Special Commission of Inquiry into Healthcare Funding – New South Wales

STATEMENT OF BENJAMIN EDWARDS

I, **Benjamin Edwards**, state as follows:

1 I make this statement from my own knowledge gained through my roles with St John of God Health Care (**SJGHC**), which are outlined below; and based on my review of SJGHC documents, which I have undertaken both in the ordinary course of my work and for the purposes of preparing this statement.

2 I am the Chief Operating Officer (**COO**) at SJGHC, a role I have held since January 2023. I live in Perth, Western Australia and work day-to-day at SJGHC in Perth.

3 SJGHC is one of the largest Catholic providers of health care services in Australia. It was established in Western Australia in 1895, and operates as a not-for-profit private health care group, employing more than 17,000 staff across Australia and New Zealand.

4 As COO of SJGHC, my responsibilities include overall responsibility of all SJGHC hospitals and other health services, via local Chief Executive Officers (CEOs). This includes overall responsibility for the Hawkesbury District Health Service (**HDHS**), via the local CEO, who reports to me.

5 SJGHC operates 8 hospitals and health care services in Western Australia. SJGHC also operates 8 hospitals and other health care services in Victoria. In New South Wales, SJGHC operates 3 hospitals and other health care services, including HDHS.

A. My background

6 Before being appointed COO of SJGHC, I was:

6.1 from February 2017 to December 2022, CEO of St John of God Murdoch Hospital;

6.2 from October 2016 to February 2017, CEO of St John of God Mount Lawley Hospital; and

6.3 from December 2014 to October 2016, Transformation Lead for SJGHC.

7 My background in the healthcare sector commenced with roles in the National Health Service in England, for which I worked from September 1998 to September 2006. Between October 2006 and December 2014, I held senior roles with Ernst & Young Global Consulting Services and PWC in the United Kingdom and Australia.

8 My formal qualifications comprise:

8.1 a Bachelor of Arts awarded by the University of Leicester (United Kingdom) in 1997;

8.2 a Post Graduate Certificate in Education awarded by the University of Leeds (UK) in 1998; and

8.3 a Level 4 Institute of Health Management qualification awarded by Edexcel/Birmingham University (UK) in 2000.

B. History of HDHS

9 HDHS is a 131 bed hospital in Windsor, NSW, which provides acute, community, and allied health services to the local community and surrounding districts.

10 HDHS provides 24-hour emergency, medical, surgical, diagnostic, maternity, neonatal, paediatric, palliative and intensive care, and coronary care services. HDHS currently provides public health services under a public-private partnership (**PPP**) with the Nepean Blue Mountains Local Health District (**NBMLHD**).

11 HDHS is on the site of the original Hawkesbury Hospital, which was built in 1820. The building was originally erected as a barracks for convict workmen, and was converted into a convict hospital in 1823. The convict hospital closed in 1841 when transportation of convicts ended.

12 In 1955, a new facility was constructed on the site, which operated until the late 1980s.

C. SJGHC's involvement with HDHS

13 In 1989, planning for a new hospital began, to replace the ageing Hawkesbury Hospital facility. In 1994, the NSW Government awarded Catholic Healthcare NSW and ACT (**Catholic Healthcare**) the contract to operate the facility. The site was handed over to Catholic Healthcare in June 1996, and the first patients were accepted in August 1996.

14 In 2015, Catholic Healthcare agreed to transfer the ownership and management of HDHS to SJGHC. The transfer formally occurred on 4 November 2015.

15 At that time, the agreement between NBMLHD and Catholic Healthcare (which SJGHC took over), was for a period of 20 years from 1996, with an option to extend for a period of five years.

16 When the contract term was due to expire in 2016, SJGHC exercised the option to extend the contract. A new expiry date of 30 June 2022 was set. As addressed further below, that expiry date was the subject of further extensions, but SJGHC's involvement with HDHS will now conclude on 30 June 2024.

D. Decision not to continue negotiations for a new contract

17 I understand that a key question that this Special Commission of Inquiry wishes to explore with SJGHC is its decision not to renew its contract – or not to continue negotiations to enter into a new contract – with NBMLHD to operate HDHS. This was a decision SJGHC did not take lightly.

18 As noted above, the original agreement relating to SJGHC's operation of HDHS expired on 30 June 2022. In July and December 2022, SJGHC and NBMLHD entered into Deeds of Amendment, which ultimately extended the contract to 31 March 2024, while the parties engaged in discussions and negotiations.

19 This process was intended to involve agreeing the terms of a new contract. The negotiations for a new contract continued during 2022 and 2023.

20 In late 2023, following a comprehensive operational and strategic review, SJGHC decided to cease the negotiations for a new contract, and not to renew the existing contract.

21 In January 2024, once SJGHC had indicated it did not wish to continue negotiations to enter into a new contract relating to the operation of HDHS, SJGHC and NBMLHD entered into a Second Amending Deed, which extended the term of the existing contract to 30 June 2024, to permit a smooth transition of HDHS to NBMLHD by that date.

