

**REPORT ON PROCEEDINGS BEFORE**

**PUBLIC ACCOUNTS COMMITTEE**

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

**At Jubilee Room, Parliament House, Sydney, on Friday 28 November 2025**

**The Committee met at 10:15.**

**PRESENT**

Mr Jason Li (Chair)

Mr Clayton Barr (Deputy Chair)

Ms Jenny Leong

Mr Michael Regan

Mr Anthony Roberts

Dr David Saliba





**The CHAIR:** Welcome to the Public Accounts Committee inquiry into the Safety and Quality of Health Services provided by the Northern Beaches Hospital. I am Jason Yat-Sen Li, Chair of the Committee and I am joined by my colleagues Mr Clayton Barr, Deputy Chair and member for Cessnock; Ms Jenny Leong, member for Newtown; Mr Michael Regan, member for Wakehurst; Anthony Roberts, member for Lane Cove; and Dr David Saliba, member for Fairfield. I acknowledge the Gadigal people, who are the traditional custodians of the land on which we meet here at Parliament. I also pay my respects to Elders past and present of the Eora nation, and extend that respect to other Aboriginal and Torres Strait Islander people, who are either present or are viewing the proceedings on the internet.

Before we commence, I make a statement relating to this inquiry. The Committee notes that there are matters involving Northern Beaches Hospital that are, or may be, subject to legal proceedings and coronial inquiry, including the potential for investigations to lead to possible criminal charges being laid. The Committee therefore will conduct this inquiry in a manner that respects the sub judice convention. This convention aims to preserve the principle of comity between the legislative and judicial branches of government. It means the House voluntarily constrains debate or inquiry into those matters that may be prejudicial to ongoing police or other investigations, or that may impact court proceedings or interfere with natural justice.

In order to safeguard the integrity of any external proceedings or investigations and inquiries, the Committee has resolved to focus on systemic matters relating to the hospital, and today's proceedings will not inquire into or receive evidence on the circumstances, clinical treatment or investigatory responses relating to individual incidents or any matter before the courts or under investigation to which the sub judice principle should apply. I therefore request that, when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming any individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa, or any matter under active coronial or other investigation. The Committee will be taking a cautious approach to the conduct of today's hearing and it may decide to pause the broadcast or conduct portions of today's hearing in private, if it deems necessary.

It is also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings a witness only has limited protections for the evidence they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings, or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings.

The Committee would like to thank all the witnesses who are appearing before the Committee today and all the stakeholders who have made submissions. We appreciate all of the input you have provided to the Committee to this important inquiry. I also note that the proceedings may be affected by the Legislative Assembly sitting from 10.30 a.m. We have done our best to ensure that the public hearing does not clash with activities of the House. However, there is a chance that we will need to adjourn unexpectedly during the afternoon panels to allow members to attend to business in the House. If that occurs, we will take a short adjournment and resume once members have returned.

**Dr TATIANA LOWE**, Staff Specialist, Northern Beaches Hospital, and Australian Salaried Medical Officers Federation, before the Committee via videoconference, affirmed and examined

**The CHAIR:** I welcome our first witness, and thank her for appearing before the Public Accounts Committee today to give evidence. Please note that Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly social media pages, websites and public communications materials. Please inform the Committee staff if you object to having photos or video taken. Could you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**TATIANA LOWE:** Yes, I have.

**The CHAIR:** Do you have any questions about this information?

**TATIANA LOWE:** No.

**The CHAIR:** Would you like to make a short opening statement before the commencement of questions?

**TATIANA LOWE:** I am here to provide evidence on behalf of the doctors union, ASMOF, and also as a staff specialist at the emergency department, as to the ongoing and serious challenges which are faced by doctors and patients at the Northern Beaches Hospital. Our lived experience shows persistent systemic failures in staffing, workload, bed capacity and critical resources. These directly affect both patient safety and the wellbeing of the medical workforce. I do think it's important to note that doctors at Northern Beaches Hospital continue to deliver the highest standard of care, but we are doing so within a structure that routinely leaves us understaffed, overstretched and unsupported.

ASMOF welcomes the New South Wales Government decision to transition Northern Beaches into public management. However, it is really important to note that transition alone will not resolve the deep structural and workforce issues that have been documented for years. I'd also like to make the point that having worked in a variety of New South Wales public emergency departments over my career, many of these issues are systemic within the broader health system and not necessarily only limited to Northern Beaches Hospital. Since the opening of the hospital in 2018, ASMOF did consistently receive reports which detailed chronic understaffing, unsafe hours, bed block and repeated equipment and resource failures. Some of these have been raised in previous inquiries, but they remain persistent in many regards and are often unresolved.

The public takeover does represent a crucial opportunity to reset the hospital's workforce, governance and resourcing foundations. On a personal and representative note, it is our fervent hope as clinicians that this time management both take note of our comments and, wherever possible, institute our recommendations. We're a fairly smart bunch. We've lived and breathed the system every day for the past seven years. We have fairly sensible things to say. We are also members of the community we serve. Northern Beaches is where we bring our families and our friends, so we are highly motivated to get it right. This review is very timely. It coincides with the industrial public health reform proposals being heard in the IRC. The public throughout New South Wales should take note. If you keep doing things the same way, you'll keep getting the same result.

**The CHAIR:** Before we begin the questions, I inform you that you may wish to take a question on notice and provide the Committee with an answer, please, in writing, by 12 January 2026. I might kick off. Based on your opening statement, in your opinion, is the safety and quality of health services provided at Northern Beaches Hospital significantly different to that at other at-level or equivalent public hospitals?

**TATIANA LOWE:** The quality that we provide is outstanding. As the Parliament would know, we certainly do very well with our KPIs but that is in spite of the conditions under which we work, especially to do with—from an emergency department point of view—understaffing and to do with the bed block that we have to deal with on a daily basis. That would be my comment. Like for like, I've been to many of our senior staff meetings where comparisons are made between various staffings at other comparative public hospitals, where we come up woefully short in terms of amounts of consultants, of registrars, of junior staff that are available to perform all the duties necessary for safety and quality.

**The CHAIR:** This is one of the things that we've been trying to reconcile with, or the Committee has been trying to reconcile. There is one narrative that Northern Beaches Hospital performs as well as, or in some cases, better than public hospitals based on the KPIs that you mentioned. Yet these very serious adverse incidents have occurred that are in the public realm. How would you reconcile those two narratives?

**TATIANA LOWE:** It's a very good question. It is very close to my heart that, just in general, there is an under-recognition of the risks inherent in delivering urgent care. I don't believe these risks change much between the delivery of care in public versus private hospitals. It is inherent in the nature of what we do that both the receiving and the delivery of urgent care carries risk. How do you mitigate that risk? Obviously, good staffing, not dealing with bed block constantly from an emergency perspective is how we mitigate the risk. The risk itself doesn't change no matter where you work, but the circumstances you find yourself in certainly would help to mitigate that. For example, if you're working in a chronically understaffed department, inevitably that pushes risk up because patients are waiting longer to be seen, there are patients in triage chairs that are just inevitably not going to be seen as quickly. The doctors are working harder.

A good example is we've actually had a look at our staffing within our emergency department. We did quite a thorough review of the period between January 2023 and March 2024. We used the data pulled from Deputy and, time and time again, we ran our department with between 10 to 30 per cent of shifts unfilled. Given that our average number of doctors is 30 per day, that means we routinely operate three to nine doctors down. At the same time in that period, we were working under a policy where we were not allowed to request casual staff for overtime until we were five junior doctors down. That kind of policy is not enforced by any of our neighbouring public hospitals. That's an example of working chronically understaffed and not able to sufficiently increase that staffing at short notice. We were constantly told that we are fully recruited, and yet the recruitment numbers failed to take seasonal movement of overseas doctors, delays in registrations, sick leave and other entirely predictable factors into consideration.

