Climate Health WA Inquiry

Inquiry into the impacts of climate change on health in Western Australia

Inquiry Lead:
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Witnesses:

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[10:00:07]

HEARING COMMENCED

5 DR WEERAMANTHRI: Dr Power, Mr McLeod, I'd like to thank you both for your interest in the Inquiry and for your appearance at today's hearing. The purpose of this hearing is to assist me in gathering evidence for the Climate Health WA Inquiry into the impacts of climate change on health in Western Australia. My name is Tarun Weeramanthri and I have been
10 appointed by the Chief Health Officer to undertake the Inquiry. Beside me is Dr Sarah Joyce, the Inquiry's Project Director. If everyone could please be aware that the use of mobile phones and other recording devices is not permitted in this room, so if you could please make sure that your phone is on silent or switched off.
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This hearing is a formal procedure convened under section 231 of the *Public Health Act 2016*. While you are not being asked to give your evidence under oath or affirmation, it is important you understand that there are penalties under the Act for knowingly providing a response or information that is false or
20 misleading. This is a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. You have previously been provided with the Inquiry's terms of reference and information on giving evidence to the Inquiry. So
25 before we begin, do you have any questions about today's hearing?

DR POWER: No.

MR McLEOD: No.
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DR WEERAMANTHRI: Thank you. For the transcript, could I ask each of you to state your name and the capacity in which you are here today, and if, throughout the hearing, you could briefly state your name just for the purposes of the audio recording.
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DR POWER: My name's Dr Glen Power. I'm the Chief Executive Officer of the Perth Clinic, 101-bed private psychiatric facility in Western Australia. I'm also serving as the Branch President of the Australian Private Hospitals Association, Western Australian branch.
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MR McLEOD: I'm Calum McLeod. I'm the Support Services Manager at Joondalup Health Campus. I'm here to talk about the initiatives that we have taken on at Joondalup Health Campus.

45 DR WEERAMANTHRI: Thank you, both. And I'm sure, Dr Power, that you'll make it clear in which capacity you're speaking as we go through the hearing. Would you like to make a brief opening statement?

DR POWER: Thank you, Tarun.
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[10:02:28]

As I'm here to represent the private hospital sector, I thought it'd be useful to give an overview of the contribution of private hospitals in Western Australia to meeting demand and serving the activity overall. But as, I guess, an opening remark, private hospitals in Western Australia, both private acute facilities, freestanding and dedicated private psychiatric hospitals, and freestanding day hospitals—for the Commonwealth's purposes, they consider hospitals that hold the declaration for private health insurance billing as part of their legislative framework. And they enumerate the number of private licensed hospitals in Western Australia as at the year 2016–17 to be 64.

Now, the state licensing regime—managed by the Licensing and Accreditation Regulatory Unit of the Department of Health—in 2019, considered that there were 122 private hospitals. Their figures are similar to the Commonwealth in respect to acute hospitals—22 versus 23—but noting that they're one year different in terms of timing for this information, which I'll certainly leave for the Inquiry's benefit. The State also includes in their number a range of smaller facilities—peritoneal dialysis units, haemodialysis units, sedation competent day hospitals or clinics, as well as what we call the class A freestanding day hospitals that are capable of delivering anaesthesia, and the acute and psychiatric facilities. So the State number, at 122, is somewhat larger than the Commonwealth's number. But let's take the, I guess, similarities between the two. State and Commonwealth are largely in agreement around the number of anaesthesia competent day hospitals and the acute private and acute psychiatric facilities. So around 64 facilities in 2016–17, according to the Commonwealth.

Those facilities contributed approximately 43 per cent of the 1.193 million separations that were performed as admitted patient care, either ambulatory admissions or multi-day overnight admissions in the year 2017–18. So 43 per cent of the total activity in the year 2017–18, according to the Australian Institute of Health and Welfare's admitted patient care volume. So in terms of the contribution to climate change, as part of the overall health sector, the contributions, is likely very significant. And we'd be pleased to frame our responses today in that context. Thank you

DR WEERAMANTHRI: If you could just outline a little bit about the history of the sector in Western Australia. Has it changed much over the last few decades? Is it much affected by rates of private health insurance, et cetera? What are the, kind of, big levers on - - -

DR POWER: Yes.

