just gives you a new inside. So it is a bit of a challenge in the system as to how you generate interest to refurbish as opposed to interest to build new.

Mr LEANE — And 40 years ago the fire codes would not determine that you had to have sprinklers, and the use of asbestos —

Prof. WAY — Fire code, earthquake code.

Mr LEANE — and all that.

Prof. WAY — It is a very different environment.

Mr LEANE — Well, that is good news.

Ms HARTLAND — Having actually been involved in the parliamentary committee on organ transplants, we spent quite a bit of time with the various services. If you could remind me: that is what will distinguish you from the new heart hospital because you are the only hospital that does heart and lung transplants in the state?

Prof. WAY — As we understand it, and no-one has told us to the contrary, the three services that we are the only provider of and would remain the only provider of would be heart transplants, the ECMO service and the ventricular assist device service, mainly because they require such an intensity of support. Particularly a standalone hospital, any standalone hospital, would be challenged to provide those because of the plethora of other clinical services that need very, very quickly to be able to respond.

I heard a bit of your debate about single-specialty hospitals. I have closed all of the ones I have ever had as a CEO and moved them onto multidisciplinary campuses for exactly the sorts of reasons that Papworth are moving. Actually the conglomeration of London hospitals have moved to Bart's, because Bart's is a multidisciplinary campus and so on.

So coming out of that train of thought, where there is a need for additional capacity my preference would always go to being on a multidisciplinary campus, but of course governments make policy and then it is up to people like me to make it work, which goes back to your question about how we are going to connect the two. I think that is a really important question. As the build develops and as their service model develops, we need to make sure that it does connect.

Ms HARTLAND — And because you are the only hospital that does lung and heart transplants your catchment is the entire state and Tasmania?

Prof. WAY — And South Australia.

Ms HARTLAND — And South Australia. So it is a pretty big catchment.

Prof. WAY — Our catchment for trauma is the whole state. We have more state services than any other provider, so ranging from HIV and infectious diseases through to haemophilia, a number of haematological conditions, trauma, the transplant programs and so on. And we run a national program for children requiring lung transplants in conjunction with the Children's, but they actually have the transplant at the Alfred. It is the only children's service at the Alfred.

Ms HARTLAND — And that is countrywide?

Prof. WAY — It is countrywide.

Ms HARTLAND — Right, okay. So when you talk about the refurbishment, in dealing with Footscray, which is my hobby horse, this is never going to happen over one term of government. It usually takes between four and eight years to actually do. So when governments talk about, 'Yes. There will be the money', there actually has to be that guarantee that there will be the recurring funding, and then if there is a change of government, there has to be a commitment to the recurring funding and not be stopped halfway. This may be an impossible question to answer, but how would you want to see health funding delivered in that way when we do have change of government? Do you think that there needs to be some kind of tripartisan agreement that projects that are going to be funded over 10 years are not stopped because there is a change of government? Do we need to actually look at ways of having all parties signing up to those major infrastructure projects?

Prof. WAY — At a level of process, as opposed to how governments make decisions, there are issues in these big capital infrastructure projects in all public systems in how you create continuity sufficiently robustly so that the projects continue to be delivered over time. If you look at the build that I have just suggested, the Alfred might wish for \$750 million, but by the time the business case is done, the building is up and the first patient moves in, there will have been two elections. You cannot, in the system we have got, go into that sort of process knowing that in all likelihood halfway through it is going to fall apart in terms of the funding stream. So I think there has to be a process of the public system understanding those sorts of commitments. Where you are

putting in large infrastructure, I think governments have to determine whether or not the money that they are committing over the term they have been elected to is going to stand the test of time past an election.

Ms HARTLAND — And also, as I understand it, there then becomes an added cost. If you do not have that eight-year plan and if you cannot do it in that seamless fashion, it will cost a substantially greater amount of money, so the economic savings of actually committing are logical.

Prof. WAY — Yes. We talk about the economic cost and the financial viability. If you do something in several stages, it produces a greater economic burden, but by doing the first stage, you may make a financial saving. So this sort of gets into the art of the doable versus the art of the desirable, and while something may be desirable, maybe you can only do part of it and getting at least part of it done meets the government's objective and it may meet the health needs of that objective. So you are always in that balancing between what is possible and what is desirable. I think that is a challenge that governments endlessly face in this sort of space.

The CHAIR — I was hoping to just talk about the impact of the Victorian Heart Hospital on your particular operations, and I am wondering: have you done any modelling on what impact the heart hospital might have on cardiac activity at the Alfred?

Prof. WAY — We have been engaged with conversations that are happening inside the Department of Health and Human Services around how the design, service and infrastructure plan is to be implemented, and there are a couple of key paragraphs in there which are about how many sites for complex cardiac care there will be going forward in the State. There is an assumption in here that there will be less, so the volume-clinical outcome association that Professor Meredith was referring to earlier on is real in cardiac. There is sufficient evidence that higher volume produces better outcomes. It means that the number of public hospital sites that we have got doing the highly complex stuff is probably more than is appropriate. So that has to be a bigger conversation than just the Victorian Heart Hospital. Then overlaid with that is where the projections for population growth sit. So we are not in a stable or declining population size like in some areas of the US; there is a growing population of some significance in this space.