If you look at, for example, ACEM which is our Australasian College for Emergency Medicine, they've produced a G23 safe staffing policy. Given that we see between 64,000 to 66,000 patients a year in the Northern Beaches emergency department, they recommend we should roster 32 to 40 doctors per 24 hours. We routinely, as I've said, have 30 on the roster and, as discussed, we operate three to nine doctors lower than that. We should have four to five consultants per shift. We routinely have three. We should roster eight doctors on a night shift. We routinely have five. It is those kinds of discrepancies which, although as a team we are well trained and do our best to provide excellent care—and I think we do provide excellent care—working under those circumstances just means the risk inevitably is higher on all shifts. It must be.

**The CHAIR:** Thank you. That's a very insightful answer, I think.

**Ms JENNY LEONG:** Thank you so much, Dr Lowe. I just wanted to clarify the chronic understaffing that you just outlined and the examples you just gave. With the kind of decisions that are made in terms of at what point casuals can be engaged and routinely seeing less consultants and less staff, is that a policy of Healthscope? Is that an issue where there's not staff available? What is the difference that you're seeing that is the chronic understaffing? What is the challenge? Is it with the recruitment and retention of staff? Is it an internal policy? Or is it indeed some other factor that needs to be identified?

**TATIANA LOWE:** I do believe some of that is peculiar to the Healthscope fiscal environment, in that you can't ask for more staff until you're five doctors down. I'm not aware of that, as a rule, in the average public ED. In fact, calls for extra staffing would often go out immediately a doctor called in sick in our public counterparts, so I think that would be a distinct difference. Whether that's related to financial constraints from higher up the chain—Brookfield et cetera—I can't speak to. Certainly, I don't want to lessen the very real staffing issues throughout health and throughout emergency medicine, and specifically in our rural hospitals. We all know that staffing is a major problem, but I do believe policies like that are quite niche and would disadvantage us in that field.

**Ms JENNY LEONG:** What about in terms of routinely seeing less consultants than what would be best practice, and other things like that?

**TATIANA LOWE:** So, correct—I think that, for me, I don't have access to all of the numbers of all the hospitals, but certainly I've been to enough of our senior staff hospital meetings, and a lot of our consultants are aware of how many endocrinologists they have at North Shore or Hornsby and how many senior registrars they might have on their team and how many juniors they work with on each ward round, and our numbers certainly are significantly less. That, again, I would see as a point of difference. Again, I can only imagine that's related to fiscal policy for hiring higher up the chain.

And you have to understand that everything is related in the hospital, so there's no one reason for bed block. Bed block is endemic. It's very destructive and it raises everybody's risks. It's a real problem, certainly from an emergency point of view. There's no one reason for it, but, for example, if you have your medical consultant coming in on a weekend and doing their ward round and they have no registrar to round with because there's no registrar employed for that purpose, and they're rounding possibly on their own with 30 patients, they're then doing all the discharge summaries, and whilst they're doing a discharge summary, that patient is not getting

discharged. It's just one small component, but you're taking a senior decision-maker, you're making them do menial paperwork which could absolutely be done by someone more junior and should be being done by someone more junior and you are not utilising them in the way they should be utilised as a senior decision-maker who should be contributing to flow through the hospital.

That is purely staffing—that is just one example of how everything feeds down the chain. On the other end, you get patients staying in the emergency department for 23 hours and they consume our emergency resources, which should be being used on patients in the waiting room and critical cases coming in the door. Not only are we having to care for admitted patients, which we all know is extremely dangerous for the patient, but we are also not able to provide beds for patients in the waiting room because they're blocked by these patients that should be going up to the ward. There's a continual knock-on effect. Even the smallest staffing issues have some kind of knock-on effect down through the system.

**Mr CLAYTON BARR:** Dr Lowe, I wanted to ask about the impact of the work you're trying to do with regard to nursing staff. We've been made aware that nursing staff tend to be of a more junior level and that the ratios aren't as they would be in a public hospital. Would you mind commenting on how the standard and experience of nursing staff affects the work of the doctors when they're doing whatever it is they're doing, either in the ED or the rounds?

**TATIANA LOWE:** Again, I can only really comment from an ED point of view. All credit to junior nurses. They're working hard. They're wanting to learn. They're in an environment where they should be able to be taught. But it is very noticeable when you not only have a predominance of junior nurses but agency nurses. Both can provide challenges because both have less institutional knowledge and they generally often have less working knowledge of that department. They may also have much less of a skill set. For example, it makes a huge difference if I come to see a patient and they've already had bloods done and had some analgesia initiated, compared to a very junior nurse who may not have those skills or may not have been accredited for that task. That makes a huge difference to the flow through the department.

I suspect the fact that we've had a brain drain, as it were, of senior nurses is related to salaries, to working conditions and to the quality of the shift they feel they're having to do. I can't speak directly for the nurses, because I'm obviously not a nurse. That's something I'd have to maybe add to after having spoken to them. But I would say as a doctor that it is very noticeable when you're working with a lot of junior nurses compared to senior nurses, who have all those skills and knowledge and capability. Institutional knowledge I think is also important, because agency does present its own problems.

**Dr DAVID SALIBA:** Dr Lowe, thank you so much for the work you do. I'll start by making a bit of a statement. I understand your points pertaining to your concerns about chronic understaffing and the equipment shortfalls there to enable the hospital to do what they do best. I want to examine serious adverse events—SAEs—and the like. Do you know from your knowledge if there were more or less serious adverse events at this hospital relative to other hospitals at a comparable standard?

**TATIANA LOWE:** I don't know those figures. I've worked in many public hospitals. As I said in my opening statement, I can tell you that emergency medicine does not exist anywhere without risk. I keep coming back to this because I believe that this is something the public is not well informed about. There is risk wherever you go; there are deaths wherever you go. Every single doctor or nurse you come into contact with in an emergency department at the end of the day is a human being, and they have an inherent fallibility and error rate. That is never going to change. Obviously, we train hard and we institute protocols. We do everything we can to mitigate those risks, and we train to mitigate those risks, but you can never make that number zero. It will never be zero.

**Dr DAVID SALIBA:** I totally get that. But from a mitigation perspective, you made comments earlier about the chronic understaffing—

**The CHAIR:** Sorry. Excuse me, everybody. Members are required to attend business in the House. We no longer have quorum as well, so we are no longer under privilege. We are going to have to adjourn the proceedings and resume them shortly once we can come back. My apologies, Dr Lowe. Government business is going on in the House. We will resume as soon as we can.

**TATIANA LOWE:** Thank you.

**(Short adjournment)**

**Dr DAVID SALIBA:** Doctor, sorry about that. We had some parliamentary business, which has now been resolved. My sincere apologies for that. Continuing on, the Auditor-General looked at a whole bunch of data pertaining to the hospital. One of the things I didn't see—and someone correct me if they have seen it—was

adverse events. I note that, with respect to the medical profession, you can't guarantee perfection; I totally get that. You gave commentary about understaffing—and the strain on staff pertaining to it—and resourcing, and how they could affect patient care, given you're five to seven doctors short. Would that, structurally, as a model, have an impact on serious adverse events?

**TATIANA LOWE:** One can only imagine that it must. I am not aware of our serious adverse events numbers being significantly different to our peers. That is something that I assume the CEC or the Department of Health would keep track of. I imagine those numbers would be fairly easy to access. I am not aware of a huge difference. Certainly it makes logical sense that if you're working chronically understaffed but you're seeing the same number of patients coming through and you're dealing with bed block to the tune of looking after patients for 23 hours in an emergency department, it's got to affect the safety of care and the risk of an adverse event occurring. It must do. Again, I don't underestimate those same conditions occurring in public emergency departments. I don't believe that they are unique to Northern Beaches. But the risk must increase with that. It can't not.