DR WEERAMANTHRI: - - - on the sector?

DR POWER: Thank you.

[10:05:50]

I guess, fundamentally, it's the demand available for receiving care in private hospitals, as would be covered under private health insurance. In Western Australia, our rate of private health insurance, as a proportion of the population, is currently 54.1 per cent of the population with hospital tables coverage. And that data is the September quarter 2019 data, so it's relatively recent. Interestingly, whilst there's an acknowledged decline in coverage across Australia in terms of percent of the population, and that rate of decline's been around 0.6 of a per cent per annum for some time, in Western Australia that rate of the decline has recently tailed off. And the September quarter and the June quarter haven't changed. So we're sitting at exactly 54.1 per cent in both quarters, which is a very encouraging turnaround from the point of view of opportunities for patients to receive care in the private hospital sector.

The Commonwealth has launched a range of initiatives to try and boost private health insurance coverage. Things like clearly defining the classification of casemix and clinical categories within each of the product tiers. And they've defined the product tiers now as gold, silver, bronze and basic, with alignment to different casemix and activity, and opportunity, therefore, to receive care in different kinds of private facilities. It's probably true to say the number of facilities hasn't changed markedly in recent years. As you can see here from the data I just quoted, the Commonwealth's figures in 2016–17, and the Department of Health's 2019 figures are largely the same. What has changed is the policy direction, with the advent of the *Health Services Act* in 2016, and I guess, an opportunity for HSPs at a public level to obtain casemix from the private sector. There's been a, you know, increase in the scale of the overall activity purchased from private sector-operated hospitals in Western Australia, in terms of public patient service delivery.

So Midland Hospital, for example, commissioned in 2015, is the latest example of that. A 367-bed facility delivering public and private services under contract with the East Metropolitan region. But prior to that, the Peel Health Campus and the Joondalup Health Campus have been running for many years as PPP, contracted out private providers, delivering a significant amount of public activity as private providers, for the benefit of all Western Australians. So certainly, from a policy point of view, that emphasis which occurred, I guess, initially, in about 1993, with the advent of the Peel Health Campus – and I apologise if the years are slightly out – but the contracting out of Joondalup and Peel in around the early 90s[1] was, I guess, the forerunner for a significant expansion of public contracted-out arrangements across Australia, and those arrangements now occur in Victoria and New South Wales, and elsewhere.

[1] Peel Health Campus was established in September 1997; Joondalup Health Campus was established in June 1996.

[10:09:13]

And quite successfully. Certainly Calum's hospital, Joondalup, is a wonderful example of what could be achieved through sensible contracting arrangements and the ability to respond to significant growth in a corridor where, you know, the private sector was able to offer a complete delineation of services in a private model against the clinical services framework, a full-blown emergency department and, I think now, probably one of the busiest emergency departments in Australia, critical care... So, you know, from an acuity point of view and a casemix-weighted point of view, the kind of casemix that Calum's hospital is delivering is comparable to any of the large secondary general hospitals on the public side that are publicly operated.

So, I guess, from that point of view, that's how the sector's evolved in recent years. And it's a very robust sector in Western Australia, given the largely stable PHI representation at 54.1 per cent, meaning that, you know, significantly, one in two people could potentially obtain their care in a private hospital should they choose to do so. We sit at about a full eight or nine per cent higher than the rest of the nation. So the national coverage, I think, is around 44 per cent. That's a little bit higher than that across the nation. So we are a state with a significantly higher coverage for PHI, which obviously provides opportunity to deliver more care in the private sector.

DR WEERAMANTHRI: So I've heard from you that, you know, the private hospital sector is providing, you know, over 40 per cent of activity in the inpatient space. And also that there's been significant increase in contracted activity from Health Service Providers in the last few years. Either historically or recently, has there been any consideration that you know of around sustainability or environmental impact written into those contracts?

