Special Commission of Inquiry into Healthcare Funding

Joint statement of Alfa D'Amato, Steven Carr and Neville Onley

Name: Alfa D'Amato

Professional address: 1 Reserve Road, St Leonards NSW 2065

Occupation: Deputy Secretary, Financial Services and Asset Management and Chief Financial Officer, NSW Health

Name: Steven Carr

Professional address: 1 Reserve Road, St Leonards NSW 2065

Occupation: Executive Director, System Financial Performance and Deputy CFO, NSW Health

Name: Neville Onley

Professional address: 1 Reserve Road, St Leonards NSW 2065

Occupation: Executive Director, Activity Based Management, NSW Health

1. This statement accurately sets out the evidence that we would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Inquiry**) as witness and the views expressed are jointly held. The statement is true to the best of our knowledge and belief.

A. SCOPE OF STATEMENT

2. This statement addresses Term of Reference A concerning the funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services and Term of Reference C concerning the way NSW Health funds health services delivered in public hospitals and community settings. It addresses the budget process and how funds are allocated, the role of Activity Based Funding in the budget process and the processes for monitoring budget performance and seeking additional funding.

3. Alfa D'Amato has previously provided to the Inquiry a joint report dated 27 November 2023 with Ms Deb Willcox, who at that time was the Acting Secretary of NSW Health A.53. (**MOH.9999.0005.0001**). Adjunct Professor D'Amato has also provided to the Inquiry a statement dated 9 April 2024 (**MOH.9999.0763.0001**).D.4.

4. Sharon Smith has provided to the Inquiry a statement dated 9 April 2024 (**MOH.9999.0980.0001**).D9

5. As much as possible, this statement does not re-canvass the matters discussed in that report or those statements, except where I perceive those matters as relevant to respond to the issues raised by the Inquiry or to address Terms of Reference A and C.

6. The information in this statement should be interpreted in the context of a pre-COVID-19 and post COVID-19 pandemic environment. The COVID-19 pandemic period, when growth in the Health budget was extremely volatile and focussed on the response to the pandemic, is not covered.

B. HEALTHCARE FUNDING IN AUSTRALIA

7. Responsibility for the funding of healthcare in Australia is split between the Commonwealth, states and territories. The states and territories have responsibility for the management of public hospitals and provision of some community and public health services, but funding for these services is shared between the Commonwealth and the respective state/territory.

8. The Commonwealth provides funding through Medical Benefits Scheme (**MBS**), Pharmaceutical Benefits Scheme (**PBS**) and private health insurance rebates, as well as funding to the states and territories to support delivery of care through public hospitals as outlined in the National Health Reform Agreement (**NHRA**) Addendum 2020-25.

9. There is a complex architecture of federal/state agreements which outline a range of arrangements between the Commonwealth and NSW to facilitate the delivery of healthcare. In addition to the NHRA, this includes national agreements such as the National Mental Health and Suicide Prevention Agreement and sectoral agreements for areas such as adult public dental services, palliative care in aged care, and the delivery of essential vaccines. Some additional funding is received by NSW from direct source revenue such as private health insurance payments.

10. NSW also works with the Commonwealth under a memorandum of understanding to improve access to primary care for people living in small rural, remote and very remote areas known as the Council of Australian Governments (**COAG**) Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative. This initiative enables NSW Health to bulk bill eligible health care services at agreed sites.

11. This engagement is led by the Regional Health Division within the Ministry of Health. NSW has 47 health sites across rural and remote NSW that have been granted an exemption under the Initiative. The NSW sites are located across 5 local health districts: Far West; Hunter New England; Murrumbidgee; Northern NSW, and Western NSW. The

majority of the funding received under the Initiative is invested in primary care through new services, improvements or new equipment.

Significant changes to national funding and governance of health introduced

12. In 2011, the COAG agreed to significant changes to how the Commonwealth contribution to public hospitals would be provided to states and territories, including a commitment to the introduction of an activity based funding (**ABF**) model. All states and territories, including NSW introduced changes to support these new funding and performance accountability requirements which came into effect on 1 July 2012 when national healthcare specific purpose payments were replaced with national health reform funding. The ABF funding model will be explained in further detail later in this statement.

13. The introduction of these new measures was designed to improve patient access to services and public hospital efficiency through the use of ABF based on a National Efficient Price (**NEP**) and improve the transparency of public hospital funding through a National Health Funding Pool and nationally consistent approach to ABF. Some services continued to be block funded.