**Dr DAVID SALIBA:** I haven't physically seen a SAER but I imagine as part of the review these SAERs would examine these chronic shortages. It would say, "This event happened. On that day, there were X number of staff, there were resource issues," or, for example, "This is the electronic management system that the hospital uses." Surely all of that would have been documented. I used to be in the military and used to do fact findings—

**TATIANA LOWE:** I absolutely 100 per cent agree with you. If it doesn't, then it's not following a just and restorative practice process, which is exactly what we are instructed to do in the event of any adverse outcomes. That is what our mandate is from the New South Wales Government. We must be just and restorative, which means we must look at the system issues and not target individuals, other than educating as appropriate. I agree with you. That is such a fundamental part of the process. Yes, we do look at all of those things: How many acute ambulances did we have on that day versus normal? What was our patient flowthrough? What was our staffing? What was our number of agency nurses? How many cat 1s or bat calls did we get on that day? Those all add to the environment in which an incident occurs and they should always be looked at, I agree.

**Dr DAVID SALIBA:** I have questions from Mr Regan, who is not here. He kindly asks, "What is the human cost of chronic understaffing on staff?"

**TATIANA LOWE:** The cumulative effects of excessive hours, unsafe staffing and unreliable rostering have taken a significant toll on doctors physically, mentally and emotionally. Many have experienced burnout, chronic exhaustion, loss of personal time and, in some cases, long-term harm to health, relationships and career trajectories. I think that you cannot underestimate the effect that these have. Some of those effects are seen throughout the healthcare system. I can speak for the ones locally for us, but I don't believe that there are many hospitals that would escape entirely. Again, that is part of why we are doing the industrial action which is happening at the moment. It is all to address that exact issue.

**Dr DAVID SALIBA:** Two final questions from Michael: Did you raise these issues with Healthscope? How did they respond? Given the announcement of the Government making the hospital public, what do you think are the opportunities and risks of this transition?

**TATIANA LOWE:** Certainly from an emergency point of view, we gathered together as a team, we documented all of our concerns, we sent a very detailed letter through to the exec at Northern Beaches. We did get an in-person response. For example, the DMS not only responded to us on email but certainly came down and talked to us. We did get some movement on some issues, for example, an agreement fairly recently to increase our staffing by one doctor on the night shift. You are still dealing with sick calls and things and so the crises still arrive.

Another recent thing that has happened is the inclusion of what is called a smart shift, which is a doctor which looks after our short stay unit, which should be staffed separately to the emergency but currently forms part of our staffing. So getting an extra senior doctor on that ward Monday to Friday, which we believe should be a seven-day thing, but at least there has been some movement. I don't believe enough movement. I believe the risks are still high. But, yes, we certainly put in a very detailed letter and did have engagement with the exec—I suppose, again, almost certainly limited by what their fiscal constraints were from above, which I can't really speak to. What was the second part of the question?

**Dr DAVID SALIBA:** The State Government is now transitioning that hospital back into public hands. What do you think are the opportunities and risks of that transition?

**TATIANA LOWE:** I think the opportunity is fairly clear. It provides an opportunity to take necessary corrective steps: to prioritise patient care; to value the workforce; to be accountable to the community; to look at specific workforce investments—safe hours compliance, improved patient flow, fair industrial conditions, robust

public oversight; to actually listen to the clinicians that have been delivering outstanding care for years in a very difficult environment and have identified countless opportunities and ideas to make it safer and more efficient for their communities and their families. We have these ideas—again, to recognise that many of these issues are systemic and, indeed, endemic throughout public health. Help us to help you, I think that is the opportunity.

**The CHAIR:** Thank you very much, Dr Lowe, for taking the time to give evidence to us today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions?

**TATIANA LOWE:** Yes, absolutely.

**The CHAIR:** Thank you very much. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. We kindly ask that you return those by 12 January 2026.

**TATIANA LOWE:** I will.

**(The witness withdrew.)**

**Mr CODA DANU-ASMARA**, Senior Industrial Officer, Australian Paramedics Association (NSW), affirmed and examined

**The CHAIR:** I'd like to welcome our next witness, Mr Coda Danu-Asmara, from the Australian Paramedics Association. Thank you for appearing before the Public Accounts Committee today to give evidence. Please note that Committee staff will be taking photographs and videos during the hearing. These photos and videos may be used for social media and public engagement purposes on the Legislative Assembly's social media pages, websites and public communications materials. Please inform the Committee staff if you object to having photos and videos taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**CODA DANU-ASMARA:** Yes, I can confirm.

**The CHAIR:** Do you have any questions about this material?

**CODA DANU-ASMARA:** No.

**The CHAIR:** Before we get started, I'd like to reiterate some points I made during my opening statement today. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry. We will therefore conduct the inquiry in a manner that respects the sub judice convention, which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming any individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa or any matter under active coronial or other investigation.

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**CODA DANU-ASMARA:** I'll make a very quick one, thank you, Chair. The first thing I'd like to say is that normally I would appear with a paramedic, who, unfortunately, wasn't able to come today. Anything that is specifically clinical I may have to take on notice; however, I am very well versed around the issues that face paramedics at Northern Beaches Hospital and elsewhere. I'm more than happy to take probably most, if not all, questions today. Anything specifically involving clinicians or clinical aptitude I might not be able to answer today.

The other thing I wanted to bring up is that the Northern Beaches Hospital certainly has a reputation, both within medicine and outside of medicine, that is both troubling and worrisome. The evidence I have received from paramedics on the ground—I spoke to many paramedics who were there. The results, I would say, go a bit against the grain about what you may have heard in previous testimonies and from evidence. The paramedics generally find that the current processes and procedures put in place by Northern Beaches Hospital tend to be quite careful, safe and quick, all of which are very important for the safety and care of patients therein. Nonetheless, the reputation of Northern Beaches has been irrevocably tainted among both the medical staff and also the patient population, which does in fact lead to worse patient care, and therefore inquiries like this do in fact have a significant power, more so than you might expect.

For example, I would like to say that there are many times where paramedics are driving a patient and the patient will say, "Don't take me to Northern Beaches, I will die there," presumably due to what has been in the media, and the paramedic is in a tough spot. Generally speaking, paramedics are not supposed to go to different hospitals. There is a matrix that has been set up so that they find the hospital that's closest and the hospital that's most free so that patient flow can continue and there are no interruptions, but then you're in a tough spot. If a patient decides they don't want to go to a particular hospital, and a paramedic is worried that this patient will die or be seriously injured if they don't go to a hospital, you have no choice but to break the matrix if you want this person to be seen at a hospital. And then you're causing patient backlog in a different hospital, or Northern Beaches ED, which as I said most paramedics actually think quite highly of, is going to be seeing fewer patients than it actually has capacity for.

Whatever outcome from this Committee and whatever outcome the Government has from the potential purchase of Northern Beaches from Healthscope, that might do a very large help for the patient population of the northern beaches. Simply just the changing of the reputation, more so than necessarily the changing of the process,

would actually go a long way. That's just something I imagine may not have been brought up in the Committee so far, and that's what I wanted to put in my opening statement. But otherwise I'm happy to take any questions.

**Mr ANTHONY ROBERTS:** Thank you for joining us today. Could you pass on to all those paramedics you represent what a fantastic job they do each and every day on behalf of us all here. The experience with the emergency department at Northern Beaches as far as paramedics are concerned—they're quite happy with that engagement between the two?

**CODA DANU-ASMARA:** I can elaborate on that. There is this thing called bed block, which paramedics refer to, or ramping, as you might probably be familiar with it. When patients are being off-loaded onto a stretcher and are waiting for a bed in a hospital, paramedics should have to stay with the patient until they're handed over to a nursing team or a doctor. Those are patient safety concerns. A lot of hospitals in Sydney have very, very bad ramping problems. We're talking about two or three or four hours wait time in major hospitals throughout Sydney. I can put up pretty much any hospital in Sydney, except Northern Beaches. It is actually one of the hospitals that has, at least from the paramedics I've spoken to, one of the fewest problems with ramping and bed block.

