Submission No 225

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Organisation: Australian Salaried Medical Officers' Federation of NSW

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Introduction

The Australian Salaried Medical Officers' Federation (ASMOF) is the Doctor's Union, representing over 5000 Registered Medical Practitioners in NSW including Staff Specialists, Post Graduate Fellows, Clinical Academics, Career Medical Officers, Interns, Resident Medical Officers and Registrars.

We thank the Committee for the opportunity to contribute to this Inquiry as we believe it is critically important, not just for the local community and staff, but also for the ongoing delivery of health services in NSW and Australia more broadly.

As the Doctors' Union it is our mission to protect and promote the best working conditions for our members, ensure doctors wellbeing across a range of domains, and advocate for a high quality public health system that promotes equitable health outcomes.

ASMOF has been closely involved in the progression of Northern Beaches Hospital (NBH), and we have been outspoken advocates for our members who have transitioned to, or have been subsequently employed at the Hospital. We have worked alongside Healthscope and NSW Health to resolve many concerns on behalf of members, and will continue to remain a strong voice for our members to address ongoing concerns, including, most importantly, patient safety.

Through discussions with our members and negotiations with Healthscope, it has become abundantly clear to us that Healthscope was inadequately prepared to establish and run NBH. They demonstrated that they have little expertise in delivering public hospital health services, and concerningly, have actively resisted identifying NBH as a public hospital or integrating NBH into the public health system.

The inadequacy of preparation to plan and set up the hospital, and failure to genuinely consult doctors, has had lasting impacts on service delivery, patient care and staffing not just at NBH, but across the broader Northern Sydney Local Health District.

Whilst we do not suggest that the hospital be declared a failure, it is fair to acknowledge that any improvements of the hospital to date can be attributed to sustained pressure from ASMOF and Unions and other advocates, and the enormous efforts from staff employed at NBH.

Doctors' contribution to the establishment and ongoing running of NBH was and continues to be critical. Our members are dedicated professionals who have gone above and beyond for the hospital, at times without payment, because they are committed to seeing the hospital thrive, and deliver high quality care to patients and the community.

ASMOF continue to oppose the model of Public Private Partnerships (PPP) on the grounds that they have a long track record of failure. We maintain that the fundamental rationale for PPPs, that a private operator will deliver better value for money than the Government, is patently false and misleading.

Our submission suggests that the fundamental flaws in the PPP model have played out in the establishment and running of Northern Beaches Hospital to date. Hallmarks of the PPP model including short-sighted cost cutting and secrecy have thrived, unchecked by NSW Health.

The recently revised ownership of Healthscope to Brookfield, a private equity business, is likely to further change priorities of the organisation from providing excellence in healthcare using a private hospital model to maximising profit.

We continue to be committed to making Northern Beaches Hospital a safe, enjoyable and professionally stimulating environment for all our members providing appropriate and safe patient care. However we hope that lessons will be learned from this exercise, and that calls for greater oversight and transparency of NBH are heeded. We have made 11 Recommendations which we believe are needed to address ongoing issues faced by the NBH.

ASMOF had consulted with our members working at Northern Beaches as well as Royal North Shore and Mona Vale in order to address all the Terms of Reference of this Inquiry. We have included a range of direct quotes from doctors which have been included in text boxes throughout this submission. Many of our members are concerned with maintaining their confidentiality through this process and quotes are presented anonymously with identifying details removed.

Recommendations:

1. Ongoing, formal consultative processes should be set up between ASMOF and other health Unions, Healthscope and NSLHD.
2. Provide complete information about NBH's KPIs, and the performance of NBH to date.
3. Urgently review staffing across the hospital in consultation with medical staff and ASMOF, and take action to increase recruitment of permanent staff, including junior doctors.
4. Take urgent action to ensure that the eMR system is functional and compatible with NSW public hospitals systems.
5. NSLHD and Healthscope take action to further integrate the hospital into the District.
6. Healthscope and NSLHD work collaboratively to map existing service provision, identify gaps and undertake district-wide planning to ensure that patient and community needs are able to be met.
7. Urgent action from Healthscope and ACL to address issues with the delivery of pathology services.
8. Improve engagement with JMOs to address concerns including responsibilities for private patients.
9. Commitment from Healthscope to honour and retain the existing conditions and entitlements enjoyed by senior doctors in NSW Health.
10. The NSW Government abandons the PPP model in future hospital planning.
11. Greater oversight of NBH from NSW Health to ensure standardisation with NSW public hospitals, including consideration as to whether Healthscope should operate as an Affiliated Health Organisation under the Health Services Act.

1. Set up to fail? Establishment of Northern Beaches Hospital

a) the contract and other arrangements establishing the hospital

e) staffing arrangements and staffing changes at the hospital

In December 2011 the state of NSW signed a contract with Healthscope to design, build, maintain and operate the Northern Beaches Hospital in French's Forest, a privately licensed level 5 hospital. Key aspects of the Project Deed were kept confidential and are therefore unable to be scrutinised adequately.

Many of our members feel there was inadequate information about exactly what NBH would be providing, and what was agreed to within the Northern Sydney Local Health District (NSLHD).

> ❖ 'It wasn't clear from outset they would be providing, no one really knew. We were not able to find out what the agreement with the NSLHD'

Healthscope implemented a strategy of artful deception for nearly four years by deliberately avoiding talking with the unions and community on important project information such as costs, proposed models of care, quality and conditions of employment.

A summary of the contract released by the NSW Government on 29 June 2015 provides some details around key principle and objectives of the Hospital.

The agreement provides for an expansion of specialties and increase in the level of acuity, improved accessibility, greater choice for patient and improved clinical outcomes.

The Contract summary also states a key rationale for the arrangement:

> 'Partnering with one of Australia's leading health care providers allows Northern Beaches Hospital to be built faster and at a reduced cost to the taxpayer…. The money saved on the capital and long-term maintenance costs can be reinvested by the State into frontline health services.' (p.7)

Section 5 of this submission will examine the model of Public Private Partnerships (PPPs), and finds current evidence supporting the rationale is completely lacking.

The remainder of this submission highlights the impact of this rationale as it has played out at NBH to date. Cost saving, cutting corners and inadequate planning for the establishment of NBH has had a lasting impact on staff, service delivery, patient care, and the hospitals capacity to integrate into the NSW public health system effectively.

1.1 Establishing the hospital

It was clear from the outset to our members that the Project was woefully short of people and that resourcing constraints were compromising Healthscope's capacity to meet the requirements of the Project Deed and make appropriate arrangements to set up and run the hospital.

Our members noted that there were initially only two points of contact at Healthscope who were completely overwhelmed with the task at hand- with one being impossible to contact. These overloaded Healthscope staff members were responsible for a huge range of tasks, including project managing construction as well as service planning.

It seems that lessons from previous models were not taken on and Healthscope appeared resistant to utilise the resources and expertise residing within existing NSW Health Services.