DR POWER: It's true to say that on the building side, certainly the construction side and commissioning side of the PPPs in terms of physical facility, would give consideration to those matters and direct the construction outcomes to be environmentally sustainable, and [… have a] significant green rating. And the *Australian Health Facility Guidelines*, which is a collaboration between jurisdictions, which had been adopted by reference into regulation here in Western Australia in our own versions—the *Western Australian Health Facility Guidelines*—certainly also contain full consideration of smart building design and green principles, to some degree. But, I guess, there may be opportunities to look further into how that policy head of power might be able to direct better outcomes in that regard.

DR WEERAMANTHRI: That's very helpful, thank you. So if we could go to the, kind of, supply side. And we've heard a lot about the importance of procurement in this Inquiry. It's a broad question, but do you

know if the supply chains for pharmaceuticals, equipment, et cetera are similar in both private and public sectors? And does the private hospitals model change when there are contracts or partnerships with the public sector? So the private alone versus private-public…
[10:13:03]

DR POWER: Yes.

DR WEERAMANTHRI: How does that, kind of, shift things?

DR POWER: From the point of view of supply chains, it's probably true to say medical equipment, clinical consumables, pharmaceuticals, are largely the same. There’s obviously a greater degree of centralised coordination of procurement in State-run hospitals—through the Health Support Services in Western Australia is a good example—where contracts can be established for provision of inputs across the sector. That doesn't occur in Western Australia across the private sector other than, say, for example, within groups, as Ramsay might, for example, have centralised purchasing and particular procurement arrangements with particular firms, and then direct that across its constituent hospitals. But the multiplicity of hospitals and operators and arrangements mean that, I guess, an opportunity for as tight a procurement control as in the public sector simply doesn't exist.

It's probably also true to say that product choice is much broader in a private hospital delivering the same casemix because the private sector can, essentially, respond to the needs or wishes or requirements of the treating clinician. The treating clinician—let's say an orthopaedic surgeon, who might have a particular product choice and consumables choice, prosthetic choice equipment choice—may, you know, be able to be accommodated, whatever that choice, in the private sector. So there's simply not as much of a directed or constrained product range as would occur in the same public sector hospital.

DR WEERAMANTHRI: And it could be a question either for you, Dr Power, or Mr McLeod, do those considerations shift when you move into a public-private partnership model?

DR POWER: No. Largely, procurement and consumables are left to the operators’ arrangements. And they would, say, for example, within a large group, fall generally under the same procurement arrangements as the rest of that group’s procurement is delivered by.

DR WEERAMANTHRI: So thank you for the written submission from the Australian Private Hospitals Association WA, and also for meeting with the Inquiry team a few months back. And you told us then that you represent approximately 21 members, meaning, I think, the private hospitals, the main ones in Western Australia.

DR POWER: Yes.

[10:15:52]

DR WEERAMANTHRI: In your submission, you gave some examples of waste recycling, energy conservation and water conservation in the sector. Perhaps I could ask, Mr McLeod, can you paint a picture for us of your particular facility at Joondalup and the initiatives underway?

MR McLEOD: Okay. So I have a set list, I can just talk through the initiatives in order. So from the waste recycling and reduction, one of the key things, I think, that we've put in place in the last couple of years is a position that purely focuses on waste. So we have an enviro services leading hand waste coordinator, and their job is to coordinate the waste diversion across the hospital. And they've been quite key in driving new initiatives, finding new initiatives and managing those waste streams. Because the more waste streams that you take on, the amount of work increases. You know, where we used to, maybe, put it in two bins or three bins, we're now, you know, spreading it amongst maybe six, seven or eight different waste streams.