It's hard to say exactly what changes this. Of course there's the fact that it serves, one would imagine, the smallest population of patients in Sydney compared to a hospital like Blacktown, for example, which serves the largest. But that doesn't change the fact that the systems that have been put in place are quite efficient, paramedics have told us. The way the triage system works—and I know the triage system is currently under question. The paramedics have told me that it has been changed since some of the incidents that have come up in the media and the news where particularly children are triaged at a higher rate than they were before in order to try to mitigate some of the damage that has been done. But that triage system is more efficient than some of the other triage systems in other hospitals in Sydney.

**Mr ANTHONY ROBERTS:** Interesting. Thank you.

**Mr CLAYTON BARR:** Part of your submission referred to paramedics sometimes going to Northern Beaches Hospital to pick up patients to take them to a public setting because they didn't have the private health cover. Can you talk about that as a role for paramedics? To be perfectly honest, I didn't really realise prior to your submission that paramedics went and picked people up to take them away from a hospital. I thought they just dropped them off, and that then it would be patient transport after that.

**CODA DANU-ASMARA:** It's actually quite common. Outside of Sydney it's very common. In Sydney it's much rarer, but outside of Sydney it's incredibly common. There's a few reasons for this. Where someone doesn't have transportation between hospitals, paramedics and patient transfer officers—who are not exactly paramedics; they have a lower skill set but are able to transport people between hospitals. You have probably seen the green cars they use. They are not currently available 24/7 in rural areas. They also are not as available in northern Sydney as they would be in the main part of the city. So paramedics are utilised in both instances to transport patients that effectively are not in any—real danger is not the right way to put it, but they're not as high acuity as other patients that they could be serving. We're talking about transfers that could be things as simple as they have a scheduled appointment to go have a surgery on Tuesday, and it's Friday.

The paramedic could be called out, and sometimes this happens in the middle of the night, particularly in rural and regional areas. I've had examples where people will come out and the paramedics will say, "You need to transfer this person. They've got a surgery." It's a six-hour transfer from Orange to Dubbo, for example. Obviously, this is not exactly the Northern Beaches Hospital, but the Northern Beaches is an interesting specific case due to the fact that it so heavily pushes private specialists and procedures more so than other hospitals due to Healthscope's ownership of the hospital. Of course, most people don't have private health insurance and therefore wouldn't be able to actually afford these procedures. Therefore, there are some needless transfers that go on in Northern Beaches specifically, where Northern Beaches has the capacity to do all these things. Because it's categorised as a private procedure, they will need to be transferred to Royal North Shore Hospital, which blocks out Royal North Shore. That's basically what I'm getting at in that submission.

**Mr CLAYTON BARR:** To be fair, I think about 85 per cent of people in the northern beaches have private health insurance. Mr Regan, you might have a better idea.

**Mr MICHAEL REGAN:** Close to 80 per cent.

**Mr CLAYTON BARR:** So it's a small number of patients. But are the paramedics picking them up from ED or the general wards? I'm just trying to get my head around that.

**CODA DANU-ASMARA:** The way it works is that they would be picked up from a loading bay that is near the ED, but it depends on the hospital, specifically. The way hospitals work is that paramedics have a loading

and deposit bay that's to the side of the hospital that sort of connects to the ED but isn't exactly in the ED. So patients can be brought in and out from there. The reason why it's that specific place is because patients can be easily lifted and put back in the stretcher.

**Mr MICHAEL REGAN:** You mentioned pushing private services. What does that look like, specifically, from what you've heard?

**CODA DANU-ASMARA:** Paramedics have said—it's just sort of building on the point from Mr Barr—in a hospital such as North Shore, a routine procedure might be done publicly. That same procedure would be done privately instead, or it would be heavily suggested to be done privately. As we said, there actually is quite a high percentage of private health insurance. But obviously, in every other hospital, you don't need private health insurance to have the procedure. This pressure on the patient population to go to a private procedure rather than a public one within the hospital—paramedics receive the brunt of this, only in the sense that they have to transfer patients who don't want that private option.

Obviously, paramedics are not inside Northern Beaches doing these procedures. So I would say that there is pressure upon people to go to use—but this is not something that's necessarily unique to Northern Beaches, unfortunately, where doctors will have extractions at private clinics and they will sometimes transfer their own patients to that private clinic if the patient has private insurance. Obviously, there's a financial incentive for the doctor to do that. It doesn't mean that patient care is necessarily worse. Oftentimes people are seen much quicker in the private, as you probably know. The problem with Northern Beaches specifically is that the pressure to do that private transfer, at least according to paramedics, is higher at Northern Beaches than it would be at an equivalent public hospital.

**Mr MICHAEL REGAN:** In your submission you talk about patients being referred to private hospitals for expensive procedures which may not be necessary. Can you give an example of that, and why it is happening and how often?

**CODA DANU-ASMARA:** I would say that the paramedics have told me—specifically this has to do with nursing homes. I also talk a little bit in my submission about nursing homes. The nursing homes are basically sometimes unable to do things that could be quite simple, like wound care or catheter change or things like that. A lot of the nursing homes in that area don't have that sort of specialty, and so the burden is picked up by specifically specialist paramedics—ECP paramedics—who go around and do the lower acuity sort of stuff. They do the wound changes and stuff. Obviously, those are currently a little bit underfunded, and so there are fewer of those than there would be normally.

To make a long story short, the flow-on effect is that someone needs to be picked up from the nursing home to do something that's quite simple, then taken to Northern Beaches. At Northern Beaches, they then are taken to a private hospital to do this thing that should have maybe happened from a paramedic specialist to begin with. That's what I'm talking about there. I wouldn't say wound care is a procedure. Rather, let's say you go to Northern Beaches. Someone might say, "I have a more comfortable room for you. You can get all that stuff you need in that more comfortable room. It's private, but you have private health insurance. That should be fine." So they get transferred out of that room and moved into a private hospital where they then get that service that could have been done by a paramedic days ago.

Those sorts of specialist paramedics—I think the statistics are something like a 12-hour shift of an ECP saves the health service tens of thousands of dollars because of things like that, where they would just go and do that simple procedure at the nursing home or at the patient's home without having to do the chain-link adventure. It's not that the patient gets bad care specifically; it's just that it was an unnecessarily large amount of movement. It's tough for these elderly patients because they live in the nursing home, they live at home, they don't want to be taken around. As I said, the Northern Beaches Hospital has that—I wouldn't say unwarranted, but unfortunate—reputation that it's a place where people die. People die at all hospitals, but it's just been in the news recently, and therefore that causes that negativity.

**Mr MICHAEL REGAN:** But there have also been mixed experiences, and that's what we hear.

**CODA DANU-ASMARA:** For sure. But it's tough because paramedics who work both in the north and in the west say, "Well, is Northern Beaches a worse hospital than Westmead?" I'm not going to get into the semantics, but there's certainly media attention around Northern Beaches right now. Specifically, the negative impact of Northern Beaches causes bad patient outcomes because patients are less likely to accept care there, and that causes difficulty.

**Mr MICHAEL REGAN:** Are there any more reflections on how local paramedics perceive it? You were touching on it then, but in terms of community sentiment about Northern Beaches—

**CODA DANU-ASMARA:** Obviously, this is now going to turn into hearsay.

**Mr MICHAEL REGAN:** I appreciate that.

**CODA DANU-ASMARA:** I'm giving you a bit of a disclaimer about that. Paramedics basically all agree that the staff at Northern Beaches are unhappy. They are unhappier than other hospitals. When I talk about staff, I talk about nursing staff, I talk about the junior doctors specifically, I talk about the VMOs, I talk about even the security staff and things like that. They're unhappier because the hours are less fair, and the conditions are less good. They have serious concerns specifically about some of the privatisation of the health care, as I was talking about, where nurses would have told paramedics about their needless transfers.

The transfers both to Royal North Shore or the transfers to private hospitals—it goes both ways. The nurse is like, "I can do this here." The paramedics have only had great things to say about the actual quality of the people there—so the nurses, the doctors. I would say four or five of the paramedics told me that the best doctors and the best nurses they ever worked with were at Northern Beaches. But the Northern Beaches Hospital itself doesn't let them practise to their full scope, as they might be able to, due to just the pressure of Healthscope to make back some of the money that they've sunk into this hospital that's obviously currently quite badly in the red.

