T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Subcommittee

Inquiry into infrastructure projects

Melbourne — 19 October 2016

Members

Mr Joshua Morris — Chair	Mr Bernie Finn
Mr Khalil Eideh — Deputy Chair	Ms Colleen Hartland
Mr Jeff Bourman	Mr Shaun Leane
Mr Nazih Elasmar	Mr Craig Ondarchie

Participating member

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Witnesses

Professor Ian Meredith, AM, director, MonashHeart, and

Mr Andrew Stripp, chief executive officer, Monash Health.

The CHAIR — I declare open the Standing Committee on the Economy and Infrastructure public hearing, and thank you to our witnesses who are present here this morning. 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 invited 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 the same privilege. Once again, gentlemen, thank you for your attendance today and for providing some testimony to the committee. At this point I might hand over to your good selves for any introductory comments that you might like to make about the work that you are doing, and then we will move into some questions from the committee from there — so to whomever would like to begin.

Mr STRIPP — Maybe I will start, and thank you. My name is Andrew Stripp. I currently work as the chief executive of Monash Health. I was appointed to that position at the end of May of this year, and I guess have been working with Professor Meredith and many others in relation to the development of the planning for the new heart hospital. It is something that we are very excited about developing, and we are in that process at the moment where business case planning, refinement of what and how we will deliver the service is very much happening. We are very happy to take questions in terms of our work that we are doing.

The CHAIR — Professor Meredith, is there anything you might like to add?

Prof. MEREDITH — Not much. I have been professor and director of MonashHeart at Monash Medical Centre and Monash Health since September 2005, and this project that we are discussing is something that we have developed over the last 14 years to try and set in place an ideal structure for managing the growing demand of cardiovascular disease and the ageing of the population and increasing burden and density of risk factors associated with the modern Western lifestyle.

The CHAIR — Could you just give us a brief overview of that 14 years in terms of how it is that we have got to where we are at this point, considering that obviously well over a decade of work has gone into where we are now? What does that look like?

Prof. MEREDITH — The work really began as we saw the growing population in the south-eastern corridor and the increasing demand and the capacity limitations of our current infrastructure and the ability to really keep up with the growing demand and the changing complexity of cardiovascular medicine. As it is with so many specialities, there is an increasing technological advancement and changing complexity. We needed to have capacity. We needed to develop infrastructure that was not limited by concepts derived from the 20th century or even the 1980s, to be honest. The way medicine is really changing today, we need to have a system that is ready to cope with disruptive change and changing infrastructure. So they were the two underlying principles we started from — how could we actually meet the demands of the population going forward, how could we futureproof the service, how could we provide safe, timely and effective care — and accessible care — for the next generation and beyond?

One of our big limitations in doing those things is meeting the changing technological face of cardiovascular medicine, which is probably one of the most rapidly evolving fields. There are other drivers as well — the opportunity to be at the face of med tech development, which globally is a very large business. Melbourne, with its tremendous infrastructure, is well positioned to have further med tech development in the health space, particularly in the hospital space. We saw all these things as potential opportunities to build appropriate infrastructure for the future.

The CHAIR — I suppose one of the questions that has been posed around the heart hospital is its location. I am just wondering why it is that you believe the project should be a standalone on the Monash campus rather than co-located with Monash Medical Centre.

Prof. MEREDITH — The first thing I would say is that the government have made the decision, and that is the decision they came to. It was a five-year period before that where the pros and cons of various models were assessed in detail by an independent strategic advisory committee. That was based on published documents pertaining to choosing the right cardiovascular delivery model for your health system, and such publications are out there. We carefully analysed those publications and looked at the pros and cons of various models. There really are five potential ways that this could be done, of which the primary two are co-location on the same site or building a standalone at the Monash University site. I think there are strengths and weaknesses with both.

There are many strengths for the infrastructure of medical education and capacity development by building on the Monash University site. I think there are arguments pro and con for both. There are many strengths, though, for the university-based development.