But they've been very good at managing the change, managing the expectations of the wards and the managers and the departments, getting them on board and getting them involved in the different initiatives that we have. So that, for us, has been quite key and has made our initiative not only just an initial success, but have made them sustainable, that they're still going. They haven't, sort of, started off with a big bang and then fallen by the wayside. We continue to drive those initiatives. We also have a Waste and Environment Committee which meets every two months. I don't think that's unusual across any of the hospitals.

But we have a broad range of people who attend, from myself, engineering, hotel services, clinical areas, theatres, allied health, and our main contractor also comes along to those meetings. They provide updates on how we are doing, how good our waste diversion is. We also have yearly audits which have been reported on there, which give us an indication that the bins that our staff are putting the waste in are the correct bins. So if there's any discrepancies, they highlight those as well. And from those yearly audits we will then, really, have an action plan and know what we need to work on to improve for the future, and also what we're doing well. So some examples that I have is that – well, the 13 months from September 2018 to September 2019, we've had an overall reduction in general waste. We've increased our waste diversion to 28 per cent as of September 2019. By bed day, our general waste is trending down and by bed day, our recycling is trending up. So it shows that we're making good consistent steps. The other thing I could talk about is what Ramsay are doing nationally.

DR WEERAMANTHRI: Could I ask you a couple of follow-up questions first?

[10:19:18]

MR McLEOD: Sure.

5 DR WEERAMANTHRI: So I'm really interested to hear about the increased number of waste streams and the buy-in you've got, because we've heard that it's actually very difficult to get consistent waste separation inside, you know, hospitals by clinical staff. So what's the trick here? How do you manage to achieve this and sustain it?

10

MR McLEOD: The staff member that we have is very tenacious and very direct and doesn't give up so, you know, it's not a goes in once and, you know, finds it a bit challenging and then just doesn't engage anymore. She keeps going back again and again and again. So she has been 15 very key. We had another staff member previously who was doing the similar role, but hadn't been able to get the traction. So for us, it was finding that person, and they've been absolutely fantastic. I would say that's been our main key driver is finding that person being able to commit, to have them as – that is their key role. So it's - - -

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DR WEERAMANTHRI: Has there been a change in staff attitude as a result of having done this now for some time?

MR McLEOD: Yes. A lot of the departments, it feels 25 that there is a passion for people, people want to do the right thing. People want to recycle. It's just giving them the opportunity and making it as easy as possible. You know, it's like people walking across a park, you know, you see where the track is, that that's the shortest route and that's easiest path of least resistance. So what we're trying to do is – the lady has done a lot of work with 30 the wards and with theatres to find out what will be the easiest way. So they'll try something, if it doesn't work, she'll go back, think about it, try again, you know, until we find that path of least resistance that makes it easy for them to make those good choices.

35 DR WEERAMANTHRI: And so just my second question is around training. So what kind of training do clinical staff need – and it might just be, you know, that person going and showing them what to do.

MR McLEOD: Yes.

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DR WEERAMANTHRI: But also, is there a need for training of facility managers, because they're certainly key, you know, whatever they're officially designated, that kind of role inside a hospital, whether public or private, the facility manager role is key to this whole environment and waste 45 issue. And it seems to me that there's little dedicated training for those staff in this whole area of environment and climate change, or I am getting it wrong here.
[10:22:23]

MR McLEOD: Okay. So I hope I've answered your question. So as a support services manager – and I oversee the enviro-housekeeping, back of house, sort of, services – one of the things that we did was we had a waste open day, where we showed all the different recycling streams that we have. We have leaflets that are given out at orientation for new staff members, which show all the different waste streams that we have. So again, it's a very simple, small flyer. And that was done in conjunction with the contractor that we have. Any posters that we put up above are around the waste bins that we want them to use. We have a lot of consultation with our clinical experts to make sure that the posters are saying the right thing, or not confusing or providing the wrong message. And yes… sorry.

DR WEERAMANTHRI: That's all right.

MR McLEOD: But yes, and from… with theatres, so theatres have a staff member who – it's not their sole job, it's one of their jobs, that they're the waste champion for that area. So theatres are a significant area.[2]

DR WEERAMANTHRI: We're just thinking about making some kind of recommendation around networking and perhaps training, upskilling of facility managers, so they could get together, across maybe public and private hospitals, and share stuff and, you know, get up-to-date with initiatives.