**Mr CLAYTON BARR:** Sorry, I find it odd. If you've got nurses with skills, surely the best way to get the best value—the best bang for buck—out of them is to let them work fully to scope as opposed to restraining them?

**CODA DANU-ASMARA:** The issue is just the profit—or at least the paramedics believe the issue is the profit motive. Every second that someone's in a hospital is actually costing the hospital money—in effect. Patients, generally speaking, cost more money to hold than they bring in, even at Northern Beaches. Having the patient come in, collect admission fee, collect a few fees in that way and then get shipped out as fast as possible is actually the most economically efficient way to have a patient in a hospital. Because every bed in the hospital—I don't know the figures off the top of my head—but let's just say it's thousands of dollars a day for someone to be in a bed in a hospital because you've got to pay the nurses, food, blah-blah-blah, whatever.

The biggest way to save money, or to gain money—for Healthscope to gain money—is to have people not be in beds as much as they can. That's why the scope—I'm not saying the nurses can't practise because that's not exactly what I meant. It's that Northern Beaches has the capacity to deliver excellent health care. That is the point that paramedics have made to me, but it seems that, for whatever reason, that excellent health care—because the executives at Healthscope seem to be restraining them to some extent. For example, if you went for a—and that goes back to the private procedures. Private procedures make the hospital a lot of money and make the doctors a lot of money, so if you can get people into a private procedure as soon as possible, that will financially reimburse Healthscope. But the issue is that irrespective of the financial reimbursements, it doesn't appear that the economic balance is working out for Healthscope at the moment, which is why it seems like it—

**Mr MICHAEL REGAN:** On that, does that mean that NSW Health could benefit from the same thing then, not Healthscope?

**CODA DANU-ASMARA:** NSW Health does do it. It's just that Northern Beaches has a higher emphasis on pushing people out to private. But the other thing is that, obviously, the New South Wales Government wants to stay budget positive as much as we can. But the Government doesn't have as much pressure as a private company to stay in the black, right? When a patient is taking up a bed in a public health facility, there's pressure to move them out—of course there is, particularly in hospitals that are very busy. But it's more about patient flow than it is about money when it comes to those bigger hospitals where you want as many people in beds as possible so you can see as many patients as possible rather than trying to get them out to private practice as much as possible.

**Mr MICHAEL REGAN:** This is a similar question that I've asked previously today: Is your association of paramedics happy about the announcement of the Minister that it is coming back into public hands in the new service?

**CODA DANU-ASMARA:** Yes. I would say that most paramedics approve of this decision. Now, I think the reason why they approve is not necessarily because of the practices, which, as I said, they're generally actually okay with the ED practices themselves, which have been fast, quick, efficient—much more than some of the other hospitals. The reason why they're happy about this specifically is due to the reputation of Northern Beaches is so bad among the community at the moment that the re-acquisition of the hospital by the Government may just change the locals' minds.

I'm not saying that you shouldn't change anything when you come in, but if the hospital was simply purchased and Healthscope had simply just gone, and this was all over the news, patient care would probably be

the same. But people would actually go to the hospital and consent to treatment, and some lives would be saved in that way, and paramedics wouldn't have to do as many needless transfers back and forth. You can kind of see that with the pressures right now on the health system to get as many specialists into the CBD as much as we can, so Ambulance recently announced that they're going to be increasing the number of specialists trained—to double them—per year, which is obviously a good thing.

The issue is that there's no extra educators in Ambulance, so basically they've told them to double the amount of specialists, but with the same training staff. Obviously that's a reaction to some things, for example, that happened at Northern Beaches where as, as I said, these ECPs and the ICPs—which are the intensive care paramedics for the very acute jobs—really do save the system a lot of money. But the issue is at the moment we're trying to get to a place that's very hard where Ambulance is under a lot of pressure to make up for some of the failings within the individual hospital and nursing home system.

We always want more specialists and we always want more paramedics, but at some point we also need more people to train all of these new paramedics that are coming in. We are always thankful that the Government has continued to announce and infuse us with more paramedics, particularly in the rural and regional areas where it is necessary, but we also need more staff to train paramedics as well. The Northern Beaches being reacquired by NSW Health can also lead to new pathways for paramedics to continue their scope of practice and learn. The ECPs and ICPs, for example, have part of their training where they have to do it at a public hospital, so they go to the EDs and help out. Northern Beaches—and this is something I would have to actually fact-check myself on—I believe is currently not part of that program. If it was fully acquired by NSW Health, that could potentially be a pathway for easier access to training for paramedics and for specialists paramedics specifically. I'm not 100 per cent sure about that one.<sup>1</sup>

**The CHAIR:** Thank you very much for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Are you happy to receive further written questions if we have any?

**CODA DANU-ASMARA:** Yes.

**The CHAIR:** Thank you very much. Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. We kindly ask that you return these by 12 January 2026. Thank you very much.

**(The witness withdrew.)**

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<sup>1</sup> The Committee received correspondence from Mr Coda Danu-Asmara, providing clarification on this statement, which is published on the Committee's [webpage](#).

**Mr JASON WARD**, Founder and Principal Analyst, Centre for International Corporate Tax Accountability and Research, before the Committee via videoconference, affirmed and examined

**The CHAIR:** I welcome our next witness. Thank you for appearing before the Public Accounts Committee today to give evidence. Please note that committee staff will be taking videos and photos during the hearing. These photos and videos may be used for social media and public engagement purposes on Legislative Assembly social media pages, websites and public communication materials. Please inform committee staff if you object to having photos and videos taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**JASON WARD:** Yes, I have.

**The CHAIR:** Do you have any questions about this material?

**JASON WARD:** No questions.

**The CHAIR:** Before we get started, I would like to reiterate some points I made during my opening statement earlier today. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry. We will therefore conduct this inquiry in a manner that respects the sub judice convention which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that when giving evidence, witnesses focus on issues specified in the inquiry terms of reference and avoid naming individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa or any matter under active coronial or other investigation.

It is also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings, a witness only has limited protections for the evidence that they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings, or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings. Mr Ward, would you like to make a short opening statement before the commencement of questions?

**JASON WARD:** Let me make a brief opening statement. Thank you very much for the opportunity to be a witness today and to submit our submission on this matter. I come to you today from the unceded land of the Dharug people in the Blue Mountains. CICTAR is a small but growing organisation that has now been around for nearly eight years. In order to improve accountability, we have a strong track record of analysing the corporate structures and financial practices of entities operating in health, aged care, early childhood education and care and other publicly funded services both in Australia and internationally. We also broadly focus on tax avoidance by multinational corporations, including large investment firms such as Brookfield.

I want to begin by congratulating the New South Wales Government on taking back the Northern Beaches Hospital into public control. I would urge the Government to consider the opportunity to take control of other Healthscope hospitals in New South Wales and to cooperate with the Federal Government and other State and Territory Governments in that pursuit. Acquiring the Healthscope hospitals out of administration would be, by far, the cheapest way to expand capacity in the public health sector. The failed public-private partnership with Healthscope at the Northern Beaches Hospital should also serve as a cautionary tale for other PPPs in New South Wales and across Australia.

Likewise, the further role of private equity firms receiving public funding for social services needs to be further scrutinised. CICTAR's extensive research on Brookfield's tax avoidance is now being widely cited in Canada as the Canadian Prime Minister, Mark Carney, is the former chair of Brookfield. I've appeared before the Canadian Parliament twice in the last month, including last week, to discuss this. All parties in Canada, excluding Mark Carney's Liberal Party, have voted to launch an inquiry into the Prime Minister's connections to Brookfield's tax avoidance and the impact it has had on the Canadian budget. Thanks again for the opportunity to be a witness and very happy to answer any questions the Committee may have.