14. The **NEP** is used to determine the Commonwealth contribution to NSW healthcare services in line with the NHRA Addendum 2020-25. Commonwealth funding essentially represents the prior year contribution plus current year reconciled activity growth (in NWAU) multiplied by the current year NEP multiplied by 45 per cent plus the current year growth in NEP multiplied by 45 per cent. Growth in Commonwealth contributions are capped at 6.5 per cent above the previous calculation (A33 and A34 of the NHRA).

15. National agencies including the Independent Hospitals Pricing Authority (now Independent Health and Aged Care Pricing Authority (**IHACPA)**), the National Health Funding Body and the Australian Commission on Safety and Quality in Healthcare were established to support these new processes.

16. To complement this new pricing mechanism, NSW introduced a purchasing framework.

17. The NHRA also required the establishment of Local Hospital Networks (named Local Health Districts in NSW) to increase local accountability and to drive improvements in

performance. Service Agreements for each network, outlining the mix of services and level of funding provided, were required to be made publicly available.

18. NSW public health services are funded at a price per national weighted activity unit (NWAU) and based on activity as negotiated in the Service Agreements between the Secretary, NSW Health and the Chief Executives of the Local Health Districts (**LHDs**) and Specialty Health Networks (**SHNs**).

19. NSW Health, as the State Manager, determines its own State Efficient Price (**SEP**) for ABF in NSW which better reflects the cost of health service delivery in NSW. Differences between the SEP and NEP are based fundamentally on differences in cost between NSW and the rest of Australia. This is recognised and provided for in the NHRA–Addendum 2020-25 as reflected in clauses A89 to A94 in the excerpt below.

> **State and Territory funding arrangements**
>
> Determining the State Funding Contribution
>
> A89. The State contribution to the funding of public hospital services and functions will be calculated on an activity basis or provided as block funding in accordance with the process outlined above in the eligibility clauses A17 to A24.
>
> A90. States will determine the amount they pay for public hospital services and functions and the mix of those services and functions, and will meet the balance of the cost of delivering public hospital services and functions over and above the Commonwealth contribution.
>
> A91. Variations in the State funding contribution in respect of individual Local Hospital Networks for services and functions funded under this Addendum may be required to enable States to play their role of system managers of the public hospital system. States may use their own proportion of public hospital funding, or Commonwealth block funding paid to the States (other than funding for teaching, training or research), to retain some funding from Local Hospital Networks and use it to adjust service levels across the State, and to respond to unforeseen events and other contingencies as set out at clause A141.
>
> A92. State funding paid on an activity basis to Local Hospital Networks will be based for each service category on:
>
> a. the price set by that State (which will be reported in Service Agreements); and
>
> b. the volume of weighted services as set out in Service Agreements.
>
> A93. It is expected that these arrangements will create incentives for Local Hospital Network efficiency. If a Local Hospital Network is able to operate more efficiently than the level of funding set by the State under the Local Hospital Network Service Agreement, the Local Hospital Network will be able to retain and reinvest the benefits accruing from efficiency in service delivery and in accordance with State policy and practice, as guided by the Service Agreement.
>
> A94. There will be no requirement for Local Hospital Networks to be paid the full national efficient price if the State considers that a lower payment is appropriate, having regard to the actual cost of service delivery and the Local Hospital Network's capacity to generate revenue from other sources.

20. In NSW, funding to the LHDs recognises where there is a higher cost to provide services, which results in LHDs receiving a Cost Price Adjustment (**CPA**). The CPA is the difference between the SEP and LHD/SHN's Projected Average Cost (**PAC**). Where the PAC is higher than the SEP, an adjustment per NWAU is calculated and applied to base

level activity. This represents the additional cost per NWAU that the LHD/SHN requires to deliver each unit of activity.

21. Regional LHDs also receive a Recognised Structural Cost (**RSC**) which recognises some of the barriers to achieving operational efficiencies that may be beyond the control of LHD management. This component is excluded when determining the amount of growth activity to be funded from the CPA.

22. The NSW Health Purchasing Framework is a fundamental mechanism for distributing resources to achieve the key priorities, directions and strategies of NSW Health, and aims to better link funding and performance outcomes to the mix and level of services to be purchased from LHDs and SHNs.

23. This process is discussed in the statement of the Deputy Secretary, System Sustainability and Performance.

24. The first NSW Health budget based on the NHRA was implemented in 2012-13. This budget was based on a funding model developed by NSW Health to comply with the requirements as set out in the NHRA.