I should say it is not without precedent. There are more than 100 dedicated standalone heart hospitals around the world, many of them 2 to 3 kilometres away from other general medical hospitals. I myself, over the last 14 years, have visited nearly 50 such establishments around the world. So the model is safe. It is effective. It allows for futureproofing. It allows for dynamic change to the structure of the hospital to meet technological changes that come along.

I think there are strengths and weaknesses with both models, though. The model that the government has actually chosen I think is a very reasonable model, and we are working along, building a business plan around that model.

The CHAIR — You say there was a decision of government to do what is happening now. Is that your preference? Do you see that as the best of the two outcomes? If you were to be the one making that choice, would you have chosen the model that the government has gone with or would you have chosen the co-location model?

Prof. MEREDITH — Personally I would have chosen this model. I think it provides greater futureproofing. Wellington Road is an eight-lane road and Blackburn Road is a six-lane road. It provides infrastructure for heliports and it provides infrastructure for other developments on that site, so that would be my preference, but had it been built on the Monash Health existing campus, that would also have been fine. The Monash Health existing campus already has 51 medical specialties and more than 7000 employees. I think to expand to another campus is quite reasonable when Monash Health is already a five or six-campus structure with cross-campus activities that are quite differentiated. So to me, it is a very reasonable and logical model. As I say, of the five potential options for how this could be done, the top two were really a standalone building on the Clayton Road site or a standalone structure. The standalone structure offers a great deal for the development of medical education and medical tourism and for leveraging the extraordinary research and technology facilities that are at the university to build a true med tech hospital, so there are many strengths in that model.

The CHAIR — You have spoken about the strengths. What are some of the risks associated with building the standalone heart hospital?

Prof. MEREDITH — Of the perceived risks, one that is often talked about in public is the duplication of services — that would be one . It is perceived by some to be less safe. This of course is not really true. As I said, there are more than 100 such establishments around the world, and many of these operate at a higher level than the services that we can currently deliver from our constrained infrastructure.

When you talk about safety, there are many elements to patient safety. Is it a case of actually delivering inferior-quality care? No, because that is a volume-related issue. Is it the case that the patient might go to the wrong establishment? The vast majority of patients will come by emergency services, and such patients will naturally flow directly to the heart hospital. There are always going to be transfer issues, but these have been well worked out around the world in other models.

And then what if the patient were to deteriorate, or their health were to deteriorate? Well, you are building into the hospital all of the vertical infrastructure that you actually need. So you would not build a heart hospital without an intensive care unit, but it is a cardiac intensive care unit. You would not build it without cardiac theatres, but they are cardiac surgical theatres. You would not build it without a diabetes service, because 20 per cent of the population has diabetes. You would not build it without renal medicine, because 10 per cent of all cardiac patients have kidney problems. So all of these sort of service-related and operational issues have really been very well thought out. I have absolutely no doubt that there are no safety issues.

Of course there is going to be some duplication if you build another campus — perhaps Andrew might want to talk to those issues. But being part of Monash Health offers a lot of strength because there will be sharing of facilities across the entire organisation.

The CHAIR — In terms of the emergency department at the heart hospital, what is that going to look like? Is there going to be a walk-up emergency department? Where is it going to be located?

Prof. MEREDITH — It should be a walk-up emergency department. Again, if I were to take you on a tour of the hospitals around the world, the one lecture that you get when you go to all of these heart hospitals is they say, 'Make sure the patients can easily come back into the establishment'.

When a patient goes home, of course their first port of call is not going to be another hospital down the road. If you think of the mix of patients coming to an emergency department at a major hospital, about 10 to 11 per cent of all of the patients presenting at an emergency department present with chest pain or a cardiovascular complication or cardiovascular problem. Those patients are going to be best managed, and are best managed, by carefully streamlined clinical protocols for managing patients in the emergency department. That can be done through a highly successful and well-structured emergency department with physicians rotating from the other Monash Health institutions who are either interested in emergency cardiovascular medicine as part of their ED training or for whom it is their long-term career.

So you do have to have a functioning emergency department. Obviously there will be emergency transport bringing patients in, but it would be the hope that a proper-functioning cardiovascular emergency would allow walk-in and return admissions to the hospital.

The CHAIR — So just to be clear, there is no confirmation at this point that there will be a walk-up emergency department at the heart hospital?