**The CHAIR:** Before we begin questions, I inform you that you may wish to take a question on notice and provide the Committee with an answer in writing, we'd ask, by 12 January. Mr Ward, thank you very much for your very detailed submission and the forensic work that you had done, particularly in respect of the financial accounts of Northern Beaches Hospital and Brookfield and its various corporate entities. Given what has happened so far in the decision of the Government to take back Northern Beaches Hospital into public hands, I wanted to ask you your views on public-private partnerships generally. I think we're aware of your opinion about the

appropriateness of a private equity firm—and, in this case, a leveraged buyout fund—running public health services. Do you believe that other forms of PPP might be appropriate in the delivery of health services within an economy, for instance, where rates of return that are required by those entities may be significantly lower than that of a private equity firm?

**JASON WARD:** As a general principle, I'm not in favour of public-private partnerships to deliver publicly funded services. In general, I think it's far better for those services to be directly delivered by the public. I'll just give you an example. We've seen very large non-profits, particularly in the aged-care sector, delivering services and essentially taking the money that is intended to pay for staff, to pay for high-quality care for residents, and using it for other purposes. Basically, you're building in a profit margin with a public-private partnership that is actually better spent directly by government services—again, with significant accountability and public oversight, and community input—rather than allowing an entity, whether it be a non-profit, a private equity firm or what have you, to be able to siphon funds for its own purposes out of that specific delivery of services.

**The CHAIR:** In your examination of the Northern Beaches Hospital public-private partnership, did you notice any efficiencies, procedures or management practices that didn't compromise care but actually allowed the hospital to run more efficiently?

**JASON WARD:** I'm not saying that that's not a possibility and that there aren't potential benefits in terms of those types of relationships. I'm not aware of any such benefits in the context of this public-private partnership. I think, sadly, those types of benefits, in terms of increasing efficiency, are usually not really there. There's a lot of hype and rhetoric around the private sector being more efficient but, in reality, so long as it's carefully managed, with sufficient public oversight and public scrutiny, the public sector is far better positioned to deliver better value for money in public services.

**The CHAIR:** As part of the evidence we've heard during this inquiry, there has been this dichotomy of narratives. There's one narrative that has held that Northern Beaches Hospital, by the examination of its performance KPIs, performs at the same level, if not better, than equivalent hospitals in the public system. We've heard that from a number of parties, and yet there have been these serious adverse events that have happened. How would you reconcile this seeming conflict?

**JASON WARD:** It boils down to a question of how you're measuring the KPIs and who's measuring the KPIs. It's certainly easy for somebody who wants to promote the idea of a successful public-private partnership to produce information that is probably a bit biased in terms of how it's presented and what is analysed in terms of delivering those services. I think it's widely understood that there have been major problems at the Northern Beaches Hospital, major deficiencies in the quality of care and certainly tragic incidents that have happened. I would suspect that under public operation, that would not have been the case.

**The CHAIR:** In the design of the project deed, it has been remarked—and I think it's known—that the cost charged to the New South Wales Government or to the public for the public services was at a discount. Why do you think Healthscope agreed to the terms of the project deed as they were, knowing that they had to provide those services at a discount and knowing—I think as you pointed out in your submission—that there was no ability to flex up the pricing or the payments, even when there was increased activity?

**JASON WARD:** Again, those deeds were all done prior to Brookfield's takeover of Healthscope as an entity, and I suspect that the calculation was that there were other ways that profit could be made from the public-private partnership that would not only balance out but overcome potential losses from the operations of the public side of the hospital.

**The CHAIR:** Could you elaborate on that a bit more? In other words, are you saying that it was part of the calculation that, even though public services would be delivered at a discount, so much money would be made on the private services that the entity would still achieve its desired rate of return?

**JASON WARD:** Yes. That's correct. And I think that's generally the case when you have a public hospital situated side by side with a private hospital. It's very easy for private sector, for-profit operators or, in some cases, not-for-profit operators to, essentially, push all of the expensive, risky operations onto the public sector and to, essentially, skim the highly profitable, easily scheduled, flexible, low-risk operations into the private sector. So I think that's a common practice that you see across Australia and across the world, where you have public and private facilities co-facilitated. And I suspect that there are other elements of the way that the PPP was constructed that had significant financial benefit for the private sector investors.

**The CHAIR:** Can you tell us about examples of what you've just been talking about? Can you point to specific examples, whether they're in Australia or overseas, of what you've just described?

**JASON WARD:** I'll give you an example that is true in Australia and is true from international studies that we've done, not necessarily in the hospital sector but looking again at the aged-care sector. In lots of countries, including Australia, this is largely delivered by private actors. And it's a lot cheaper for an aged-care operator to not staff adequately and to have residents suffer from bedsores and other things. And then, when that becomes a medical problem, those costs are then shifted onto public health facilities. This is certainly the case in Australia. It's certainly the case in the UK and in many other jurisdictions where we've done deep analysis of nursing homes and aged care. The private sector pushes costs onto the public sector.

**The CHAIR:** And have you done any analysis of the financial outcomes of some of these cases, whether they be Australian or other international examples? What sort of returns have private operators or even private equity players been able to achieve from these sorts of arrangements?

**JASON WARD:** There have been significant financial returns to private operators in this sector. Many years ago now, we did a study that was featured by the BBC on their *Panorama* show, which, I guess, would be the equivalent of the *Four Corners*, on HC-One, which was at that time the largest care provider. During the peak of COVID, they were begging for more funding from local councils and meanwhile shifting millions of dollars in dividends to the Cayman Islands. There is huge profits that can be made from this sector. And I think, in Australia, if you look at recent investments that have been made on taking over aged-care companies—despite the fact that the industry continues to cry poor, there are substantial profits that can be made from that sector and that continue to be made from that sector by, essentially, siphoning costs. The most common method of doing it is through the real estate ownership. Essentially, an entity can separate the ownership from the operations, pay itself large rents and then claim it doesn't have money to adequately pay staff or provide the care that residents truly need and that the Government expects when they fund those services.

**The CHAIR:** Have you looked at a specific example, probably overseas, because I can't think of any in Australia, where a private equity player has taken a hospital group private—done what you've described, I think, in your submission as the private equity playbook—and then realised an exit from that, whether by relisting the entity or selling it to somebody else at a significant profit? Have you looked at specific examples of where that play—obviously, in respect of the Healthscope play, it hasn't been successful in Australia. Have you seen similar plays that have been successful in other jurisdictions?

**JASON WARD:** Absolutely. In the United States, where the private equity takeover of hospitals has advanced farther than in any other jurisdiction, this is a particularly common practice, where the private equity firm can actually leave the hospital operating company in bankruptcy. But it has made significant profits from the sale of the real estate along the way. Not too dissimilar from the Healthscope situation with Brookfield, the entity is left with unsustainable levels of debt but has paid out dividends throughout the process, so that the investors who put their money into the fund are actually getting decent returns. But what's left behind is communities no longer having any access to any healthcare services. Some of the initial real estate investors in the Healthscope deal, when Brookfield came in, have been complicit in these types of structures in the United States with, I think, what was the largest private, for-profit hospital chain in the United States.

**The CHAIR:** Would you have access to further information about those case studies? Would you be prepared to provide them to us if we asked you for them?

**JASON WARD:** Absolutely. Some of that has been well documented, so I can provide others who have already written about this and documented that case in great detail.

**Mr MICHAEL REGAN:** I think you've touched on this a bit, but I'll just narrow it down a bit. Given your broader view of Healthscope, not just as it relates to Northern Beaches Hospital, how would you characterise its behaviour as a corporate citizen?

**JASON WARD:** Healthscope's behaviour as a corporate citizen? Brookfield as an entity has been a major investor in the insurance business but, in the case of Healthscope, it's been more than happy to blame the private health insurance sector for its woes and to blame its own workforce for rising costs. Those have contributed to the situation, but Brookfield has been very much responsible for the demise of Healthscope and has not been a responsible player in the health sector in Australia, nor has Brookfield been a responsible player in its numerous other investments in Australia.