25. ABF funding (both National and State) reflected a staged implementation, initially only applying to acute inpatient services and emergency department activity (2012-13) before being followed by sub-acute services and admitted mental health (2013-14) and non-admitted clinics (2017-18). Non-admitted (community) mental health services will transition from Block Funding to ABF in 2025-26.

26. Health services considered by both the Commonwealth and its agencies to be excluded from Commonwealth funding contributions (‘out of scope’ services) continued to be provided by NSW Health and were funded predominantly from State Government contributions. The table below extracted from the 2024-25 Service Agreement for Murrumbidgee LHD demonstrates the various funding streams.

4.3 Budget Schedule: NHRA Clause A95(b) Notice: Part 3

Murrumbidgee Local Health District	ABF		Block	Total	C'wealth Contribution	
	NWAU	$000	$000	$000	$000	%
Acute Admitted	43,365	$251,535			$106,602	42.4%
Mental Health - Admitted (Acute and Sub-Acute)	4,423	$25,252			$10,872	43.1%
Sub-Acute Services - Admitted	6,654	$40,894			$16,357	40.0%
Emergency Department	12,149	$77,419			$29,866	38.6%
Non Admitted Patients (Including Dental)	13,237	$78,880			$32,541	41.3%
Teaching, Training and Research			$15,384		$5,782	37.6%
Mental Health - Non Admitted			$25,418		$9,883	38.9%
Other Non Admitted Patient Services - Home Ventilation						
Block-funded small rural & standalone MH			$265,852		$74,833	28.1%
High cost, highly specialised therapies						
Other public hospital programs						
Innovative Models of Care						
Public Health			$3,505		$1,582	45.1%
In-Scope for Commonwealth & State NHRA Contributions Total	**79,829**	**$473,981**	**$310,160**	**$784,141**	**$288,318**	**36.8%**
Acute Admitted	1,385	$7,923				
Mental Health - Admitted (Acute and Sub-Acute)	18	$102				
Sub-Acute Services - Admitted	481	$2,753				
Emergency Department	571	$3,267				
Non Admitted Patients (Including Dental)	183	$1,300				
State & Other Funding Contributions Total	**2,637**	**$15,346**		**$15,346**		
State Only Block			$8,202	**$8,202**		
Restricted Financial Asset Expenses			$1,220	**$1,220**		
Depreciation (General Funds only)			$33,709	**$33,709**		
Total	**82,466**	**$489,328**	**$353,290**	**$842,618**	**$288,318**	**34.2%**

27. Each year, the IHACPA publishes an annual NEP Determination and an annual National Efficient Cost (**NEC**) for public hospital services for the coming financial year.

28. The NEC underpins funding for services that are not suitable for ABF, such as small rural hospitals. The NEC determines the Commonwealth Government contribution to block funded hospitals.

29. The NEP has two key purposes. The first is to determine the amount of Commonwealth Government funding for public hospital services, and the second is to provide a price signal or benchmark about the efficient cost of providing public hospital services.

30. NSW has considerable interaction with the Commonwealth agencies established under the NHRA. NSW is represented on all major formal committees including the Jurisdictional Advisory Committee (**JAC**) and the Technical Advisory Committee (**TAC**) which meet on a regular basis. All states and territories are able to make submissions to IHACPA on the development of the NEP and NEC, including the Pricing Framework, on an annual basis. This is on a formal basis whereby IHACPA is required under the NHRA to issue papers through the Jurisdictional Health Ministers for a 45 day consultation period. Major items covered under this requirement are the:

    a. Consultation Paper on the Pricing Framework

    b. Draft Pricing Framework

    c. Draft NEP determination

d. Draft NEC determination

31. NSW has a robust process in place for reviewing these documents and assessing the impact of changes on LHDs and SHNs. IHACPA is not compelled to adopt recommendations provided by jurisdictional responses with the result that there is frequently minimal change between draft determinations and the final determinations. Examples of requests by NSW which were not adopted by IHACPA include adjustments for Cultural and Linguistically Diverse (**CALD**) patients, Homelessness and a review of the requirement for Mechanical Ventilation as a determinant for the ICU loading.

32. Each NEP Determination includes the scope of public hospital services eligible for Commonwealth Government funding (the General List of In-Scope Public Hospital Services) under the NHRA and adjustments to the price to reflect legitimate and unavoidable variations in the cost of delivering health care services.