The CHAIR — I note that the government's cardiac plan says that it will consolidate complex interventional and cardiac surgical services from the south and east at the heart hospital. How do you think that consolidation will affect you?

Prof. WAY — There are two parts to this. The most complex work, as we understand it, will remain at the Alfred, which is a bit of a challenge in reading this document — so the heart transplants, the ECMO and the VAD service will remain at the Alfred. In order for those services to remain viable there needs to be an amount of routine work so that on the days when there is not a heart transplant to deal with or there is not a VAD to implant there is other work for the surgeons to do. Otherwise we will have surgeons who are permanently on call but do not have any day job, and that is a real challenge just in terms of providing a reasonable level of employment.

So we have continued to make an assumption that we will be at least as big as we are and that there may be some growth that comes to the Alfred as a consequence of population growth, but no-one has confirmed that from the Department's perspective. We are not party to the development of the heart hospital's business case, so we do not actually know what their assumptions are. The department of health has the role of system manager in this space, so we are assuming — maybe rightly, maybe wrongly — that they are actually making those connections and that in funding us and telling us about our strategic plan going forward they will make those points clear to us.

The CHAIR — My next question follows on from there. Do you think the number of procedures that will be performed at the Alfred is likely to decline?

Prof. WAY — No. It has to go up.

The CHAIR — I am just curious, though: if you are building a new heart hospital that is going to be focusing on delivering heart surgery and the like and you are already doing the work that you are doing, is the heart hospital only going to be filling the gap in the growth rather than taking work that would have ordinarily been done at the Alfred?

Prof. WAY — So this plan reassures me that the Alfred will not be losing any work; that is what it says. So it has to be something else, and because I am not involved in the development of that plan I do not know.

The CHAIR — Because obviously, as you have already stated, to be able to continue to do the work that you are doing you need that workflow, for want of a better word to assist that.

Prof. WAY — Yes.

Mr LEANE — But you would have waiting lists now.

Prof. WAY — Unlike many of our other public health services, we do not have long waiting times.

Mr LEANE — So are you saying that it is not a good thing to have more services available?

Prof. WAY — No, I am not saying that.

Mr LEANE — It just seems to be — —

Prof. WAY — It depends what you mean by more. So more sites, this plan sets out a plan. This is a policy position. It sets out a plan that reduces the number of sites doing complex surgery; it says that in the plan. It also says the Alfred will remain doing the complex surgery it does.

The CHAIR — I suppose the challenge that I see, and I am not sure if I am sensing frustration from yourself, is that it appears as though the Alfred has been sidelined from the development of the heart hospital, and indeed the work that is going to be done there, the priorities that are going to be given to it and the impact that it is going to have on your organisation. Am I correct in that assumption?

Prof. WAY — I think it would be fair to say that my board were disappointed not to have been involved in the discussions about what the heart hospital might be or even to have an opportunity to bid or be engaged in the provision of services from it.

The CHAIR — The committee has heard previously from the VCCC and others that are working in a highly collaborative way in terms of delivering health services. It appears through this process that a completely different model has been brought about, where the normal providers of such services, such as yourselves, have been sidelined from the development of the heart hospital. Going forward, what could remedy the issues as you see them to this point?

Prof. WAY — Well, I do not know there is anything to remedy particularly, if the department, as the health system manager, are actually taking account of the commitments and the policy positions that are outlined here. There is undoubtedly demand that is not being met in the health system today. So unmet demand and growth may be the basis of the business case for the heart hospital. If you look at most big health developments, you do not open 100 per cent of the facility on day one; you go for a smaller number, and then the remainder are shelved and are opened over time as the population and as the demand grows. Indeed the Alfred Centre at the Alfred, which is our big elective surgery facility, was built on exactly that basis.

The CHAIR — Just one final question from me, on the Sandringham emergency department. The government has suggested that it may close the emergency department at Sandringham Hospital. I am wondering: did Alfred Health actually ever consider closing the ED or indeed reducing its hours?

Prof. WAY — We were asked to look at a range of ways of identifying savings, and we put a whole range of options back to the department of ways that savings could be made, and that was one of the several options that we put forward, none of which have been exercised.

The CHAIR — So a range of services and the government sort of just picked that one out and ran with that. Thank you, Professor Way.

Mr LEANE — I want ask one more question.

The CHAIR — Yes.

Mr LEANE — I think the Chair was leading you into the position that you were going to say that the Alfred Hospital are disappointed there is going to be a new heart hospital built in Monash.

The CHAIR — That was not my question at all.

Mr LEANE — Is the Alfred Hospital disappointed there is going to be a new heart hospital built in Monash?

Prof. WAY — The Alfred is not disappointed about a growth in facilities for the state, absolutely not.

Mr LEANE — I think it is important that is on record because that is where the Chair was trying to take it.

The CHAIR — That was certainly — —

Mr LEANE — So thank you. That is clear.

The CHAIR — Thank you for not guessing about my intentions, Mr Leane, because that was not my intention at all.

Mr LEANE — I know exactly what you were saying.

The CHAIR — Thank you very much, Professor Way, for your contribution. You will receive a copy of the transcript of today's evidence for proofreading and it will ultimately make its way onto the committee's website. Once again, thank you very much for your attendance today.

Witness withdrew.