MR McLEOD: Yes, that would be very good. I mean, we're quite lucky within our Ramsay group that, you know, we share information with Hollywood Private Hospital, you know, and there's initiatives that they've started that we've gone, "That's fantastic. We'll have some of that". And, you know, we've, you know, taken on those initiatives. But yes, to expand that to the public sector, as well, and have that transparency and sharing ideas would be fantastic.

DR WEERAMANTHRI: Thank you. Would you like to talk about the Ramsay initiatives nationally?

MR McLEOD: Yes. I mean, what I can do, I can – really, what I'm going to talk to is, this is our *Ramsay Way*, which is the national magazine. I don't know if you just want to – I can give that to you. So specifically that page.

DR WEERAMANTHRI: So I might just read this into the record. Yes, so this is the *Ramsay Way 2019* – is it edition three?

MR McLEOD: Edition three, yes.

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[2] The point Mr McLeod is making here is that theatres are a significant area for waste diversion.

DR WEERAMANTHRI: And it's page eight.
[10:25:10]

5 MR McLEOD: Yes.

DR WEERAMANTHRI: Thank you.

MR McLEOD: And so I was part of one of 35 staff who
10 went to Sydney and took part in the corporate social responsibility strategy that Ramsay want to undertake. So basically, they were asking people from hospitals all over Australia, all different backgrounds, you know, clinical support services, catering, what they felt that Ramsay needed to do. So Ramsay did this not only in Australia, but they were doing it in France and in
15 the UK and their other locations around the world. So they're coming up with a global strategy. And the other article that's there is, 'Ramsay's hospitals wage million dollar war on waste', where Ramsay Healthcare have a one million environmental sustainability fund to support hospitals to undertake projects that reduce carbon emissions. And any one hospital can get funding
20 up to $100,000.

DR WEERAMANTHRI: That's terrific information for us to have. And particularly that incentive fund idea. Is that a new initiative?

25 MR McLEOD: So yes, that's come out as of September 2019, yes.

DR WEERAMANTHRI: And I think it's a signal of the sector, Ramsay, the sector, taking this whole issue quite seriously.
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MR McLEOD: Absolutely, I would agree. There's been a lot more focus on that from, not just locally, because we feel we're doing a lot at our local hospital level, but it's recognising that, you know, Ramsay completely support what we're doing.
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DR WEERAMANTHRI: Thanks, Mr McLeod. Dr Power, are you aware of the Global Green and Healthy Hospitals Initiative which is being promoted by the Minister in discussion with the public Health Service Providers? Could this initiative be relevant to the private hospital sector in
40 Western Australia?

DR POWER: Yes, certainly, Tarun. It's a wonderful framework that builds, I guess, an approach around categories like leadership, chemicals, waste, energy, food, pharmaceuticals, buildings, transport and so
45 forth. So from a hospital point of view, it aligns very nicely with, I guess, the common model of hospitals worldwide. Speaking to one operator, the Epworth Group in Victoria, who've been a member for some time, they consider that… the feedback from their Chief of Facilities, Andrew Bond, and Chief Executive

Officer, Dr Lachlan Henderson, is that they consider the framework to be a really useful opportunity to learn, within those categories,
[10:28:18]

5 from others and participate in the online forums, and examples and benchmarking and so forth, that are available through that initiative. So whilst membership by Australian hospitals is not wide, it's certainly something that could be promoted more across the private sector and others.

10 DR WEERAMANTHRI: Thank you. We've heard from some of the Health Service Providers already. And the same question we've asked them as we're asking you, which is, clearly, you know, the sector is making initiatives in this sustainability area, but are you getting any specific feedback from staff or patients about their expectations of private hospital facilities with
15 respect to waste and minimising your environmental footprint?

DR POWER: Probably something we can both speak to Calum.