Prof. MEREDITH — In the Victorian cardiac services plan as written, and I may be mistaken, it is a planned emergency department, but it has been left the option of having a walk-up emergency department, but it will mostly be through ambulance admissions in the first instance. But we would expect and I would hope that those involved in operating the hospital in four or five years time when it is built recognise the critical importance of having open public access.

The CHAIR — Just to clarify, so it may or may not have a walk-up emergency department — this is something that is yet to be determined; we do not know at this point?

Prof. MEREDITH — It is planned that way, but the Victorian cardiac services plan was written in a somewhat open-ended way with respect to that issue if I recall.

The CHAIR — Would you be able to provide the committee with some further advice on where that is at — whether it is that report that you were referring to or the like?

Prof. MEREDITH — Sorry, what was the question again?

The CHAIR — Obviously you have said that there is a plan that indicates that this may be the case or is planned to be the case. Could you provide that information to the committee?

Prof. MEREDITH — Most definitely. The model-of-care document that is being used to underpin the feasibility study in the planning is based around having a walk-up emergency department. This would be the most logical thing to do. It is a lesson that most of the people involved in the heart hospital have been told repeatedly when visiting other establishments around the world.

The CHAIR — Okay. I would like to ask about Papworth Hospital in the UK, which I understand is a top cardiac hospital. It has just made the decision to move to Cambridge and co-locate with, is it, Addenbrooke's Hospital? I am just wondering what view is on why it is that some of the major cardiac hospitals are moving back to the co-location model?

Prof. MEREDITH — Do you want me to talk to that?

Mr STRIPP — If you like.

Prof. MEREDITH — Perfect. So you have picked out one little establishment. Now, the Papworth was quite a run-down facility, as you know, with an ageing structure, and there is a desire to actually congregate services so that you make them larger. So if you look at what you could do with Monash Health, you could either develop another detailed cardiovascular service at Dandenong, then a separate one at Casey, ultimately one at Warragul. You could build even more infrastructure at Box Hill, or you could look at the capacity limitation that we have at Monash Health and say, 'What is the best way to provide a service to 2050?'. And the

best way to provide a service to 2050, meeting volume quality objectives, providing timely, accessible and effective care, is to develop one centre. So if you look at Barts hospital, Barts hospital is the accumulation of three small cardiac centres into a standalone, dedicated cardiac centre. Now, Papworth is certainly moving, and it is doing so in order to improve infrastructure, but there are other models where standalone heart hospitals have been highly effective.

I think we have to look at not one but all the examples around the world if we are to see it in perspective, and I think the best model for Victoria, particularly Monash Health, would not be to duplicate all these costly infrastructures at each local hospital but to build a concentrated hub-and-spoke model. That, I think, is the underpinning of the Victorian cardiac services plan: major hubs for high-cost, high-complexity and low-frequency procedures, and then to distribute to the spoke low-cost, low-complexity common procedures. That is going to provide us with the best volume quality structure. So there are good examples of where centres are coming together — Chicago is another place, Los Angeles County another — and where heart hospitals are moving together to create one larger structure.

Mr LEANE — Thanks so much for your evidence and congratulations on getting closer in your vision for what will be a fantastic facility. I suppose getting back to the standalone facility, the specialised facility in heart care, it is interesting that when the VCCC gave evidence to us around its specialised facility around cancer services it was said that before opening they had the interest of experts in that field from right around the world to come and work there. I think the buildings will be fantastic but I suppose that the people you get to work there are just as or probably more important, I would say. So is that your expectation? Do you think that once this facility is built that, like the VCCC, it will attract a lot of interest from the best people around the world?

Prof. MEREDITH — I think that is a very, very important point, because the most important thing is the human capital. The single most important and valuable asset to the running of a safe, effective and culturally sound organisation is having a critical mass of the right people working there and providing the environment that would attract them there. MonashHeart already has that brand and reputation; we are just capacity limited. I think building the right infrastructure will attract the right talent pool to take us further into the 21st century. We have a problem with brain drain. We have a significant problem that some of our best and brightest do not come back to Australia, because there are better facilities with better infrastructure and better conditions for them to further their research. It is a great pity that we do not retain those people or attract them back after putting so much effort into their undergraduate and postgraduate medical education. So I would see that a facility like this would be the next step.