- 'There is no corporate memory going from hospital to hospital'
- 'They appeared to have developed a model based purely from a business perspective and as far as I am aware had no experience in running a public hospital'
- 'Healthscope envisioned specialists in their room bulk billing'

For example NSW Health offered to Healthscope to adopt their policies in relation to many clinical matters, and were rejected by Healthscope who said they had their own, despite a lack of evidence of this, and having little to no capacity to develop their own policies prior to the hospital opening.

Senior doctors employed at Royal North Shore Hospital (RNSH) who attempted to meet with Healthscope and staff within the LHD to co-ordinate services were routinely ignored.

- 'The big issues in [Department] that were ignored from our perspective at RNSH were:
  - A lack of desire to co-ordinate with existing services in NSLHD in terms of shared treatment protocols, data collection, care co-ordination, patient transfers, MDTs [Multi Disciplinary Teams] and so on. They actually had no idea about [Department services] and could not be educated.
  - A lack of interest in having staff with cross accreditation between NBH and existing centres and involving us with their staff appointment process
  - No plans for palliative care.
  - No realisation that a teaching hospital requires staff functioning at a higher level than district hospitals.

  Every time we tried to educate them we were told that they had run hospitals before.'

The dismissal of the views of senior clinicians with years of experience in health service delivery reveals that Healthscope failed to understand their responsibility to operate effectively as a public hospital or integrate into the existing service environment. This was also clearly demonstrated through the examples of the hospitals Haematology services:

Haematology

The Haematology Department at Royal North Shore proactively sought involvement to integrate with NBH, but their request was declined. At a meeting less than 2 weeks prior to the opening of the Beaches, Healthscope stated that there was no need involvement from the Royal North Shore (RNS) Haematology Department. Approximately 4 days before opening NBH realised there was no Haematology services, and so RNS were called upon at the last minute to provide a 24 hour/7 day a week phone consultation service.

The initial agreement was to provide coverage for a period of 8 weeks. However, the arrangement continued into February, with NBH seeking further extension.

Members disclosed to ASMOF their serious concerns with respect to patient care, workload and loss of income. Members advised that they had no access to the medical records and imaging at NBH and could not enter information into the NBH medical records. They have no way of documenting the request for and provision of advice. They provided care outside of any normal or reasonable circumstances.

Doctors were of the firm view that systemic provision of advice under such inappropriate conditions must cease. At the time there no effort on the part of Healthscope to provide appropriate haematology support at NBH. Only with further escalation were the issues resolved.

The development of appropriate policies, systems and models of care was also hampered by the inability for staff transferring to NBH to work on these matters prior to opening.

Staff were told that NSLHD would not release staff to work on set up of NBH. Some reported that they were later advised that Healthscope didn't have the resources to undertake adequate consultation processes regardless.

- 'the opportunity was there to get help from people who weren't employed in the district- they didn't'

- 'the changeover meant on one day you were employed by NSW Health and the next by Healthscope- there was virtually nobody to set the hospital up.'

Senior and junior medical staff instead put in many hours of unpaid work, including working after hours and weekends because of their concern to ensure that hospital was able to adequately and safely manage patients.

Even when they were able to provide input, members have provided examples of when their concerns and expertise were not heeded. Senior doctors warned that a model of care proposed that didn't involve Junior Medical Officers was not going to be effective, as patients are too medically complicated, but they were ignored:

- 'The model of care for critical care (where there was insufficent qualified medical and nursing staff to provide the model adequately) and private medical inpatients (where a model with minimal onsite junior staff was proposed despite the strong warnings of experienced doctors) were particularly bad…this placed a great strain on the junior staff. Things needed to change'

Instead it appears Healthscope viewed themselves as a private entity that goes about things its own way. The absolute failure to make arrangements for doctor's time and input in setting up the hospital showed a complete lack of awareness of how to run a public hospital.

It also appears that NSW Health had no control or oversight of this process and the inadequate investment being made in setting up the hospital.

It resulted in models of care and staffing arrangements not being properly established prior to opening. It culminated in Northern Beaches chaotic opening, and unacceptable level of risk to patients upon opening.

1.2 Staff Contracts

Since 2013, when it was first announced that the NBH would be a privately-operated hospital, ASMOF fought to ensure that medical staff who migrated to NBH have their entitlements guaranteed and protected.

As a result, the NSW Government made a commitment to all migrating staff that all existing conditions and entitlements would be protected for two years.

For three years prior to the opening of the hospital ASMOF and the other Health Unions were tirelessly seeking answers from the organisation regarding basic information relating to the appointments of our members, and the services to be provided. We were reassured that existing terms and conditions would be honoured to ensure that the hospital attracted the best doctors.

In spite of this commitment, Healthscope's approach to senior doctors' contracts who were migrating to NBH from public hospitals turned out to be unfair and disrespectful. We were shocked by their disregard for the rights of the senior medical practitioners who were soon to be Healthscope employees.

- 'I received my contract the day before I started and I know there were a number of VMOs who withdrew from their positions due to lack of clarity and refusal to pay superannuation.'

On Friday 5 October 2018, at 2.41pm, a few weeks out from opening, Healthscope sent ASMOF the contracts for our members and offered us till COB Monday 8 October to provide comments. We naturally sought an extension to this to be able to review the contents properly, which was not accepted until the following Friday. By 9 October 2018, only one day later, the majority of Staff Specialists had received their letters of offer for signature.

The employment conditions offered to our members were inferior to the conditions previously promised by Healthscope and the NSW Government and were in breach of the Project Deed the Staff Specialist (State) Award and Determination, and the relevant Policy Directives.

Healthscope cherry picked provisions from the Award and Determination, creating ad hoc Training Education and Study Leave (TESL) and billing arrangements specialists with the intent to pressure them to agree to the terms preferred by Healthscope. The driving agenda was clearly to reduce the costs of paying specialists their correct salary on migration to NBH.

There were additional matters included in the letters of offer that did not match fundamental conditions, such as ordinary hours of work, duties and responsibilities, recognition of continuous service and leave entitlements and part time working arrangements. They were also significant omissions regarding core fundamental terms for the appointment of senior medical officers such as credentialing, scope of practice and clinical privileges.

The offer also contained a significantly less favourable condition relating to their medical indemnity which was not provided to ASMOF in the draft letters of offer.

ASMOF advised members not to sign the contracts until Healthscope amended and reissued them.

Only through urgent and vigorous negotiations were ASMOF were able to secure fundamental terms and conditions for our members. We were able to achieve this with the support of the Northern Sydney LHD Chief Executive.

Under sustained pressure, Healthscope clarified important conditions for Staff Specialist's unique employment at Healthscope, including indemnity, managerial allowance, election of private practice, and the zero payment of infrastructure charges or other levy's relating to rights of private practice. Healthscope further conceded and agreed to provide access to TESL funding generated from the billings of senior staff specialists, a condition they vehemently opposed previously.