33. The Commonwealth, states and territories can apply to have services included or excluded from the General List. This includes new and innovative models of care and approaches to public hospital funding. The Commonwealth and a state or territory can also agree to trial an innovative model of care through a bilateral agreement. IHACPA will consider each state and territory's recommendations against published eligibility criteria and publicly release its determination and associated rationale. All applications are assessed in a single annual process which aligns to the NEP Determination.

34. In June 2024, following negotiations with IHACPA and the Commonwealth, a bilateral agreement was signed by the Commonwealth and NSW Minister for Health which identified five innovative programs as in scope for 2022-23, 2023-24 and 2024-25. These programs were – Royal Prince Alfred Virtual, Telestroke, Pathways to Community Living (PCLI), Virtual Clinical Care Centres and Northern Sydney LHD Frail Aged Program.

35. The IHACPA determine a series of price adjustments to take into account the higher cost of delivering hospital services to some patients. The list of adjustments is outlined in the table below with the respective value represented in dollars for the 2024-25 Service Agreements.

By NWAU Adjustments	24/25 Target	24/25 ABF Budget	24/25 ABF Budget	
			7 Rural LHDs	Metro LHDs
	NWAU24	$ M	$ M	$ M
Price Weight (incl. Private Pat Adj)	2,924,120	$16,843 M	$5,015 M	$11,828 M
Paediatric Adjustment	14,314	$81 M	$10 M	$71 M
Remote Area Adjustment	11,236	$64 M	$54 M	$10 M
Indigenous Adjustment	5,566	$32 M	$17 M	$15 M
Radiotherapy Adjustment	4,553	$26 M	$5 M	$22 M
Dialysis Adjustment	8,720	$50 M	$9 M	$41 M
Multidisciplinary Adjustment	6,797	$39 M	$9 M	$30 M
COVID Adjustment	4,808	$28 M	$7 M	$21 M
ICU Adjustment	131,253	$761 M	$106 M	$655 M
Total	**3,111,368**	**$17,925 M**	**$5,233 M**	**$12,692 M**

36. IHACPA uses a series of complex formulas to calculate the price of an ABF activity. The formula below, for the price of an admitted acute ABF activity, shows how the adjustment factors are incorporated into the price:

$$\{[PW \times A_{Paed} \times (1 + A_{Res} + A_{Ind} + A_{RT} + A_{Dia}) \times (1 + A_{Treat}) \times (1 + A_{C19}) + (A_{ICU} \times \text{ICU hours})] - [(PW + A_{ICU} \times \text{ICU hours}) \times A_{PPS} + LOS \times A_{Acc}] - PW \times A_{HAC} - PW_{AHR} \times R_{AHR}\} \times NEP$$

Where:

PW means the price weight for an ABF activity

A_{Paed} means the paediatric adjustment

A_{res} means each or any patient residential remoteness area adjustment

A_{Ind} means the Indigenous adjustment

A_{RT} means the radiotherapy adjustment

A_{Dia} means the dialysis adjustment

A_{Treat} means each or any patient treatment remoteness area adjustment

A_{C19} means the COVID-19 treatment adjustment

A_{ICU} means the intensive care unit adjustment

ICU hours means the number of hours spent by a person within a specified intensive care unit

A_{PPS} means the private patient service adjustment

LOS means the length of stay in hospital (in days)

A_{Acc} means the private patient accommodation adjustment applicable to the state of hospitalisation and length of stay

A_{HAC} means the hospital acquired complications adjustment

PW_{AHR} means the price weight for an ABF activity of a linked avoidable hospital readmission

R_{AHR} means the avoidable hospital readmission risk adjustment factor

NEP means the national efficient price

37. The quantum of the adjustments applicable to the current NWAU (NWAU 24) are shown in Exhibit 1 to this joint statement. There is an order of precedence applicable to the adjustments in the NWAU calculation which are set out in the NEP Determination.

38. The application of adjustments can substantially alter the final NWAU value and consequently the level of funding provided to the LHD. The table below demonstrates the impact through four scenarios of a single sample procedure:

Example Scenario

- I03A Hip replacement, major complexity, age 50, 10-day Length Of Stay with no adjustors (therefore inlier payment only).
- All treatment at Royal North Shore Hospital.
- State Efficient Price (SEP) of $5,675

Example	Patient's Residency	Applicable Adjustments	Base NWAU24	Adjustments NWAU24	Final NWAU24	Funding – NSW SEP
1	Major City	Nil	6.2264	-	6.2264	**$35,335**

2	Very Remote	Indigenous Radiotherapy Dialysis	6.2264	6.2887	12.5151	**$71,023**
3	Major City	Elected to utilise Health Insurance	6.2264	(2.1543)	4.0721	**$23,109**
4	Remote	Indigenous Radiotherapy Dialysis ICU	6.2264	7.596	13.8224	**$78,442**

C. DEVELOPMENT OF THE NSW HEALTH BUDGET

39. The NSW Budget is prepared by NSW Treasury. The annual budget process generally requires Ministers to prepare a submission for the Cabinet Committee on Expenditure Review (otherwise known as the Expenditure Review Committee or **ERC**) around February/March prioritising funding requirements for the budget and forward years.