Mr LEANE — And even attracting people the other way: attracting some of the best — —

Prof. MEREDITH — And brightest — most definitely.

Mr LEANE — Yes. Coming the other way, which at VCCC has been their experience, and I would say that the heart hospital would absolutely be no different when it is finished; it will be state of the art. As far as research in this area, being in the same precinct as the university, what sort of interaction with the university will the heart hospital have?

Prof. MEREDITH — I think it will have a lot. There are extraordinary research and biotech facilities: CSIRO; the imaging facility — the synchrotron — will be directly across from the PET scanning facilities at the institute; and biodiversity. All of the different departments will provide extraordinary synergy for research developments and early-phase med tech developments that can come through the hospital.

The one missing link we have got in med tech really is that we do not take enough of that into human clinical trials and develop it to a stage for commercial spin-off here. So if we could do that while providing excellence in clinical care, we would be setting ourselves up for a very successful new business dimension for Victoria going forward.

Mr LEANE — I suppose coupled with that is that it is the perfect precinct and your facility would be the perfect facility to train the best people in this field, I would imagine, so far as the up-and-coming people. I would imagine that a lot of people would want to learn there as well because of the nature of the facility, the location of the synchrotron and everything you have mentioned.

Prof. MEREDITH — Very true. Tertiary education is a very important part of the economic wealth of this state. Medical education could be a very important part of that. Both undergraduate and postgraduate training are significant enterprise activities that could be undertaken by the heart hospital, and that is one of the underpinnings of the business model.

Not only will we be providing safe, timely and effective care and providing capacity for the future, we will also be able to provide a financial structure for the state in terms of medical education and training: undergraduate, postgraduate, internationals. I think there are a lot of opportunities in building on that university site and having a close partnership with Monash University in some of these other what you might call more enterprising approaches to how the hospital could function in this century.

Mr LEANE — You mentioned in your initial statement medical tourism. Could you expand on that? I know sometimes that when state-of-the-art facilities like the VCCC and what-not are functional, people from other jurisdictions come and look at them from a point of view of 'This is the way to do it'. Is that where that comes from?

Prof. MEREDITH — No. Long before the term was popular, we have been writing documents about this. When we look at medical cardiovascular tourism, in 2005 it was already nearly a $2 billion business from South-East Asia —

Mr LEANE — Wow.

Prof. MEREDITH — and if we have a tiny fraction of that coming this way — —

Mr LEANE — Okay, yes.

Prof. MEREDITH — Now, what it must be now would be at least four or five times that. I am not exactly sure what the total value of medical tourism in the cardiovascular space going to Europe or North America would actually look like, but we should be able to harness some of that coming to Victoria.

Mr LEANE — Right.

Prof. MEREDITH — Now the critical thing is that it is not just the facilities; it is the reputation. It is the brand and the reputation, and the brand and the reputation mean influence and influence is the thing that is going to actually help the medical tourism development. I believe that could be a strong and growing foundational business for Victoria in this century.

Mr LEANE — And in the case of the heart hospital, that would be people coming from overseas for procedures and care?

Prof. MEREDITH — They do now.

Mr LEANE — They do now?

Prof. MEREDITH — They do now, so people pay quite handsomely to do that now.

Mr LEANE — Yes. So when you have got a state-of-the-art facility and you have attracted some of the best people back and attracted some of the best people from overseas, then as you said, with the reputation, it will not be too hard to get that message out in targeted parts of the world, and people will be very attracted to that.

Prof. MEREDITH — There are 500 million mobile phone users who have health applications on their phones today.

Mr LEANE — Wow.

Prof. MEREDITH — Five hundred million. Most of those have daughters, sons — children — who will look it up and say, 'We want your heart valve replacement to be done at Monash Medical Centre', or at MonashHeart or the Victorian Heart Hospital' or 'We want your targeted cancer therapy to be done at VCCC'. So the traditional model of referral, where you see your doctor and your doctor refers you to another doctor, is all but gone. Most people these days make decisions on what information they can gather through health

technology and what you might call m-health applications. This is the foundation for developing a highly successful Victorian medical tourism business from which we will all benefit.