ASMOF is certain that the poor processes surrounding the hiring of staff has deterred doctors from working at the hospital, and contributed to ongoing staffing issues.

2. A calamitous start- opening of Northern Beaches Hospital

b) changes to the contract and other arrangements since the opening of the hospital

d) standards of service provision and care at the hospital,

e) staffing arrangements and staffing changes at the hospital

When Northern Beaches did open on 31 October 2018, the inadequate preparation in setting up the hospital was exposed, despite repeated assurances from Healthscope that everything was good to go.

Within hours of the official opening of the hospital, reports of a litany of issues began to emerge. Anaesthetists threatened to cancel all elective surgery due to severe staffing and equipment shortages and other systemic problems.

Within days of the Hospital's official opening, the Chief Executive resigned. Shortly after, senior medical staff passed a vote of no confidence in the Director of Medical Services, who also resigned. The accounts of our members working at NBH and Royal North Shore Hospital reveal the extent of the chaos and the risks to patients, with the view that disaster was only narrowly avoided.

- 'The initial Healthscope management seemed overwhelmed and were almost impossible to communicate with during the opening weeks…

  It was only due to the hard work and professionalism of the junior medical staff (in particular), nurses, allied health and senior medical staff that the first few weeks were not disastrous.'

- 'there was no overhead system- so alerting doctors of an emergency was not possible- after a few days of drama we had to buy walkie talkies. ..

  When setting up [Department] we went down to 2 rooms - one had gear from a hospital they had closed in Victoria and one had new stock- and just wandered around trying to find things. We just took what we wanted.
  Much of the gear we could choose from was not compatible - for example we had Paediatric defibrillation pads- but they did not fit the defibrillator we had. We had cardiac blood pressure cuffs- but not the brand that fitted the machines we had. Different wards ended up choosing different monitoring, so things do not fit from one department in the hospital to another.

  We had critical lack of gear- some vital drugs were not available for weeks- when a premature Newborn was delivered the hospital was scoured for prostaglandin to keep the baby alive and surfactant to help it breathe. There was none- this is criminal for a hospital that says it is ready to deliver babies. These drugs were eventually sent by taxi from Royal North Shore.'

- 'In the first month I saw many patients who had waited 90 min and hadn't been triaged so left and drove here; some who were triaged and found it so traumatising they left to come here (reports of nursing staff close to tears during triage process and clearly feeling pressured)…
  Many patients reported lack of basics (Panadol etc) that influenced their perceptions of care'

Doctors-in-Training (DiTs)/Junior Medical Officers (JMOs) were particularly impacted by the inadequate set up, and were frustrated by management inaction to address their concerns. They

provided ASMOF with detailed information regarding these serious concerns which had gone unanswered and unaddressed. In November 2018 these included:

- Acute staff shortages, lack of organised relief arrangements
- Lack of essential supplies, eg. resuscitation trolleys not being stocked, oxygen not available, no-on site blood bank, insufficient hand hygiene pumps, no safety cannulae, medication shortages.
- Inadequate and unsafe supervision
- Inequitable patient loads
- Excessive and unsafe hours being worked - often unpaid
- Lack of Policies/Guidelines/Forms for critical care e.g.: no separate forms for insulin administration exist; no emergency management plan for hypoglycaemia to allow nurses to administer urgent medication; no forms for heparin infusion; no stroke calls; no tiered escalation of deteriorating patients as required by NSW Health Policy Directive and guidelines regarding deteriorating patients.
- Limited access to basic entitlements, eg. limited study leave, unsuitable accommodation arrangements, locked out of on-call rooms for doctors to rest when fatigued
- Inadequate internal communication systems (e.g. phones supplied do not receive signal in parts of the hospital)
- Delays for urgent tests.
- Inadequate Health IT system, reports difficult to view, and in many cases appear as blank pages.
- Poor orientation: few employees were familiar with equipment and processes. An example was difficulty and delay in obtaining blood for a patient suffering from post-partum haemorrhage due to staff not being familiar with the process to obtain the necessary probably life-saving blood product.
- Medico-legal issues

These issues were not ‘teething problems’ or ‘hiccups’ as described by the Premier and Minister for Health. Junior doctors are able to distinguish between ‘teething problems’ which they expected and were prepared to work through, and systemic issues which presented real challenges, which should have been foreseen and eliminated with proper planning before opening.

The dedication of the junior doctors to their patients and colleagues allowed them to work around those challenges and to implement their own ad-hoc systems to ensure patient safety at some not insignificant cost to their own well-being.

These concerns lead to, what the Sydney Morning Herald described as ‘an extraordinary letter’ from ASMOF to the Secretary of NSW Health on Friday 16 November . ASMOF wrote to the Ministry outlining our belief that a range of items within Project Deed between the operators of Northern Beaches Hospital and NSW Health and the Government of NSW were not being complied with.

Those provisions included:

- 59.5.c.i: JMO Positions must be directly associated with the treatment of Public Patients;
- 59.5.d.iii: Operator must provide JMOs with appropriate and adequate supervision at all times.
- 59.5.d.iv: Operator responsible for providing safe working environment for JMOs at all times.
- 59.5.d.v: Operator responsible for managing attendance of JMOs…including rostering and covering absences.

To the Ministry's credit, ASMOF was contacted immediately to discuss the letter and an urgent, peak level meeting with ASMOF, The Ministry of Health, HealthScope, NSLHD and AMA NSW was scheduled for the following Monday morning. This was at the same time as the official opening of the NBH and required several key personnel who would have been expected to attend the grand opening to attend this more pressing meeting.

The parties to the Monday meeting at the Ministry resulted in a joint statement with four key principles:

1. Healthscope, ASMOF, AMA, NSLHD & the Ministry agreed to meet weekly to discuss emerging issues;
2. Healthscope is to ensure that JMO workload distribution is appropriate to the number of patients;
3. The working group is to be the primary channel of engagement and to have consistent messaging to the community and staff;
4. Healthscope is to create more efficient internal engagement channels to allow issues to be raised and addressed, anonymously where appropriate.

These measures contributed to improvements at the hospital, however ASMOF believe that a re-commitment to some of these measures is required to ensure that ongoing issues (identified in Section 3) can be addressed.

The difficulties encountered in the first months of the hospitals operation once again revealed a gross misunderstanding of what is necessary to run a major public teaching hospital with nearly 500 beds, and a failure to implement proper systems and processes. The doctors at NBH were nothing short of heroic in ensuring patient safety in the face of significant logistical, staffing and other operational challenges.

Recently ASMOF's concerns about staff and patient safety were further vindicated by the independent accreditation authority- Health and Education Training Institute (HETI). HETI's December 2018 report (which was only publicly released last month) raised concerns with staff shortages, an unreliable paging system, and delays in test results, among other issues. It showed beyond a doubt that the challenges were not 'teething problems'. Our persistence in seeking access to the HETI Reports would not have occurred without our lodging a GIPA request, which was initially denied, and then appealed via NCAT.