40. NSW Treasury Policy and Guidelines TPG21-11: Parameter and Technical Adjustments and New Policy Proposals (Measures) provides guidance on submitting budget proposals for ERC consideration. All budget proposals require classification into either a parameter and technical adjustment for continued delivery of existing services or programs or a new policy proposal (**NPP**).

41. The Ministry of Health has established the Ministry Investment Review Committee (**MIRC**) to provide central coordination of NPPs, assess any competing priorities and ensure compliance with NSW Treasury funding requirements. The MIRC reviews emerging NPPs and makes recommendations to the Ministry Executive on the merits and prioritisation of each NPP.

42. The development of business cases is an iterative process that involves Ministry policy units, which are responsible for developing NPPs and business cases, and Financial

Services and Asset Management Division and the Economics and Evaluation Unit, which assist with developing detailed costings and cost-benefit analyses respectively.

43. The NSW Health Budget Submission is prepared by the Ministry of Health and comprises NPPs and supporting documents, including business cases. This includes business cases developed to address key emerging priorities. In the 2024-25 budget cycle, NSW Health submitted a number of business cases including requests for additional funding to meet the escalating costs of health goods and services and address the health needs of a growing and ageing population. Setting of priorities for inclusion in the final submission are recommended by the Ministry Executive Team and are a decision for the relevant Minister.

44. The ERC considers the proposals around May as part of the annual budget process. The allocation of the budget across portfolios is a matter for the NSW Government.

45. NSW Treasury is responsible for assessing the NPPs submitted to ERC for consideration and providing advice on each proposal to the Treasurer.

46. Since 2019, NSW Health and NSW Treasury have met on a fortnightly basis to discuss budget issues, including discussions and feedback on NPPs and business cases.

47. Part of the interaction with NSW Treasury during the budget process involves a review of the funding model, which considers the extent to which budgeted expenditure is sufficient to respond to price and activity growth in the coming year.

48. An indicative outline of the process and responsibilities for last financial year are outlined in the table below.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
NSW Health	NSW Health prepares P4 submissions for half-year review	Initial NSW Health internal Budget Submissions Preparation	NSW Health internal Budget Submissions Preparation P6* submissions (projections only if material changes from P5 are evident)	NSW Health internal Budget Submissions Preparation PTA Submissions	P9 submissions, LHD certification process NPP Submissions (funding proposals and business cases)	P9 submissions Prepare briefing material for Minister and ERC where applicable	P10 submissions Prepare briefing material for Minister and ERC where applicable	Prepare briefing material for Minister and ERC where applicable
NSW Treasury	Budget priorities set. Treasurer provides Ministers initial advice on the expected priorities	Deliver the 23-24 Half-Yearly Review and the mid-year update on the finances and economic outlook	Treasury stocktake on the Budget objectives	Treasury stocktake on the Budget objectives	Policy and financial assessment of funding proposals and business cases submissions	Budget ERC submissions and attachments uploaded into e-Cabinet.	Policy and financial assessment of funding proposals and business cases submissions	Policy and financial assessment of funding proposals and business cases submissions
ERC	ERC considers urgent and unavoidable issues	ERC considers urgent and unavoidable issues	ERC considers urgent and unavoidable issues	Budget Proposals for ERC consideration	Budget Proposals for ERC consideration	Budget Proposals for ERC consideration	Budget ERC meeting & decisions Commonwealth Budget	State Budget Announced

*P# refers to a period/month in the financial year. E.g., P6 is December, P9 is March etc.

49. NSW Health is expected to manage within its agreed budget. However, subject to agreement with Treasury, the Ministry of Health may seek additional funding during the year in accordance with TPG21-11.

50. Examples of recent supplementary funding from Treasury include Bargaining Parameters for industrial negotiations, establishment of new initiatives, funding to meet the cost of legal settlements and various Federal Funding Agreements announced by the Commonwealth.