22 There were broadly four reasons for SJGHC deciding to end the negotiation process for a new contract with NBMLHD for the HDHS. Those reasons can be categorised as two broad strategic factors, and two more local factors.

23 The two broad strategic factors relate to:

23.1 the challenging healthcare environment nationally, both in the public and private sectors; and

23.2 a changed attitude to PPP arrangements in NSW.

24 The two local factors relate to:

24.1 the commercial and financial performance of HDHS; and

24.2 the timing for the decision whether to continue to pursue a new contract.

25 I deal in more detail with those matters below.

i. Challenging healthcare environment

26 Since the COVID-19 period, the macro environment in which providers of healthcare services have been operating has changed significantly. In short, it is more difficult to operate hospitals which are financially sustainable largely because costs have increased significantly, and there have not consistently been equivalent increases in funding.

27 This increase in costs has included the costs of medical and surgical supplies, insurance, and utilities but most importantly staffing. Staffing costs have increased because there are shortages of skilled workers in some areas, meaning that a provider has to use locums or other temporary agency staff, who generally cost more than permanent staff.

ii. Changed attitude to PPPs in NSW

28 A key reason for SJGHC taking over the contract with NBMLHD from Catholic Healthcare in 2015 was that HDHS provided a foundation for SJGHC to consider an expansion of its operations in NSW via PPPs.

29 SJGHC operated (and continues to operate) other private hospitals in NSW, but HDHS was its first PPP in the state.

30 However, by about 2019, SJGHC had observed that, as a general proposition, PPPs were a less popular way to operate public hospitals in NSW. Accordingly, from around this time, SJGHC began to consider that it was unlikely that its strategy for expanding its healthcare operations in NSW via PPPs would be successful in the longer term. This caused SJDHC to reconsider its strategy in this area, and in particular the role of HDHS in that strategy.

iii. Commercial/financial performance of HDHS

31 A significant factor in SJGHC's decision not to continue discussions to enter into a new contract with NBMLHD, and to allow the existing contract to expire, was the deteriorating financial position of HDHS, which reflected the sector-wide environment in which increased costs exceed funding levels.

32 In summary, operating margins have declined since FY2020. This culminated in very poor financial performance in FY2023, which was anticipated to continue for FY2024.

33 This financial deterioration was primarily driven by the growing gap between the available funding and cost of operating HDHS.

a. Costs at HDHS

34 HDHS has had difficulties recruiting and employ permanent doctors due to competition for such workers with other healthcare services. This has necessitated an increase in the use of agency and locum doctors to fill rosters, which has caused staff costs to increase. As noted above, this is not an issue confined to HDHS.

35 In addition to issues with recruiting doctors, HDHS has also had to deal with shortages of other trained professionals. For example, HDHS has had difficulties recruiting junior and graduate nursing staff, meaning the nursing staff was increasingly comprised of more experienced nurses, who are more expensive.

36 Another cost pressure has been due to an increase in high acuity medical patients presenting at the hospital over time, most likely due to the aging demographics of people in the local area. In each of the last few financial years, there has been an increase in medical admissions as a proportion of total admissions. Medical admissions generally attract lower amounts of funding to a hospital, than surgical admissions. When a hospital becomes full with medical patients, who typically present via the Emergency Department, it can restrict the amount of surgical activity that can be undertaken, which impacts the hospital's overall financial position.

37 A further cost pressure on HDHS is the general increase in the cost of all medical supplies, as well as most other expenditure items due to inflation in recent years.

38 In 2023, SJGHC undertook a review of HDHS, to examine whether any efficiencies could be achieved in its operations. However, the review concluded that the hospital was running very efficiently, and that further attempts at saving costs by reducing any inputs would have an adverse impact on the quality of care, which was obviously not an acceptable outcome for SJGHC.

b. Funding for HDHS

39 SJGHC raised the issue of funding with the NBMLHD on several occasions during 2023, and indicated that, SJGHC would need increased funding in order to be able to continue to operate HDHS. SJGHC was informed that it was unlikely that further funding would be available. In relation to those matters, SJGHC only had interactions with the NBMLHD, and not directly with the Ministry of Health, which is not unusual in SJGHC's experience dealing with government negotiations.

40 In addition, the commercial pressure on SJGHC in its operation of the HDHS was not anticipated to be alleviated under a new contract with NBMLHD. To the contrary, the proposed terms of the new contract being negotiated with NBMLHD included terms which were likely to mean the financial position of HDHS would deteriorate further.

41 In particular, the funding issues that SJGHC perceived it would face under a new contract included:

41.1 A lower contract price as a result of a change in the pricing methodology.

41.2 new abatement penalties if KPIs were not met; and

41.3 the proposed contract would require that there be multiple years of financial losses before the contract could be terminated by SJGHC. This was a different mechanism from the previous contract, and would have increased risk on SJGHC.

