

**Submission
No 213**

**THE SAFETY AND QUALITY OF HEALTH SERVICES PROVIDED BY NORTHERN
BEACHES HOSPITAL**

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I have worked as a clinician in the NSW Public Hospital system for 34 years. During this time, I also held several higher-level administrative roles. I have also worked in a co-located, completely separate, private hospital for 25 years. Hence, I have a reasonable understanding as to how the public and private health systems work to provide the best outcomes for patient care and how the funding is derived.

It is clear from recent reviews that the Northern Beaches privately run Public Hospital experiment has been a failure (from both a financial and clinical perspective) and should have never been entered into in the first place. We should have learnt from previous failed attempts of such a model (e.g. Port Macquarie Hospital in the 1990s).

Private hospitals do work well in managing health care for elective procedures that have clearly defined treatments and relatively predictable outcomes and time courses (i.e. elective surgery and pregnancy). Private hospitals can/may take emergency admissions although, the patients are generally initially managed in a Public Hospital emergency department, if it is within their scope of practice and if they have capacity. As a result, suitable patients can be “cherry-picked” to enter this system if they are deemed suitable (less complicated comorbidity/medical conditions) and hold the appropriate private health insurance policy. This enables a constant throughput of patients at fairly predictable rates.

Public hospitals should, and must, take **any** patient in an emergency who has **any** surgical/medical problem **irrespective** of their private health insurance status. Admissions are generally via the emergency department or as directed semi-urgent admissions to the ward. If a patient’s needs are above the level/scope able to be provided by the hospital, the patient is still cared for/resuscitated until they can be safely transferred to an alternative appropriate hospital. This constant flow of urgent/emergency cases, often with more complex needs, means that public hospitals have a lower capacity for elective surgery given that urgent cases are appropriately prioritised and hence elective cases are often cancelled. Another important factor impacting on the flow of patients through a public hospital is that overall, they have a more complex level of health care needs that result in significant increases in their length of stay (often resulting in bed block). These factors result in a significant increase in the true overall cost of care for a given admission when compared to a private hospital.

The funding models between private and public hospitals are completely different:

Private hospitals generally only accept private patients (during the COVID pandemic there were some rare exceptions) and essentially charge the patient and their fund for every test, procedure, operation or occasion of service that is carried out on them during their hospital stay. Their fund pays for some or all of this cost and whatever is left over is paid by the patient (i.e. a gap payment); private hospitals are **never** left out of pocket as they can not only charge for the true cost of patient care they can also add on a premium so that they can make a profit for their shareholders.

Public Hospitals can have both public and private patients admitted under their care although the ratio of public versus private varies significantly from hospital to hospital even within the same city. Public Hospitals receive all their funding for public patients from the Government using the complex method of Activity Based Funding (ABF) that utilises a National Weighted Activity Unit (NWAU) that attempts to adjust the amount of money received by a measure of complexity. This payment does not necessarily represent the true cost of patient care, and it also relies on accurate coding of each clinical event that occurs within the patient's stay. A few key words being present or absent in the medical record can result in a major funding difference and expected length of hospital stay for a given patient admission. Public Hospitals that admit private patients can charge the patients' health fund (no gap) for some of the clinical events that happen during their stay. However, due to this "extra" payment the Government reduces that amount that it pays via the ABF model. As a result, there is only a small financial advantage to the Public Hospital for treating a private patient. However, this total amount paid (fund plus discounted ABF) still may not represent the true cost of patient care. From a patient's perspective, being admitted privately to a Public Hospital will mean that they will be (mostly) cared for by the specialist of their choice and are often provided a free daily newspaper and television access. They do not necessarily get a single room as these are often limited and are allocated based on clinical need and not financial status.

The main premise behind the Northern Beaches Hospital model was that there would be a 70 % private versus 30% public patient admission rate based on the proportion of people holding private health insurance in their catchment area. Therefore, approximately 70% of patient care would be profit generating. A second premise was that "*private enterprise can always run a given entity more efficiently than the Government*", in this case the care of publicly admitted patients. Healthscope likely took on this contract believing this premise although I don't think that they truly understood the ABF model and expected that they would be paid for the true cost of the public patient care. Despite this apparent initial lack of understanding, I would think that they would have/should have quickly adjusted their processes to "game" the ABF system to ensure that they received the maximum amount payable for each public patient that they cared for. Despite this and being 6.5 years since the NBH first opened, they have been not only able to break even regarding the costs incurred in treating public patients and they also appear to have received several bailout payments by the Government (Local Health District) in compensation for this shortfall.

The failure of Healthscope to be able to economically manage public hospital patients likely indicates that the second premise above is not in fact true. It would also suggest to me that public hospital funding via the ABF model is flawed and inadequate and needs urgent revision. There have been concerns by the public and in formal Government reviews that financial decisions have influenced decisions about patient care. Financial considerations should never be the primary driver of clinical care, and I feel very concerned for my clinical colleagues at the Northern Beaches Hospital if this pressure was imposed upon them.

In going forwards I think the following should occur:

- The entire hospital should return to Government control as soon as possible but ensuring that this is a well-managed and a safe transition.
- Healthscope should not be rewarded by receiving the cream off the top, as I do not feel that we should privatise the profits and socialise the losses.
- Healthscope should not receive any compensation for any perceived past or future loss of profit.
- Patients with private health care can still be admitted to the hospital as private patients as described above.
- A blended single hospital managed by a private entity and the Government will **increase** not decrease the risk to patient care given that the following will likely have to occur:
 - Patients often transfer from public to private and when things become complicated can transfer back to the public. This will complicate clinical decision making and the ability to follow the patient's clinical course. This will increase patient risk.
 - There will likely be two distinct patient medical records systems as the Public component will need to transition across to the new Statewide Single Digital Patient Record (SDPR) which will be a critical requirement given the significant number of patients that move between the NBH and Royal North Shore and/or other public hospitals. Two separate records will increase clinical risk. If there are differences between the systems such as paper versus electronic documentation (i.e. medication charts, fluid balance charts, chemotherapy etc.) this will further exacerbate this risk.
 - The more services that need to be duplicated across the public and private divide will again increase patient risk and will also increase overall healthcare costs.
 - Equity of access to services may be influenced by two competing patient services.
 - There are some services that will have to be publicly run (i.e. the Emergency Department) although other services such as the operating theatres, ICU and dialysis etc could end up with a complicated and cumbersome oversight committee again with competing interests of both parties which will increase the potential of failures of care.
 - It is likely that pathology services will be duplicated with the public patients being tested via NSW Health Pathology (so that it can be view in the SDPR) and the private patients by a Private Provider. The more silos there are the higher the clinical risk and cost.
 - I hold the same concerns in the point above for the provision of Radiology/imaging and anatomical pathology services.

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