Indeed it is only because ASMOF and our members agitated so strongly that there were significant changes to the operation of NBH. For this reason ongoing formal consultation processes with health unions and health staff is essential to ensure that the hospital is proactive in addressing concerns.

Recommendation 1: *Ongoing, formal consultative processes should be set up between ASMOF and other health Unions, Healthscope and NSLHD.*

3. Rapid repair- improving care to the community

c) ongoing arrangements for the operation and maintenance of the hospital

d) standards of service provision and care at the hospital

e) staffing arrangements and staffing changes at the hospital

Massive pressure was placed on Northern Beaches Hospital to fix the gamut of issues facing the hospital, and ASMOF believes that significant improvements have been made since we raised our concerns in November last year.

- 'The new management team listened to staff and provided resources appropriately. The models of care were changed. Additional junior staff were recruited. The dysfunctional emergency alert system was overhauled. This has resulted in major improvements. While things are not perfect they are now functioning well'

- 'I am proud of the safe, consultant-led care that our patients receive. We have a strong safety culture among clinicians who seek to deliver the best care possible, who learn from the adverse events and near misses which occur in all health systems.'

Doctors and nurses have worked tirelessly with the new management to develop policies, address staffing issues and develop sustainable models of care of the hospital.

Many junior and senior doctors now report that they enjoy working at the hospital, and find the atmosphere of the hospital to be collegiate.

- 'the [Department] has a large team of motivated, up to date, enthusiastic consultants and has cared for some critically unwell patients including young children, young adults and older patients… the support we show each other within and between departments is better than most other hospitals I have worked in. I would certainly bring my children here if they were injured or unwell.'

Some examples of improvements identified by senior doctors include improved services, such as the establishment of a Medical Admissions Unit (MAU), which was previously completely rejected by management, but is now in place. There are increasing outpatient services and extra capacity in services such as aged care, which doctors believe are running well. Some high risk policies have also been ticked off and there is greater policy consistency with NSW Health.

The perspective of some of our members at NBH is that hospital is now performing well, and that service offerings in fact exceed care previously provided in the district, although some of these services are only available to private patients (as allowed for in the Project Deed):

- 'I would say that these [standards] are now high. The ED is busy but performing well. A wide-ranging aged care service is working effectively. There is now access to palliative care. The population of the Northern Beaches is now considerably better served than previously with direct Consultant care in many specialties (Cardio, Respiratory, Neurology, Renal, Haematology) that were not feasible in Manly/Mona Vale. Services such as EEG are now available…
  the standard of specialist care is higher and facilities for public patients are undoubtedly better.'

- '…many medial subspecialties now being available (geriatrics, haematology, MAU) and surgical specialities that were not present at Mona Vale or Manly, representing a definite improvement in the level of service provision.'

- 'The Northern Beaches Hospital now offers higher levels of acute patient care that was available before. Examples include:
  - Emergent cardiac catheterization and surgery (previously not available)
  - Low dose CT scanning for children (previously not available)
  - Access to onsite MRI scanning (previously not available)
  - Elective birthing from 32 weeks gestation (previously 36), with 14 Special Care Nursery beds
  - Well-equipped theatre complex with 17 operating theatres
  - Onsite and on-call Interventional Radiology (previously not available)
  - Increase in sub-specialties onsite (neurology, renal medicine, haematology, endovascular surgery)
  - Increased Emergency Medicine consultant cover
  - Higher level Intensive Care Medicine services including 20 ICU beds'

Doctors also see significant potential in the hospital to continue improving the standards of care at the hospital even further.

> ❖ 'While the systemic issues remain a barrier to the delivery of safe and quality patient care, the staff (clinical and non-clinical) work above and beyond to compensate for these issues and to ensure patients receive healthcare at the expected standard.
>
> Provided that the broader systemic issues … (staffing, eMR and pathology) continue to be addressed, I believe that NBH still presents an enormous opportunity to create a centre of excellence for healthcare.'

Some senior doctors also report that patient satisfaction at the hospital is high.

However it remains difficult to make conclusive judgements on how much the standards of service provision and care have improved NBH due to a lack of publicly available information, and lack of transparency around the hospitals Key Performance Indicators and whether they are being met.

There also appears to be a lack of consistency between the KPIs set for other hospitals in the NSW public health system and those for NBH.

Recommendation 2: *Provide complete information about NBH's KPIs, and the performance of NBH to date.*

4. Challenges remain- ongoing risks

c) ongoing arrangements for the operation and maintenance of the hospital

d) standards of service provision and care at the hospital

e) staffing arrangements and staffing changes at the hospital

f) the impact of the hospital on surrounding communities and health facilities, particularly Mona Vale Hospital, Manly Hospital and Royal North Shore Hospital

Although aspects of the hospital have undoubtedly improved, members continue to raise with us their concerns around ongoing systemic challenges. Whilst some challenges are to be expected as the hospital matures, as we approach almost a year of NBH's operation, these issues are well overdue for resolution.

Many of these issues stem from the poor planning identified in Section 1, and continue to reveal fundamental flaws in the PPP model. They also demonstrate that Healthscope has maintained their ideological belief that NBH is a private hospital, rather than a privately operated public hospital.

4.1 Staffing & Recruitment

NBH staffing arrangements continue to be unstable across the hospital and have placed junior doctors at particular risk. Adequate staffing levels and lack of permanent staff are a current concern for our members.

- ‘A more stable workforce is something to work on.’
- ‘there is a heavy reliance on locum staff (JMOs) and VMOs [Visting Medical Officers] which is not ideal from a budgetary or morale point of view’
- ‘Currently and for the foreseeable future, there are not enough JMOs to complete the workload within ordinary hours
  - Patient loads are in excess of what is expected, appropriate and safe
  - Present team allocations are insufficient to ensure safe and quality patient care
  - Medical and surgical teams in particular are not “right-sized”
  - Between ordinary, overtime and on-call hours, Registrars are generally working far in excess of safe hours
  - Leave (including sick leave and ADOs [Allocated Days Off) is generally not covered. It is not uncommon that multiple teams are absent a member’

An unreasonable workload is forcing junior doctors to undertake unacceptable and unsafe overtime, with subsequent risks to patients and doctors themselves.

A lack of permanent staff can have a de-stabilising effect on health services and disturb continuity of care. There is a particular reliance on locums for senior medical coverage on night-shift. Whereas public hospitals are bound by a range of staffing requirements including that agency and casual staff are to be minimised, NBH does not have the same requirements.

There are mixed reports from ASMOF members as to whether senior clinician’s expertise on appropriate staffing models has been listened to. Some senior doctors report that management has heard what is needed, and these doctors have been able to develop adequate staffing models for their Department. However other members have reported that there has been no consultation with senior doctors about where gaps are, and requests for staff with certain specialised skills have been ignored.

ASMOF members have also raised issues around recruitment processes and transparency. Some senior doctors have reported that they are unaware of how hiring decisions are made, and that there also appears to be inconsistencies in which doctors participate in the public roster.