20 MR McLEOD: Yes. I would agree that people's expectations are that anything that's being used in the hospital, that it's automatic that it would be disposed of responsibly, and everywhere we can, you know, reduce it or reuse it or recycle it, absolutely. I think that's not an unrealistic expectation that people have now when they come into the hospital.
25

DR POWER: And from my point of view, taking a brief look through some of the patient feedback we've had over the past couple of years, patients that are longer length of stay admissions certainly have longer time to contemplate what's going on around them, and make useful
30 observations of things like energy initiatives that we might take, or water conservation, planting choices in gardens, packaging choices on their meal trays, this sort of thing. So certainly, the feedback from patients is constant and useful. Staff feedback, certainly – and particularly in the younger generations with an activism in this space are really keen to be involved in the
35 initiatives at the hospital level, and make time to do so. So it comes from both patients and staff.

DR WEERAMANTHRI: Dr Power, at this point, is there any observation you'd like to make as CEO of Perth Clinic, which is a private
40 psychiatric clinic, about that sector because we haven't really talked about that in the Inquiry so far, you know? Because they would be longer stay patients, I imagine.

DR POWER: Yes, yes. I'd like to just, I guess, talk in a
45 general sense about the importance of length of stay as a contributor to utilisation of all resources – energy, water, and consumables. In Australia, it's true that the private health sector, in general, operates at a greater 'length of stay' efficiency than the public sector for largely the same casemix. Certainly,

the acuity of admissions in the public sector is generally higher, but the casemix, or diagnostic categories, are very similar across public and private hospitals, you know, whether it's a voluntary psychiatric admission in the facility like mine, that may stay for 18 days, 20 days. Or, you know, medical, surgical, hospital admission in a private sector hospital. You know, the diagnostic groups are largely the same.

[10:34:40]

So from the point of view of a contribution to climate change, the fact that the private sector's focus is on length of stay, the private sector's, it… just going back a step to the remuneration model from the health funds, private sector hospitals are paid on an episodic basis, generally, or a per diem basis for the longer length of stay, for example, psychiatric or rehabilitation admissions, but generally, the medical, surgical admissions are paid on an episodic basis. A single case payment within which the private sector hospital can manage the length of stay and obviously, the sooner you can complete the admission and get a good outcome and discharge the patient, the greater the opportunity for making a margin on that single case payment, which means that the emphasis on efficiency in the length of stay contributes to greater environmental benefit… whereas most private hospitals are not full. Therefore, you know, a shorter length of stay simply means you can turn the light out in the room and stop servicing, you know, the waste disposal there. And there's limited water use there, or less water use.

So just all of the inputs are generally less because of the shorter length of stay. Therefore, you know, it wouldn't be unreasonable to say that that constant focus on length of stay management in private hospitals is an enormous environmental benefit, given the same casemix, largely, that is seen across both public and private sectors. And particularly, in the longer length of stay facilities, the segments of the sector like my own, the private psychiatric facilities, where patients, as I said, across Australia, on average, according to the Australian Private Hospitals Association, stay around 20 days. And the same figure in a public hospital is some four or five days longer, I understand. So the opportunity for saving, again, is quite significant in terms of a benefit to the environment. So that average length of stay across the public sector – and I've got the AIHW's last enumeration in… bear with me. I'll find it for you.

Yes, 2.2 days, on average, for both ambulatory and multi-day admitted casemix in the private sector, and three days for all ambulatory and multi-day casemix in the public sector. So a 26.6 per cent difference for, well, largely the same casemix across both sectors,[3] which would obviously have an important benefit to the consumption of resources and environmental outcomes in that regard. So, I guess, the payment model in the private sector can drive efficiencies, and thereby an opportunity to conserve resources in delivering that care.

[3] Dr Power clarified that the 26.6 per cent difference was for largely the same casemix across the two sectors.

DR WEERAMANTHRI: That's a very interesting point which hasn't been made to us before, so we'll take that on board, thank you. I suppose it goes into that 'reduce, reuse, recycle'.