**Mr MICHAEL REGAN:** What reform would you like to see prevent private equity in health care in Australia?

**JASON WARD:** There are lots of opportunities to have greater scrutiny over private equity investments. If private equity is going to invest in an entity that is highly dependent upon public funding, either directly or indirectly, it should face significant scrutiny. The Foreign Investment Review Board should have some understanding. Private equity firms investing in that, at a minimum, should be required to disclose who the limited

partners are in the fund. Right now there are ways to find that out, but it's not easy. It's not easy for the public or for governments, necessarily, to understand who's actually the driver or who's benefiting from the actions of the investment firm. In this case, a major investor in Healthscope has been Caisse de dépôt et placement du Québec, CDPQ, the public sector pension fund in Quebec, but that's not widely known or acknowledged. Frankly, the good people of Quebec have a right to know what their funds are investing in as well. There may be other investors that would raise concerns who might be part of those private equity funds.

**Mr MICHAEL REGAN:** In your submission, you reflect on the difference between Ramsay Health Care and Healthscope. What can we learn from that comparison?

**JASON WARD:** In general, Ramsay has been run in a much more ethical and efficient manner. I'm not saying that there aren't issues and problems with how Ramsay has been run, but I think the two make a very good comparison. Ramsay has been a very strong and healthy taxpayer in Australia over an extended period of time, whereas Brookfield has structured the Healthscope business and many of its other businesses in ways where it has barely paid a cent in tax over the whole period of time. That's largely done through various offshore related-party transactions and a complex ownership structure that has allowed Brookfield to take the fairly significant revenues of Healthscope.

It's not a small operation, but it has been able to distribute the profits in a way that has avoided tax in Australia. We've done extensive work on Brookfield in other countries as well and seen the same pattern of behaviour. As I mentioned in my opening remarks, this is a really live topic that's being discussed in the Canadian Parliament as well, and we're hoping to push Canada to follow Australia's lead in adopting public country-by-country reporting so that we can actually have some visibility on Brookfield and other multinationals, see what they're doing and look to close more loopholes to disallow this type of behaviour.

**Ms JENNY LEONG:** Apologies that I can't be in the room with you. Thank you so much, Mr Ward, for your submission and, indeed, the detailed work that you do. We're very much focused on the elements of public-private partnerships and the delivery of health services. I think you mentioned at the beginning that Healthscope has interests in other health provision. I think that would probably be quite a shock to many people in New South Wales, given the media attention simply on the Northern Beaches and the focus on the Government taking back control of the Northern Beaches Hospital. I wonder if you could provide details of what other interests Healthscope has in the delivery of health services in New South Wales.

**JASON WARD:** Not necessarily on Healthscope, but Brookfield as an investor is the dominant owner of GenesisCare, which is one of the largest cancer care oncology providers in Australia. Like Healthscope, it has gone through a series of various private equity ownerships. These things tend to get recycled through by different private equity owners, who strip out the profits they can and then pass it on to the next private equity owner. In addition to Brookfield, it appears that probably the three largest cancer care operators in Australia are all owned by various private equity firms. This is a crucial part of the health sector. This is a growing public health issue, and Australia has become reliant on private equity companies to operate care in that space.

We see private equity entering into early childhood education and care, and the results of that have been quite shocking and damning in terms of recent revelations. There's private equity in aged care, and has been for a long time, and private equity is involved in NDIS delivery. In each case, it's how do you extract maximum profit in the shortest amount of time. The long-term benefits to the community and the long-term benefits to the business itself are not really of consideration to those private equity firms. It's a purely short-term extractive model, and it definitely needs to come under significant scrutiny. It's public that the Australian Taxation Office is also very concerned about private equity and about how it structures its business in Australia. Increasingly, private equity and, in particular, Canadian public pension funds alongside Brookfield are buying up our infrastructure assets as well and extracting profits that don't benefit anyone in Australia. Those profits are being shifted offshore.

**Ms JENNY LEONG:** As a follow up to that, we've seen in other areas of policy and, indeed, delivery of public services—you talked about infrastructure. But in terms of, for example, the delivery of housing and developments, we've seen that there's been public scrutiny over the impact of lobbyists but also of financial vested interests where people are benefiting like, say, developers or real estate agents, and their roles—whether they can be local councillors and those kinds of potential conflicts.

In your capacity looking at corporate tax accountability, do you think there's enough scrutiny over the potential impacts of vested interests and people benefiting from private equity in the context of policymaking decisions and legislative decisions that are being made like this? Noting that my Greens colleague—when Healthscope first was flagged and the Northern Beaches Hospital was being set up—flagged the fact that there had actually been donations from Healthscope or, indeed, their related entities, to the Liberal Party at the time, I wonder what kind of oversight or scrutiny you would see as necessary to look at the influence of private equity and potential or perceived conflicts?

**JASON WARD:** I do think there's not enough scrutiny over political contributions, for one, from private equity firms and/or their facilitators. We still continue to have a problem with big four accounting firms that are providing advice to the private equity, facilitating relationships. There continues to be a problem with a revolving door between private equity firms, investment firms, big four accounting firms and the law firms that they use to advise them. There needs to be much more public scrutiny, particularly on the revolving door question, but also on political contributions as well.

**Ms JENNY LEONG:** Thanks, Mr Ward, for all your work.

**The CHAIR:** Mr Ward, thank you very much for appearing before the Committee today. The Committee may wish to send you some additional questions in writing. The replies will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions?

**JASON WARD:** Absolutely.

**The CHAIR:** Thank you. The Committee staff will also email any questions taken on notice from today and any supplementary questions. We kindly ask that you return these answers, if you can, by 12 January 2026. Thank you very much.

**(The witness withdrew.)**

**Ms LAUREN HUTCHINS**, Assistant Secretary, Health Services Union, affirmed and examined

**Ms PRUE IRVINE**, Organiser, Health Services Union, affirmed and examined

**The CHAIR:** I welcome our next witnesses, Ms Lauren Hutchins and Ms Prue Irvine from the Health Services Union. Thank you for appearing before the Public Accounts Committee today to give evidence. Please note the Committee staff will be taking photos and video during the hearing. The photos and video may be used for social media and public engagement purposes on the Legislative Assembly social media pages, websites and public communication materials. Please inform the Committee if you object to having photos and videos taken. Can you please confirm that you've been issued with the Committee's terms of reference and information about the Standing Orders that relate to the examination of witnesses?

**LAUREN HUTCHINS:** Yes.

**The CHAIR:** Thank you. Do you have any questions about this material?

**LAUREN HUTCHINS:** No.

**PRUE IRVINE:** No.

**The CHAIR:** Thank you. Before we get started, I'd like to reiterate some points I made during my opening statement earlier today. The Committee notes that there are matters involving Northern Beaches Hospital that are, or may be, subject to legal proceedings or coronial inquiry. We will therefore conduct this inquiry in a manner that respects the sub judice convention, which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that, when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa, or any matter under active coronial or other investigation.

It's also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings, a witness only has limited protections for the evidence that they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings. We will now move to questions from the Committee. Before we begin, I wish to inform witnesses that they may wish to take a question on notice, and we would ask that you provide answers to these by 12 January 2026 if possible.

**Mr CLAYTON BARR:** Thank you so much for appearing. Would it be fair for me to make a bit of an assumption that some of the HSU members who are now at Northern Beaches Hospital would have transferred in from the former public hospitals of Manly and Mona Vale? Would that be true?

**LAUREN HUTCHINS:** That's correct.

**Mr CLAYTON BARR:** I actually wanted to set that out, because I want to ask this question: Have your members experienced any noticeable changes around the nature of their work, the expectations or the methodologies, having shifted from being employed in that public sector across into the private sector?

**LAUREN HUTCHINS:** Yes, they have. I think Ms Irvine is probably best placed to respond to that.

**Mr CLAYTON BARR:** Could you talk to that, please, Ms Irvine?

**PRUE IRVINE:** Yes. A lot of our members who did come over from Mona Vale and Manly have said that the workloads have increased. They don't have the proper equipment to do their roles, specifically in the cleaning department. At Manly, they said that they had specific tools to clean out birthing tubs in the maternity suite, and they don't have that at Northern Beaches, which means that the potential for bacteria to still remain in those bathing tubs is still there.