Mr LEANE — Yes, and then it is a return on investment, which I had not thought of before anyway. So actually it will be some sort of a return. You build these types of facilities, you get the best people and then you have got that return coming into the state. That is very interesting.

Prof. MEREDITH — If I could go one step further, I would say this could potentially be just the first or second step towards a new economic reality in Victoria. We will not continue to make cars, we are not going to build submarines and we will not make flat screen TVs, but the one thing that we are good at and where we punch well above our weight is medical science, medical research and medical technological developments. We can actually harness all of those things. This is an extraordinary state of intellects, and if we harness all of that and build the right health facilities like the VCCC, like the Victorian Heart Hospital and perhaps other specialist institutions in the future — like neurosciences, movement disorders; there are lots of things — this could be a very successful economic underpinning of how Victoria operates in the future.

The reason I say that is that if you travel to Houston and you see the Texas institutes — Texas Heart, Texas Children's, Baylor College of Medicine or the MD Anderson Cancer Center — and you see how successful they have been and how much of the City of Houston's GDP depends on health, oil and gas, yes, there it is: the second-biggest item in terms of funds flowing to Houston is health and health technology. There is no reason, with the concentration of people we have, the intellects, the 100 years of reputation and the wonderful research institutions, why the heart hospital could not be the exemplar from which we then go on to build similar things — movement disorders, dementia — —

Mr LEANE — And there are already plans for the Maroondah breast cancer centre, which will specialise in that field. As you said, there will be a few jewels in the crown as far as what you were talking about — as far as medical tourism — goes. That is great. That is very interesting.

Prof. MEREDITH — I agree with you. I think there are reaches far beyond just providing the service, but at the very least we will be providing a fantastic service to 2050 and beyond for the people of south-east Victoria but with the bigger picture in mind.

Ms HARTLAND — If we continue to look at that model of the medical tourists, while you were talking about that, that sounded really interesting, but in my mind, what about the uninsured pensioner? The wealthy Asian tourist sounds like they will be able to get treatment pretty quickly because they will be able to pay for it, but what about the elderly uninsured pensioner on a waiting list? What kind of time will they have to wait for their triple bypass or their valve replacement?

Prof. MEREDITH — I am so glad you asked that question. I have spent my entire 28 years in public medicine looking after uninsured patients and as a tireless advocate for people without a voice, so I am a great believer in access, equity and timely and effective care for all people. The problem is: how do we fund that? Even though I have worked my entire life in public health, the way to fund that is to have financial sustainability — to have some degree of financial autonomy and independence — so that you can meet that demand.

The reality is that in Monash Health — Andrew has to cover his ears for a minute — every week there are 7000 people waiting 5 to 12 weeks for some cardiovascular service. It might be a minor service, but there are 7000 people every week waiting for something. I am a taxpayer. I am not happy about that. That could be me. But we do the best with the facilities that we have got. Not all of this actually appears on category 1 waiting lists; that is how you categorise things. But people are waiting for simple things, whether it be an ultrasound test of their heart or a stress test.

This is not right. If we are to do this well and provide for our community, our citizens, all Victorians and all Australians, we have to have a way to fund that, and as long as we build a facility to provide all of those needs — and anything in terms of enterprising models is above and beyond that capacity — it should work. All of our modelling from day 1 has been to provide the capacity for those uninsured people who live here and who deserve to be treated in an equitable, accessible, timely and fair way. So every model we have ever developed is saying, 'What would we need in 2025, what would we need in 2030 and what would we need in 2035 to meet the public demand?'.

Ms HARTLAND — How much do you expect would be raised through medical tourism, and do you feel assured that that money will go back into medical services rather than into general revenue?