A lack of proper processes around recruitment provides fertile ground for favouritism and the potential for discriminatory employment practices, and there is every possibility that this is occuring.

- ‘There is no formal process…favouritism thrives’

There appears to have been insufficient processes in the appointment of 'Craft Group Leaders'- who have been appointed in lieu of traditional Heads of Department. The way these leaders were appointed/elected was not transparent, and members have reported that their roles and responsibilities are not clear. Management have stated that Heads of Department positions will be established, but this has not yet occurred.

The NSW public health system has a rigorous approach to recruitment of medical staff, which is designed to ensure that there is fairness and transparency in appointments. Recruitment of doctors at NBH must be looked into to ensure consistency with best practice standards.

Recommendation 3: *Urgently review staffing across the hospital in consultation with medical staff, and take action to increase recruitment of permanent staff, including junior doctors.*

4.2 Electronic Medical Records

Challenges associated with the hospitals Electronic Medical Record system, provided by Telstra Health, are having a big impact on the day to day work of our members, and represent a risk to patient care.

- 'now one of the biggest day to day problems'
- 'The EMR system we use is not great. One [Department] visit generates 5-8 nursing notes- nobody has time to trawl through that- and the doctors cannot edit a document- also meaning multiple documents are generated.
- We are constantly told it will be fixed but I haven't noticed significant improvements.

Doctors have reported that they were initially misled about what would be provided, and were assured that there would not be 2 record systems.

However medical staff must now navigate multiple systems. Members report the eMR system has poor functionality, is frustratingly slow, and is prone to failure. It does not support the kind of team-based care that is delivered in a public hospital, and instead appears to have been developed with individual clinicians in rooms providing care in mind.

Most alarmingly, the dysfunctional system is incompatible with public systems, which is affecting the free flow of essential patient information which is necessary to provide safe patient care.

- 'The communication between Northern Beaches and North Shore is very substandard and that's having the biggest impact on patient safety. We are not able to view the patient medical record, radiology and pathology… we are operating behind the 8 ball to start with.

  So much depends on IT being fluid. Clinical records, medications, all should be readily available on Powerchart and we used to be able to see that with Manly and Mona Vale Hospitals… standards of referral have gone now.'

- We can't see any old pathology or notes from NSW health unless we go find a computer (there are only a couple in the hospital) that will log you into the NSW Health system. This is very dangerous.'

- 'As a clinician, you can't read what the medical assessment was as no access to records unlike prior manly/Mona Vale records which is problematic as many patient share their care across the 2 sites.

  Similarly can't read their discharge summaries as can with e-health from other LHDs eg Gosford, tweed heads, children's hospital
  This is a retrograde step and the hospital should use the same eMR [Electronic Medical Record] as every other public hospital in the state to ensure the information can be shared.

  Staff who work there report not being able to switch through screens so can't see the results of a patient as you look at documentation vs triage etc, so very poor functionality of the system which increases the risk of error'

The Cerner Health Information Exchange (HIE) product, which was planned to improve integration and provide a read-only view from NBH into the NSLHD Cerner PowerChart system, is still not functional.

The provision of health IT has been contracted out to the lowest bidder, and they have delivered a subpar service. Change has been promised but not delivered. ASMOF suggests that the medical record system should be upgraded as a priority, as it is represents a risk to seamless patient care within NSLHD.

Recommendation 4: *Take urgent action to ensure that the eMR system is functional and compatible with NSW public hospitals systems.*

4.3 Integration within Northern Sydney Local Health District & NSW Health

The contract summary of Northern Beaches repeatedly refers to the importance of integration, with reference to an 'integrated hospital', 'integrated health care' and 'integrated services' in its scope and objectives. However ASMOF members working in NSLHD have found very little evidence of any attempts at integration. They have been left in the dark where there should be strong working relationships, and members believe co-ordination of care is suffering as a result.

Issues with medical records are one important factor which are affecting the capacity of NBH to integrate effectively into the NSLHD.

- 'They can fix up the clinical services as much as they like, but unless they fix up the IT the whole relationship between Northern Beaches and North Shore is going to be fraught.'

Our members working at Royal North Shore and Mona Vale report uncertainty as to exactly what services are provided at NBH, and there appears to be a profound lack of communication between the hospitals. There is also a complete lack engagement structures which would be expected of health services working together to deliver truly integrated health care

- 'The setup is still less than desirable and there is no co-ordination of care across the district. A huge opportunity has so far been lost.

  We should be running with the same protocols and same systems (medical records and electronic systems) across the LHD. There should be clinical groupings in each sector that meet regularly to manage care and discuss relevant issues (i.e. a cancer group, a surgical group, a paediatric group etc). NSLHD staff should be on medical appointment committees at NBH. It shouldn't be this private silo working in isolation with staff they can attract. It should be a seamless co-ordination of care between public and private centres. We are their friends and supporters, not their competitors.'

The working environment for our members at RNSH and Mona Vale has changed, and some members identify that their workload has now increased which will be further explored in **4.4 Service gaps and impact on NSLHD.**

Members at RNSH are clearly concerned about the ongoing performance of NBH and how it will affect the hospital and service provision in the district.

- ‘My greatest fear is given the Beaches diabolic performance so far, in the very near future they will be bought to their financial knees and come crawling back to the government for a major cash injection or further cut services. One can only assume that any money sent in their direction will come out of the RNSH budget which is already facing financial crisis. The end result will be 2 x C grade public facilities and decimation of the world class departments developed at RNSH over a century through staff dedication and millions of hours of unpaid work.
The increasing and aging public in our catchment area deserve much better…’

Measures to support NBH’s integration into NSLHD that will support the optimal delivery of care are urgently needed. This should include formal consultative processes, joint planning, and shared responsibility for outcomes.

It should also be supported by a compatible policy framework. ASMOF is advised that only a handful of clinical policies have been developed, far short of the many dozens required by a major public teaching hospital

Recommendation 5: *NSLHD and Healthscope take action to integrate the hospital into the District.*

4.4 Service gaps and impact on NSLHD

ASMOF members have identified that there continue to be gaps in services provided by NBH, and this is particularly affecting our members at Royal North Shore Hospital. For example a senior doctor has provided ASMOF with evidence that services that were previously provided free of charge have now been discontinued, resulting in increased pressure on the public system, and diminished equity for public patients.

- ‘I work at RNSH. There seem to be a few patients either bypassing NBH or transferred from NBH A+E [Accident and Emergency] because that service is not provided e.g. that particular sub-specialty service is not provided.’