42 The funding model for HDHS, as a PPP healthcare provider, is complex has four 'streams', and it is not always clear whether a particular source of funding will be available. For comparison, funding for a private hospital would see Health Funds typically make a single payment for each patient treatment, which encompasses all related costs of providing the care.

43 In relation to HDHS the first part of the funding was based on a mechanism known as 'Activity Based Funding'. The key features are:

43.1 a rate per 'National Weighted Activity Unit' (NWAU) (a measure of health service activity expressed as a common unit of resources) based on the NSW State Price;

43.2 funded activity levels for acute care, an Emergency Department, sub-acute and non-admitted care (eg, community care and outpatient care); and

43.3 recurrent or one-off additional funding amounts for certain items, which may include:

(a) Transitional Aged Care Programmes;

(b) Training, Teaching and Research.

44 The second part of the HDHS funding has come from 'top-ups' during the year, which might be provided for items such as backdated salary and wages (due to EA outcomes in-year), Information Technology developments (as required by the NBMLHD), or due to other unforeseen events such COVID-19. This type of funding generally needs to be specifically requested from the NBMLHD, and it is usually not automatically available.

45 The third part of the funding has been a mechanism to request an amount for activity overruns during the year. For example, there might be demand for more orthopaedic care services. If requested, there is sometimes more funding available for these activities. The NBMLHD has sometimes been able to provide up to an additional 2% funding for such overruns, however, again, HDHS has to make a specific request for this funding, and it is not automatically available, and not necessarily granted at the level requested by HDHS.

46 Finally, an area of particular complexity – which is particularly relevant at HDHS – is capital funding. Capital funding includes new equipment, improvements to the physical buildings, and other similar expenditure.

47 Capital investment is separately funded to operational expenses, and is available in three separate 'buckets', as follows:

47.1 Under $10,000 – capital expenditure at this level is expected to be funded by HDHS from NWAU funding. This is the same for other public hospitals.

47.2 $10,000 to $250,000 Minor Works & Equipment (**MW&E**) – SJGHC's understanding is that other public hospitals have expenditure at this level funded through a separate MW&E budget from their Local Health District. HDHS has been asked to provide substantial funding towards MW&E from its operational funding (in the region of $400,000 per annum for the public hospital).

47.3 $250,000 plus – Asset Refurbishment Replacement Programme (**ARRP**) – HDHS is able to make a submission to the NBMLHD, which in turn makes a submission to the Ministry of Health, to access funding for expenditure of this level. HDHS has received some funding for an ARRP, but it is not guaranteed every year, and a submission will not necessarily be granted.

48 The impact of this complex and uncertain system of funding for capital expenditure is that it has been harder for SJGHC to plan for capital expenditure for HDHS. Moreover, the application process for an ARRP is slow and there can be a delay between the request for capital funding, and an outcome, meaning SJGHC has often been required to self-fund equipment which needs to be replaced to keep HDHS running, if for example an item of equipment is critical to clinical care.

49 A further impact of the lack of capital investment over time is that the ageing buildings in the HDHS facility require higher repair and maintenance costs each year, which places a further burden on the operational budget.

iv. Timing

50 As set out above, SJGHC and NBMLHD agreed to extend the existing contract to 30 June 2024. The contract states that a party must provide 3 months' notice to terminate the

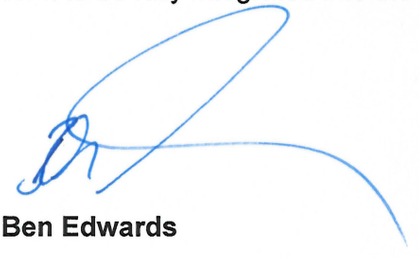
contract, which meant SJGHC needed to decide whether to extend the contract beyond its formal expiry date by 31 March 2024.

51 In view of that deadline, SJGHC reviewed the financial performance of HDHS in FY2023, and the year-to-date information for FY2024, which showed a further significant deterioration of the financial position. Specifically, HDHS expected to suffer a significant loss, in the vicinity of $4M for FY2024. In view of the financial position of HDHS at that time, and because the contributing factors do not appear to be changing, SJGHC decided that it could not continue its involvement with the hospital.

52 The decision to end SJGHC's involvement with HDHS was also influenced by the terms of the new contract proposed by NBMLHD. In particular, the proposed contract would require that there be multiple years of losses before the contract could be terminated. This was a different mechanism from the previous contract, and would have placed SJGHC in the position of having to absorb substantial further losses if the financial performance of HDHS did not improve in the new contract period.

E. Other remarks

53 It was a difficult decision for SJGHC to end its involvement with HDHS. However, it considers that it will be in the best interests of the community, patients, and staff for the hospital to be operated by the NBMLHD, which will allow it to be fully integrated into the public health and hospital system in NSW.



Dated: 4 June 2024

Ben Edwards