**Mr CLAYTON BARR:** The consequence of that risk is the possible—

**PRUE IRVINE:** Yes, so they're cleaning out the tubs after a woman gives birth.

**Mr CLAYTON BARR:** Yes, of course. In terms of the workloads increasing, can you just give me a bit more detail around that?

**PRUE IRVINE:** Yes. I think they cut staff. There were a lot of cuts to staffing quite early on, which meant that people were working with unsafe ratios. Specifically, that would be in security as well. The security team went from, I think, having five people on shift to three, which put our members at a lot of risk of harm. The nurses and the patients in the hospital were also at risk because the security weren't attending code blacks and other emergencies in the hospital.

**Mr CLAYTON BARR:** Did you say they weren't?

**PRUE IRVINE:** They weren't able to, because they were stuck doing other things.

**Mr CLAYTON BARR:** What about allied health workers? Can I ask specifically about them? Again, did they transfer from the public into the private, and did the nature of their work change? Can you comment on that?

**PRUE IRVINE:** As far as I'm aware, there's not many that did transfer over from Manly, but the comments that they have raised were that they don't have the correct equipment to do their roles. There's a room filled with broken equipment that can't be used. Patients are often left in their beds because the beds aren't working. They struggle with their roles as well.

**Mr CLAYTON BARR:** Finally, can I just get some clarity? Northern Beaches Hospital was operating in part a public part of that hospital but in another part a private part. Your members would work across all of that. Is that correct?

**PRUE IRVINE:** Yes. Correct.

**Mr CLAYTON BARR:** Was there a noticeable difference between what was happening in the public section compared to what was happening in the private section, or was it across the board higher workloads?

**PRUE IRVINE:** Across the board it was higher workloads.

**Mr CLAYTON BARR:** And not always having the necessary equipment.

**PRUE IRVINE:** Correct.

**Mr MICHAEL REGAN:** I've just got a question which I've asked everyone today. Are you happy about the Minister's announcement? Are you happy that it's coming back into public hands?

**LAUREN HUTCHINS:** I might take that one. We commend the Government for making the announcement, but we are cautious and concerned about a narrative that is currently circulating about how that will operate. We are aware there was a public forum where there was much discussion about ensuring that part of the hospital remained private, and I understand that there are some concerns about a full public hospital being in the Northern Beaches. But our members who are working today—who have been at the coalface of this failed experiment—tell us that the arrangement that exists has put patients at risk and it has put staff at risk. The only way that we can ensure that patients and staff are safe is to ensure that this is run by NSW Health.

We appreciate that there are those who want to make choices about their health care. Although, personally, my view is that all health care should be public, but there are options available for people in the area already which would ensure that those needs are met. The idea that we could half-return this to public hands and yet still be at the behest of those who have some interest in privatisation, I think is unacceptable to our members. It's certainly unacceptable to the HSU. Though we are very supportive of the announcement, we are concerned that it will not go far enough. It is our view that Northern Beaches Hospital should be a public hospital.

The expectation for everyone walking through those doors there should be the same as it is for someone in Nepean, at Prince of Wales and at RPA. There should not be another experiment on how we run a public hospital. We appreciate that that private hospitals co-locate with public hospitals all the time, and that there is some efficiency to that. That cannot exist at Northern Beaches. We understand that there has already been a review to say that that cannot operate in that way. Our members shouldn't have to have two masters, absolutely. Their only master should be the New South Wales public and delivering services to those people who need it.

**Mr CLAYTON BARR:** Can I just go to the "two masters" comment? Do your members at the old or current version of Northern Beaches Hospital tend to get rostered either into the public part of the hospital or the private part? Just by way of rostering, do they tend to either work there or there?

**LAUREN HUTCHINS:** Healthscope is their employer, so Healthscope rosters them as they see fit. We do understand that Healthscope makes decisions on how they're rostered to best benefit some parts of their organisation over others. I don't know, Ms Irvine, if you want to add to that.

**PRUE IRVINE:** Yes. They are rostered just under Healthscope, not public and private. However, I do believe more staffing go to the private wards.

**Mr CLAYTON BARR:** But they could be rostered anywhere in the precinct.

**PRUE IRVINE:** Correct.

**Mr CLAYTON BARR:** Not specifically, okay.

**The CHAIR:** I might ask a question I've asked other witnesses today as well. There are two competing narratives that we've heard across the evidence in this inquiry so far. There's one narrative that says it's accepted that there has been understaffing. It's accepted that there has been under-investment in equipment, yet the level of care and the quality of care that is provided at the hospital is equivalent, at least equivalent to that of public hospitals. Some have said that's because staff—medical staff, nursing staff—have gone above and beyond to provide that. Yet serious adverse incidents, tragic things, have occurred at Northern Beaches Hospital. How would you reconcile these two competing narratives that Northern Beaches Hospital hits its KPIs, sometimes outperforms its KPIs under the project deed but also reported publicly, but yet these terrible things have happened.

**LAUREN HUTCHINS:** I would say to your point that you have incredible staff that are very dedicated to serving the patients and their families that enter that hospital, and who absolutely have gone above and beyond with shrinking resources and shrinking staff numbers to make sure that they deliver on the care that they signed up to deliver. The fundamental principle of all of this is that this is a service that may meet its KPIs, but it's driven by profit. Ultimately, that means that at some point a decision is made about where money goes and, for us, when we see wards being shut down and when we see wards being rented out to film studios, those aren't decisions made in the best interests of the people of the Northern Beaches. How you get from an incredibly dedicated staff to adverse outcomes that we're aware of is because someone at the end of all of this is making sure that the shareholders' needs are met as well. They might be meeting your KPIs, but at some point they're also meeting someone else's KPIs that have nothing to do with the provision of health.

**The CHAIR:** In your opinion, or from what you understand from your members, is the quality of care at Northern Beaches Hospital significantly different from that of other hospitals—equivalent hospitals?

**LAUREN HUTCHINS:** I certainly know that our members at other hospitals, if they were told to reuse equipment in a maternity ward, would certainly be able to raise that immediately and that would be addressed. We are absolutely convinced that there are differences in the services that are provided. I know that there are other incidents that we're aware of that Ms Irvine can go to because there is a difference between the application of policies, because our members at Northern Beaches are directed to work under Healthscope policies versus our members in NSW Health, who have a very clear set of instructions through those policies about how they operate. I might hand to Ms Irvine to speak to that.

**PRUE IRVINE:** There was one specific example that occurred last year where a mental health patient from the public part of the hospital—his head was slammed into a wall because his legs had been kicked out by a staff member and they then restrained him in the prone position for a very long period of time, which is outside the NSW Health policy, and a staff member sat on the patient's back. There were other members there who were saying that this is wrong and that this is not within our policy, and it was ignored.

**LAUREN HUTCHINS:** I think, to Ms Irvine's point here, there is a clear difference in how Healthscope addresses matters of security versus how NSW Health addresses issues of security. The training is different. The requirements are different. There are very different systems there that have led to adverse outcomes for patients as a result of that.

**The CHAIR:** If we were to ask you to provide some more detail about the specific policy differences that you are talking about, would you be prepared to do that? I think we'd find that very helpful.

**PRUE IRVINE:** Yes.

**The CHAIR:** That would be terrific. Thank you very much for coming to give evidence before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions, if we had any?

**LAUREN HUTCHINS:** Yes.

**PRUE IRVINE:** Yes.

**The CHAIR:** Thank you very much. The Committee staff will also email any questions taken on notice today and any supplementary questions from the Committee. We kindly ask that you return those answers by

12 January 2026, if possible. That concludes the public hearing for today. I thank all the witnesses who appeared before the Committee. I thank my fellow Committee members, Committee staff, Hansard and the staff of the Department of Parliamentary Services for their help in the conduct of the hearing.

**(The witnesses withdrew.)**

**The Committee adjourned at 12:50.**