5 [10:35:07]

It's on that reduce end, if you can… you know, the best thing you can do is reduce the – I'm just thinking out loud here – reduce the amount of care in these high environmentally impacting settings.

10

DR POWER: Yes, indeed.

DR WEERAMANTHRI: Is this an issue that's being discussed at a board level in your sector, and what would it take to elevate this issue to that

15 strategical board level? And I'm just asking broadly, is it about risk management, is it about financial impact, or is it about corporate values? And I do note that, you know, the sustainability newsletter you've just given us from Ramsay does talk about corporate social responsibility.

20 MR McLEOD: Sorry, you'll just have to ask me that question again.

DR WEERAMANTHRI: Sorry, the framing is around corporate social responsibility, in terms of why you might be doing your international

25 work. But there are also other potential drivers for having this discussed at a board or strategic level, which might include, you know, it's actually… you might save some money by being environmentally sound, or it might be about risk management, in that there might be actual risks around capital or supply chains or whatever it is, which is driving the consideration at board level.

30

DR POWER: I could make some sector-wide comments. I mean, there's no doubt that that triple bottom line is widespread in, you know, the public facing information sources by most private hospital operators in Australia these days – that financial, social and environmental

35 imperative. And, you know, the extent to which consumers might seek to product differentiate is an interesting topic. These days, consumers are so much more aware of their opportunity to determine where they go for their care. You know, they'll have a diagnosis made, obviously, by a specialist, and then there's plenty of opportunity to determine where they go, with which

40 operator and under which flag they are admitted. Most specialists will have credentials across numerous providers, in many cases.[4]

So the consumer can drive the determination of which site they might be admitted through, and obviously in perusing public-facing information,

45 websites and environmental credentials and other matters, you know. I'm sure, particularly in younger generations, an increasing interest in… or wanting to go

[4] Dr Power later clarified that many, rather than most, specialists having credentials across numerous providers.

somewhere that flags their environmental commitment, their lesser footprint environmentally and so forth. I don't have any information on that in terms of quantification, but I could well imagine it's a feature of people's decision-making in terms of choice of destination for admission.

[10:38:06]

DR WEERAMANTHRI: So that triple bottom line reporting, as you say, it's our impression that that's actually, probably, more prevalent in the private sector than it is in the public sector, and has been there for decades. And I think most of the, you know, top 100 companies – not talking health here, but just generally – would have some kind of sustainability reporting or even separate sustainability plan and report separate to the annual report. You don't see that so much, I don't think, in the public sector. Have you got any impression about whether the private health, or private hospital, sector has similar, kind of, separate reports or parts of its annual reports that deal with sustainability?

DR POWER: I don't have any examples that I can give you. But I'm certain they exist, it's just such a commonplace consideration these days, in that… particularly the publicly listed companies. I wouldn't be surprised if Ramsay[5] doesn't showcase their initiatives in their annual documents and public-facing information.

MR McLEOD: Yes, I would agree. So I don't have any specific details, but from my recollection, I'm sure that they do, even in the Joondalup Health Campus's annual report, they have a section about what they're doing from a corporate social responsibility view. Sorry - - -

DR WEERAMANTHRI: Yes, no, that's - - -

MR McLEOD: - - - I can't give you details.

DR WEERAMANTHRI: - - - that's fine. Thank you. Okay. So we're just coming to the last few minutes of the hearing. There seems to be – we've talked about it a little bit – a plausible connection between hospital waste, hospital costs, and then by inference, insurance premiums, if you can get hospital costs down. Are you aware of any discussions between health insurers and private hospitals about the range of issues we talked about this morning?