- 'A colleague of mine and myself provided a free specialist outpatient clinic at Manly Hospital to patients on the Northern Beaches. Healthscope discontinued these clinics despite schedule 14 clearly outlining the provision of this clinics - even an expansion. The view is that private specialists can provide these services to patients on the Beaches in their private rooms which of course is not bulk billed and therefore not accessible for all patients who cannot afford private gap fee in excess of $200 per consult…

  This has led to a significant increase of these referrals to Royal North Shore Hospital who is beyond its capacity to provide outpatient services to our community. For example the current waiting time for non-urgent general neurology outpatient appointment in Royal North Shore Hospital is longer than 1 year clearly outlining the demand for such services.'

- Firstly, patients. In my last week of work, I personally had several patients recently treated at the Beaches who decided to self-present to RNS. All were complex..

  Secondly, Ambulance Service NSW. Numerous times I have been told that they have bypassed the Beaches as they are unsure if they will be appropriate or require secondary transfer …

  Thirdly, GP's. ..I have received numerous calls from GP's referring patients out of area to RNS, as either they do not want to refer to the Beaches or the patient wants to come to RNS. Admittedly this happened prior to the Beaches opening, but has increased in my experience. Explaining to GP's that I will not accept patients that should present to the Beaches represents another hard to measure waste of everyone's time.

  Clearly my personal feeling is that the Beaches Hospital has not lessened our work load. Indeed, I feel that it has created a complex environment of patient and ambulance service uncertainty that has led to a higher work load at RNS that numbers alone do not reflect, nor tell the whole story.'

Other members have also pointed to an increased demand on RNSH services when certain specialities are not covered at NBH, or when patients self-select to attend RNS due to their view that they will receive better care.

ASMOF have also been advised of issues with:

- Mental Health Drug and Alcohol Services: lack of comprehensive services. This affects our members as they have to work at NBH even though they are not employees, in order to provide cover for patients seeking these services.
- Outpatient services: continue to be developed, but gaps still exist.
- Transport for clients seeking outpatient services can not be provided which results in patients needing to seek treatment further from home.

Once again a lack of transparency around the services that NBH was contracted to provide and what is currently being provided is affecting the delivery of comprehensive care. A co-ordinated approach to meeting unmet patient need is desperately needed.

Recommendation 6: *Healthscope and NSLHD work collaboratively to map existing service provision, identify gaps and undertake district-wide planning to ensure that patient and community needs are able to be met.*

4.5 Risks to equity from PPP model

The NSW Government's Contract Summary confirms that although the hospital is privately run, patients will be prioritised according to their health needs, and not whether they hold private health insurance.

> ❖ I believe that access to good health care is a fundamental human right and must be independent from your ability to afford such care on your own.

However members have provided some information to ASMOF which calls this into question. We have been alerted to the fact there is an unfair process for public waitlists for surgery (which are managed by a separate Bookings and Admissions team) and it appears that NBH may be underutilising waiting lists to maximise profit. Surgeons have been told that patients who fall within Category B or C urgency must wait out the minimum period before being given a date- however even when surgeons have the capacity public patients are still being made to wait unnecessarily. Surgeons are struggling to fill their lists as a result of this, and it has implications for continuity of care for doctors-in-training.

This appears to be due to poor planning, which has seen the hospital short of NSW State Weighted National Activity Units to cover costs for public patients.

If patients face a wait ahead of them, they may be more likely to utilise private health insurance, maximising profit for the hospital.

- 'my patients are also having to 'wait' unnecessarily for their procedure. Whilst I understand that some patients may choose to utilise their health insurance and this is advantageous to myself and the hospital, I feel there should be a fairer process.'

- 'I was told about a patient that needed a cardiology procedure who elected to be admitted as a private patient due a significant wait, and left the hospital with a $30,000 bill. '

Our junior members have also discussed with ASMOF industrial staff issues around pressures to maximise the uptake of private health insurance. However as they are likely to be rotating through Northern Beaches in future, they are naturally apprehensive about compromising their careers at this early stage and being on record about this.

The best possible care must be delivered to patients, regardless of their capacity to pay. We are concerned but not surprised by these member accounts, as we believe they represent one of the risks of the profit-driven PPP model which has the potential to undermine health equity.

Greater transparency as recommended in this submission may go some way to address this risk.

4.6 Community Trust

With claims from Health Minister Brad Hazzard that new hospital would be a 'Disneyland', and promises of free MRI scans and hotel-like facilities, community expectations were high for the $2.14 billion hospital.

There was a widely spread expectation of community that they were getting a new public hospital and many in the local community were expecting a bigger, better hospital with a wide range of sub specialties available. Some new service offerings are now being delivered, but there was a stark mismatch between what was anticipated, and what Healthscope planned to deliver. Furthermore, many community members are not well informed about the gap fee system, and may be surprised by billings they face accessing care at NBH.

There is no doubt that community trust has been greatly eroded because of the difficulties faced at NBH, and the publicity surrounding challenges and errors in care. The significant turnover of staff has fueled uncertainty among the general community.

- 'I still hear many patients say that won't go there because of negative publicity'

- 'The general current feeling from patient conversations is that that there isn't the level of confidence in gold standard care that there should be for the size and level of institution... This is further impacted by negative news articles that further sustain this feeling.'

Lack of community trust is contributing to an increased workload on staff at nearby hospitals, as patients feel safer going elsewhere.

The NSW Government must play a key role in rebuilding community trust and to do this the hospital must recognise its responsibility as a public hospital and publicly report on its performance.

- 'There is no transparency about who is responsible for monitoring the Beaches performance and whether it includes clinicians or it is simply an administrative number crunching process with interjections from the media about deficiencies and life threatening mistakes which result in knee jerk reactions.'

The performance and standards of a public hospital must be transparent and be open to scrutiny to the public. The public interest should out-weigh the commercial sensitivity of protecting KPIs.

Again we reiterate our Recommendation 2, that complete information about NBH's KPIs, and the performance of NBH to date is provided to the public.

4.7 Junior Doctors

ASMOF is concerned that Junior Medical Officers at NBH appear to be bearing the brunt of many of the systemic issues facing the hospital, and this is posing a significant risk to junior doctors' safety and wellbeing. This risk has been identified by both senior doctors and junior doctors themselves.

There is a significant cultural shift for Junior Medical Officers who have worked at North Shore and Hornsby hospitals, and then find themselves at Northern Beaches.

This experience is disorienting for trainees, as the working environment is so profoundly different to what they are accustomed to. This environment is noticeably different even from Affiliated Health Organisations (i.e. the old "Schedule 3 hospitals") such as St Vincent's and Calvary Mater.

The Junior Medical Officer Unit, which has oversight of JMOs, is understaffed and JMOs emails and calls can go unanswered. There have been a number of issues associated with rosters including lateness and incompleteness. JMOS have also reported their pay being late.

It has taken repeated and significant efforts from ASMOF and our members to ensure that the concerns of junior doctors are addressed by management. Junior doctors themselves often don't know who to raise their concerns with.

- 'The Healthscope members showed a complete lack of understanding of what JMOs do. They showed that they only care about the bottom dollar... Maybe they could listen to their doctors to determine where the problems are and how to fix them.
  We need some work life/balance and not to be putting ourselves and patients at risk by working exhausted.
  ...The cost of working there is too high and they exploit our desire to give our patients the best care possible, despite circumstances.
  I'm strongly considering leaving the hospital so that I can spend some time with my (neglected) family.'