Prof. MEREDITH — That is a very good question. Medical tourism is one of the potential enterprising models that we could use to fund a highly effective public health service. There is also medical education and training. There is also med tech research and contract clinical trials. There are many other things that we could actually do in that space. We have modelled various types and sizes of medical tourism facilities to put funds back in, and that may have to grow in accordance with the growth and needs of the hospital in general. The question you asked is not that simple to answer other than to say that we would want to provide a service that would contribute financially to the hospital, and it is our understanding that all revenue raised from those activities would indeed go back, but that would be dependent on the governance structure and things well beyond my pay grade to decide. Do you want to comment on that?

Mr STRIPP — Just, if I may, a couple of things. What we are talking about is doing a business case which has the inclusion of increased capacity, not the substitution of public capacity, for medical tourism — or private capacity — but increased capacity to enable that area of development to be undertaken. As Ian has alluded to, we do that on the basis of an analysis of whether that is sound for us to pursue. We do that then in the context of saying that revenue would come back into Monash Health as the overarching governing body, with a focus on continued growth and development of the research and the services of our cardiovascular service, the Victorian Heart Hospital. So I think the simple answer is yes, and it is around not doing it instead of but about adding capacity, which is why we do not pursue that today — because we do not want to see a substitution of service. It is an additional service.

Ms HARTLAND — What is your current catchment?

Mr STRIPP — In terms of size?

Ms HARTLAND — Yes.

Mr STRIPP — It is around 30 per cent of the state's population, so it is fairly substantial. It is about 1.5 million people and rapidly growing.

Prof. MEREDITH — Just on that topic, we provided 16.8 per cent of the public cardiovascular services in Victoria out of one hospital.

Ms HARTLAND — Is this a model that could or should be replicated? I am in the western suburbs. My big bugbear is Footscray Hospital, which is literally falling down around them. It often appears to me that medical care is done on how marginal your seat is rather than actual need. I am really interested in this model, and I am really interested to see whether this could be replicated in other areas — in the west or the north, particularly with those huge growth areas. Do you think that is something that could be done?

Mr STRIPP — This model being a standalone heart hospital, or the medical — —

Ms HARTLAND — Yes.

Mr STRIPP — Sorry, just checking. I think it is an option of course that can be done. Whether you have more than one heart hospital with Victoria's population, I think, would require more analysis and careful consideration. We have a comprehensive cancer service. That of course sits alongside a range of other cancer services. Monash Health has a substantial number of cancer services, as do other hospitals. What we have is a concentration of a centre of excellence. We would expect that, for instance, the heart hospital provides that opportunity for a centre of excellence and partnership with other services. Given the question of how that would be replicated around the state or whether there are other domains that you would pursue in others, is it possible? Yes. You would just want to go through the analysis, given the size of our community overall.

Ms HARTLAND — Thank you.

Prof. MEREDITH — The idea of hub-and-spoke models of care, though, where you can concentrate to get volume and quality, is really the way to go forward, and there should be pillars that meet the requirements of each of the segments of the city and the state.

Mr STRIPP — We have some examples of excellence in that in Victoria already.

The CHAIR — I have just two final questions. With regard to the planning process that you are going through at the moment for the heart hospital, do you have an expected completion date for the planning of the hospital?

Mr STRIPP — The business case is under development at the moment. We are working closely with the university and the Department of Health and Human Services. My understanding is that that business case will go to government sometime this year. I am not familiar with the exact date. We would hope that that would be fed into government processes around a decision on the nature of the facility and the funding envelope.

The CHAIR — That was going to be my final question in terms of the overall cost of the project. Can you give us a ballpark figure in terms of what the expected cost of the hospital might be?

Mr STRIPP — Again, we have got architects, planners et cetera working on that exact question, so I do not have a precise dollar figure that I can give you. If you have a look at similar types of constructions, in terms of where we are up to it is going to be somewhere in the order of $300 million to $400 million, but it could be a bit more or it could be a bit less. It will depend on the exact refinement of the option that is decided on.

The CHAIR — If we were to say in the vicinity of $400 million, we would not be terribly off the mark?

Mr STRIPP — No.

The CHAIR — Thank you very much, gentlemen, for your evidence today. You will be provided with a transcript of today's evidence for proofreading, and ultimately that will make its way onto the committee's website. Once again, thank you very much for your attendance today.

Witnesses withdrew.