DR POWER: I guess the remuneration model – as I said, an episodic payment does provide opportunities for initiatives to be driven to save inputs and thereby improve margin. But given labour is by far and away the largest component cost of delivering care in public and private hospitals, the opportunity to drive premiums down by a focus on waste or non – if you like – labour-driven inputs, I wouldn't think is great. But it would certainly be real. The sector's not in discussion – to my knowledge, having

[5] Here, Dr Power is referring to Ramsay Health Care as an example.

been in the private sector now for 13 years in largely the same sort of role, with several operators Healthscope, Ramsay and others. Perth Clinic, now, as a privately operated and owned facility. Certainly, we're not being driven by the [health insurance] funds to focus on waste or energy or environmental outcomes as part of a push to reduce premiums.

[10:41:15]

DR WEERAMANTHRI: We've had some informal discussions around the potential – for example, should there be a greater incidence of extreme weather events, driving up a range of premiums, whether that could have a future flow-on effect into people's capacity and willingness to pay for private health insurance as another insurance cost. So potentially, if you're paying more for other insurance costs, you might say, "Well, I don't have the capacity to pay for private health insurance". Has that been raised with you at any point?

DR POWER: There's no doubt that price sensitivity is an issue in the privately insured marketplace presently, and the federal government's reforms are focused on endeavouring to achieve a cap on the growth in premium indexation going forward. I think the federal Minister's on the record, currently as, you know, wanting outcomes less than three per cent indexation outcome across each health insurance group federally in the next round. And that premium growth has… a focus on constraining that premium growth certainly exists in order to remove the, I guess, the pressure on price sensitivity within that market. And the evidence of the effectiveness of that approach is certainly being seen. So, for example, the data in WA I mentioned earlier. The link between all other expenses to a person and private health insurance and other insurances I'm not so certain about. But yes, certainly, price sensitivity is an issue within the private health industry.

DR WEERAMANTHRI: Okay, last question, which is kind of looking forward. So the Inquiry has to make some recommendations about, you know, the next few years, and we're certainly getting a sense that people want to partner with government, and everyone feels that they have a role. And perhaps you could reflect a little bit of the Australian Private Hospitals Association in WA, and whether you feel, you know, you'd like to be part of the partnership going forward to see what more could be done, particularly given your share, you know, of the activity in the hospital sector. And also whether there's an opportunity to, kind of, share initiatives and successes, not just amongst your members, but broadly between private and public.

DR POWER: If I could speak for the sector, or certainly the members of which I'm aware, they'd be very keen to participate in a state-coordinated forum that shared information across both the public and private sectors. It's good business to, you know, be well aware of ways to reduce your inputs and provide a better marketable outcome from the point of view of environmental sustainability in your public-facing persona as a

corporation. So, you know, these all make good business sense, and I'm sure everybody would be keen to participate in those kinds of initiatives.

MR McLEOD: I would agree. Some of the ideas that we've had have come from, you know, hearing about what I know the hospital is doing, and then investigating that and going, you know, “We are now going [10:44:44]

to take that on”., you know, so the more communication… And I know that within Ramsey nationally, the group of 35 that we had for the corporate social responsibility meeting, you know, there's a lot of chatter amongst those. And yes, to have the same within the state would be fantastic, in my view.

DR WEERAMANTHRI: Great. Dr Joyce attended a Green Healthcare Forum in Victoria a month or two back, which was, I think, a good opportunity to share information. And personally, I'd love to see that kind of forum here in Western Australia at some point next year, as potentially a kind of follow-up to this Inquiry. So it would be great to have both the private and public health sectors represented.

DR POWER: Terrific.

DR WEERAMANTHRI: Dr Power, Mr McLeod, thank you both for your attendance at today's hearing. A transcript of this hearing will be sent to you so that you can correct minor factual errors before it is placed on the public record. If you could please return the transcript within 10 working days of the date of the covering letter or email, otherwise it will be deemed to be correct. While you cannot amend your evidence, if you would like to explain particular points in more detail or present further information, you can provide this as an addition to your submission to the Inquiry when you return the transcript. If we could keep this edition of the Ramsay Way, we’ll put this as part of the record of this hearing. Once again, thank you both very much for your evidence today.

MR McLEOD: Thank you very much.

DR POWER: Thank you.

HEARING CONCLUDED