ASMOF has also at times encountered a fundamental lack of respect for the work undertaken by junior doctors.

Night-doctors

An example which is emblematic of this lack of respect and cultural differences demonstrated towards junior doctors at NBH relates to night shift doctors. In May Healthscope management accused some doctors of not responding to calls, sleeping in beds in ward and leaving the kitchen in mess. A harsh letter was issued to our members, prohibiting sleeping during night shifts, and limiting access to kitchen facilities and the Education Centre. They also advised that CCTV would be monitoring Night Registrar/Locum activity.

ASMOF intervened on behalf of our members and requested that NBH observe the status quo until consultation could occur. Management ultimately decided not press the letter but were keen to push the "the main message"- that although doctors are able to rest and recline and have access to meals and refreshments, they are expected to be available for work when required.

Night shift doctors have subsequently spoken to ASMOF and advised that earlier in the year there were some problems with a couple of locums, but that the people who caused those problems are no longer at NBH, and haven't been for some time. Night shift doctors also indicated that there are occasions when calls are not immediately responded to as the doctor involved is engaged in an activity which should not be interrupted (e.g. cannulation or catheterisation), and that assisting in ED, except obviously in an emergency, is impractical as it would be necessary to return to the ward for ward based duties, which could then not allow continuity of care to the ED patient.

The way this issue was handled caused unwarranted stress. It demonstrated a demeaning attitude towards hard working cohort who given their time feely to the hospital. Threats of surveillance were disrespectful and unnecessary.

Kronos

Kronos is a time keeping and rostering system that NBH have introduced. A lack of consultation and communication about this new system caused significant concern for JMOs. There were no policy guidelines or processes in place for what would occur in different scenarios eg. if a JMO was doing mandatory training offsite. Although we now have clarification, management initially gave no consideration to how this system would impact JMOs before they were pushed.

Pathology

Junior doctors have also raised concerns with pathology services which have been contracted out to Melbourne based company ACL. ACL have made significant commitments to service, including offering 3 daily rounds and on call pathology.

However members have reported that ACL are not meeting their service commitments and rounds are routinely late or missed. This causes hold ups in care, and can also result in over-testing of patients where doctors undertake their own tests because they have not been done in a timely manner by ACL. Duplication in testing, at no small cost, has also occurred due to issue tracking results.

Furthermore, there are issues with the reports provided, which do not have adequate detail around pathology requests and processing. Pathology records are also not integrated with eMR.

Timely and accurate pathology services are essential to a well functioning health service.

Recommendation 7: *Urgent action from Healthscope and ACL to address issues with the delivery of pathology services.*

Public/private interface

Another key point of concerns for JMOs is the public/private interface. Junior doctors continue to report that private patients are still primarily looked after by NSW Health employees, which is a breach of what is we can which is clearly outlined in Project Deed:

> '59.5.c.i: JMO Positions must be directly associated with the treatment of Public Patients'

This creates ongoing risks and uncertainties and it is unclear whether the JMO's extra workload in looking after private patients is being accounted for in team allocations.

The demarcation between public and private patients is complex. Private patients are in public wards and public patients are in private wards, and JMOs can not simply skip patients in the same ward.

Healthscope has thus far failed to clarify responsibilities for private patients. Expectations from administration around treating private patients do not reflect the complicated mix which is the reality working at the hospital.

Increases to junior doctor staffing for private patients may assist with the issue, but further action will be required to manage and distribute the workload equitably.

Engagement of JMOs

There have been ongoing issues with communication between Healthscope and JMOs, which has fostered mistrust. Recently Healthscope has agreed to regular consultation meetings with junior doctors, which ASMOF believes is an important step to seeing concerns resolved proactively.

- 'I am hoping that these are productive and fruitful and that through these meetings effective strategies are implemented to address the systemic issues'

ASMOF will continue to support JMO members in meetings with Healthscope management.

Recommendation 8: *Improve engagement with JMOs to address concerns including responsibilities for private patients.*

4.8 Staff conditions and entitlements

Through our dealings with Healthscope, ASMOF has become aware of a lack of knowledge around our members industrial conditions and entitlements.

NBH employs a diverse range of our members, operating on varying conditions and entitlements. This includes Staff Specialists who migrated from NSLHD, Staff Specialists employed directly, Junior

Medical Officers who rotate through from various Districts in NSW Health, and JMOs employed directly.

The policy intersection between NBH and NSW Health also continues to raise issues. For example, Healthscope recently proposed an Overtime Policy for junior doctors which was inconsistent with the equivalent NSW Health Policy Directive and the Medical Officers Award. This has now been resolved with the input of ASMOF and the JMOs. But it is easily possible to perceive that the dollar is driving management's behavior, not respect for JMOs, NSW health policy or relevant industrial instruments.

To date our experience with Healthscope is that they often make decisions which are not properly considered. There is a lack of experience in dealing with the types of industrial entitlements of the employees, such as rights of private practice and training, education and study leave for senior doctors.

A significant issue that has recently emerged is the variation to senior doctors entitlement to superannuation.

Prior to migration, a senior doctor employed by the Crown was entitled to a salary and various entitlements in accordance with the Staff Specialist (State) Award 2018. Further, they were entitled to superannuation pursuant to the First State Superannuation Act 1992.

In the most recent pay period, members noticed their superannuation contribution was reduced to about 1% of gross earnings for the period, instead of the expected 9.5% previously received under NSW Health. Healthscope advised they 'had passed the quarter earnings of $54030', i.e. the maximum superannuation contribution base, which limits the superannuation contribution requirements for an employer.

However, pursuant to the relevant clauses of the Deed, at the time of migration, it was understood Healthscope intended no change to the amount of superannuation entitlements received by senior doctors. Despite this, the reduction to their superannuation will have a demonstrable impact upon their current salary arrangements.

A better understanding of and commitment to our member's rights is needed.

Recommendation 9: *Commitment from Healthscope to honour and retain the existing conditions and entitlements enjoyed by senior doctors in NSW Health.*

5. Do not repeat- Public Private Partnerships

g) the merits of public private partnership arrangements for the provision of health care

There is no question that we need to increase the funding of our public hospitals to meet the demands of the future. However, we must also recognise the potential pitfalls in how we approach

this. Privatising on the basis that a private operator will value-add to the funding the Government provides is misleading.

- ''No one in health has any idea how much health costs, we see it time and time again.'

In January 2018, ASMOF, alongside the other Health Unions, forced the current Berejiklian Government to concede against privatising five regional Hospitals in NSW. It was a state-wide campaign that saw us fighting in Goulburn, Wyong, Shellharbour, Maitland and Bowral.

Over the course of the campaign, ASMOF consistently posed the question to the Government – *show us the evidence in NSW where a public private partnership has worked?*

The answer from the Government was always Northern Beaches Hospital, even though the hospital had not yet opened.

5.1 PPP ideology

Much of the discourse surrounding PPPs is one of efficiency. There has been a steady implementation of a policy orthodoxy that profit-driven businesses are always more efficient and better able to deliver outcomes than a well-run public sector.

This has been repeatedly proven incorrect, and private, for-profit organisations have shown time and time again that profit will always be their primary aim – not the provision of quality services.

The basic operating discipline of a private provider is to maximise profit. ASMOF believes that profit should not be the core motive in the delivery of quality health care. Private companies are required to meet their legal obligations to their shareholders first and foremost, which may conflict with the public interest. It is folly to expect a public benefit to emerge from private profit seeking.

Ostensibly, private management will drive efficiency more rigorously than public management because of the desire to generate profits, potentially leading to cost savings to the state government.

But what we have seen in hospitals is that the drive for efficiency sees better marketing, cutting workers' rights and a reduction in safe patient care.

What guarantees are there to prioritise safe patient care, clinical and medical education, the teaching & supervision of JMOs or workers' rights?

Our experience is that the private operator will seek to employ doctors on a contractual basis, as they will not have to bear the costs of paying for time spent on training, education, research and quality improvement. This will undermine our entire public health system and put at risk the patients in the communities who rely on our care.

A comprehensive report from the McKell Institute in 2014 has shown that PPPs are risky business and that the efficient argument does not stand up to scrutiny. The report draws upon research from the Productivity Commission from 2009 that shows that public and private hospitals had similar average costs across Australia, although public hospital costs in both NSW and Victoria were lower than private hospitals. The authors note:

> 'The assumption that privatisation and outsourcing will deliver better services at a lower cost can be an enticing drawcard for policy makers seeking to reduce expenditure in healthcare. However, the evidence examined in this report finds that the expectation of budgetary savings is rarely met. Notably, decisions to privatise and outsource are often reversed at a later date once it becomes clear to policy makers that the strategy has resulted in a net negative impact on state balance sheets.'[i]

The McKell Institute argues that the resurgence of public-private health partnerships, which largely fall out of vogue following the disasters in the 1990s, is down to a ideological belief that the market will provide healthcare more efficiently, rather than solid evidence.

5.2 Lack of Transparency & Accountability

If a private company runs a service, they are not democratically accountable to the public.

The insertion of commercial confidentiality clauses into PPP contracts effectively limits the publics access to information, thereby jeopardising the chance of informed public debate and healthy public accountability outcomes, which in turn is a threat to good governance and public accountability.

PPPs diffuse political accountability because it increases the distance between political decision making and the actual provision.

We have seen this occur at Northern Beaches, and the suppression of HETI's report was one example of this lack of transparency.

5.3 Long term contracts

Long term contracts reduce political influence and flexibility for future governments: while political and economic contexts might change, contracts stay the same.

Long term contracts deny the public sphere the capacity to revise policies and practices in response to changes in need and understanding of good practice.

A rationale for PPPs is that it "transfers the risk" of aspects of system performance, including failure of management to achieve efficiency targets, from the public sector to private sector managers.

However there are many risks in the delivery of health services. The contracts are worded in such a way that basically the government is boxed in such that if any of the deal assumptions ever need to change, the public is going to have to be the one to pay.

5.4 Case studies

Unfortunately, public-private partnerships have been part of the NSW Government's agenda for over 30 years but there is yet to be a successful hospital privatisation

Port Macquarie Base Hospital (NSW)

The first privatisation of a public hospital in Australia happened in Port Macquarie in 1994 by the then LNP State Government.

In 1996, the then (newly elected Labor) NSW Minister for Health Dr Refshauge reported that the running costs of the Hospital were between $4.5 million to $6.5 million more than running a public hospital of the same size providing the same services.

Dr Refshauge said that Port Macquarie Base Hospital was an "unmitigated disaster". It was a dismal economic and health policy failure. It had one of the worst performances of any hospital in state with long waiting lists and concerns about the services it provided.

Following a massive community backlash, it was bought back by the state Labor Government in 2004 at a cost of $80 million. Port Macquarie was described by the NSW Auditor General as a hospital where the public had “paid for it twice and then gave it away”.

La Trobe Valley hospitals (Vic)

In 1996 the Latrobe Valley’s Moe and Traralgon hospitals were merged into one privatised service. Within 6 months the private operator came to the government for more money and within four years the hospital reverted to public control, with the company reporting losses of $6.2 million in 1999.

Modbury Hospital (SA)

In 1995 Modbury Hospital was contracted to a private provider for 10 years, renewable to 20 years.

Within two years the private provider was experiencing financial losses and lobbying for an increase in the contract price, which the government agreed to. In 2007 the private provider handed back the service.

Robina Hospital (QLD)

In 2000 Robina opened as a privately owned and operated public hospital, but was brought under public control at taxpayers’ expense following mismanagement by the private providers.

North West Regional Hospitals (Tas):

Set up under a PPP arrangement in the 1990s, the North West Regional Hospital encountered significant cost over-runs that resulted in the Tasmanian Government buying out its contract and returning it to public control.

5.5 The future of PPPs and the Northern Beaches Hospital

There is a consistent pattern in the examples provided. The main driver for this was not health reform or health policy. It was driven by Treasury and the blind adherence to microeconomic reform, but based on flawed and blind ideology. They demonstrated

- a lack of tangible benefits to the state
- limited government control over quality
- cost overruns
- poor contracting management
- increased risk for the state following contract difficulties
- cost blow outs
- drops in quality of services to the public.

More generally, the failures point to the questionable starting point that companies should be allowed to seek profits from public health care provision. It is not only morally dubious, but, experience would suggest, impractical and unsustainable. The intrusion of the profit motive

inevitably produces a race to the bottom in service quality that it totally inappropriate to the provision of public health care.

It is ASMOF's firm view that PPPs remain too risky to be repeated. The public hospital system allows clinicians to support and care for the most vulnerable in our society, and we need a funding commitment that continues to support that.

Recommendation 10: *The NSW Government abandons the PPP model in future hospital planning.*

Affiliated Health Organisations (AHO, previously known as Schedule 3 hospitals, under the Health Services Act), for example St Vincent's Public Hospital, are publicly-funded but privately-run and owned not-for-profit facilities.

AHOs must ensure employees receive the same pay and conditions as staff of the NSW Health Service and it is mandatory that AHOs comply with all NSW Health Policies. This arrangement ensures that there is consistency in the delivery of public health services, and represents a much better model for how NBH could better operate.

Recommendation 11: *Greater oversight of NBH from NSW Health to ensure standardisation with NSW public hospitals, including consideration as to whether Healthscope should operate as an Affiliated Health Organisation under the Health Services Act.*

[i] The McKell Institute (2014) *Risky Business: The pitfalls and missteps of hospital privatisation,* accessed here.