Changes following COVID-19 pandemic impacting health service provision

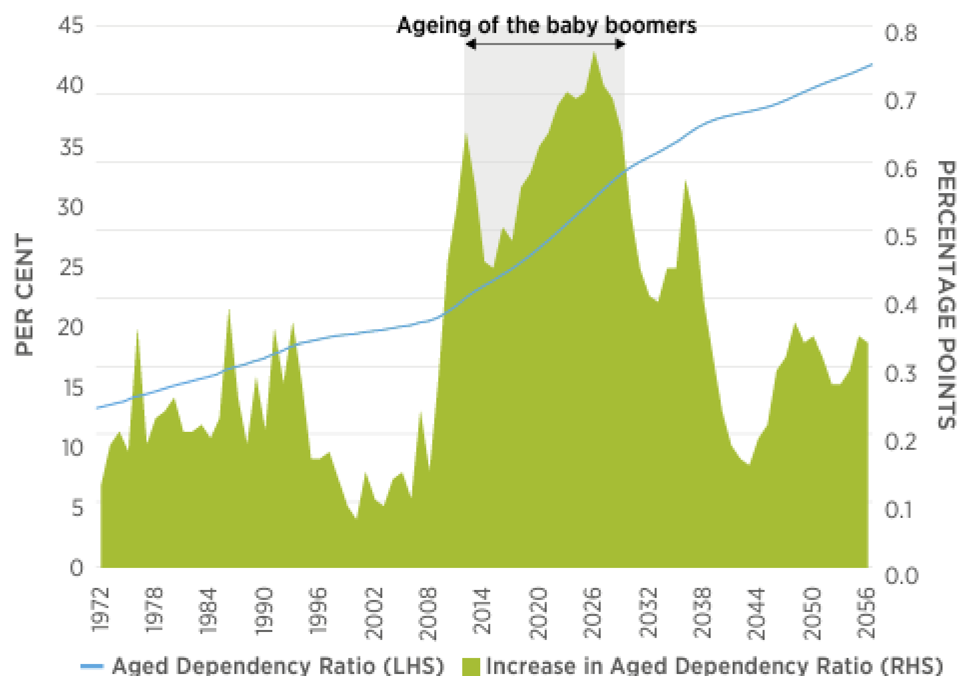
51. Prior to COVID, Health funding was relatively stable. The expense budget was growing at a relatively stable rate of around 5.0 per cent per annum, largely due to the implementation of a growth funding model in 2009-10 which provided an approved rate for annual expense growth. In addition, wages growth was constrained to 2.5 per cent per annum, the number of new builds coming on line was limited and inflation was within or below the Reserve Bank of Australia's 2-3 per cent target range. As a result, the budget was able to address issues such as volume growth (including growth associated with new builds), equity and efficiency.

52. Post COVID, progress has been made in pivoting towards a new environment. However, a number of challenges remain which will impact the ability of NSW Health to continue to deliver high quality, safe and accessible care:

a. Cost escalation- There have been significant cost increases across the supply chain base driven by inflation, labour and transportation and suppliers withdrawing from the Australian market, reducing competition. Between 2021 and 2023 HealthShare NSW observed that costs for critical medical supplies, such as prostheses, pharmaceuticals and medical equipment rose by 4-6 per cent. For example, prior to COVID, absorbent dressings cost $1.83 each. Now they cost $3.20 each (a 75 per cent increase). These increases are now embedded in the cost base. In addition, workforce cost challenges include difficulties in attracting staff to regional and rural areas and a dependency on agency staff and VMOs.

b. Demand growth due to demographic changes - The NSW Intergenerational Report suggests that the ageing of the population will continue to climb with the rate of increase, associated with the ageing of the baby boomers, still accelerating.

NSW aged dependency ratio



Source: 2016-17 NSW Intergenerational Report

The segment of the population aged 65 years or higher are the heaviest users of the NSW Health system, driven by age related disease. From 65 years onwards, NSW residents consume an average of 0.667 NWAU or $3,785 of health services per

person per year. This is almost four times higher than NSW residents aged under 65 years, who consume an average of 0.187 NWAU or $1,061 per year.

c. Increased pressure on NSW Health as default provider of healthcare. There are failures in primary care provision, with access to services constrained due to lack of availability and out of pocket costs. There is an increase in number of patients unable to be discharged home or to appropriate care settings due to lack of availability or supports, despite being clinically ready for discharge. This has been compounded by the closure of Residential Aged Care Facilities, particularly in rural and regional areas and the inability of providers, in both aged care and NDIS, to provide appropriate care for individuals with more complex conditions.

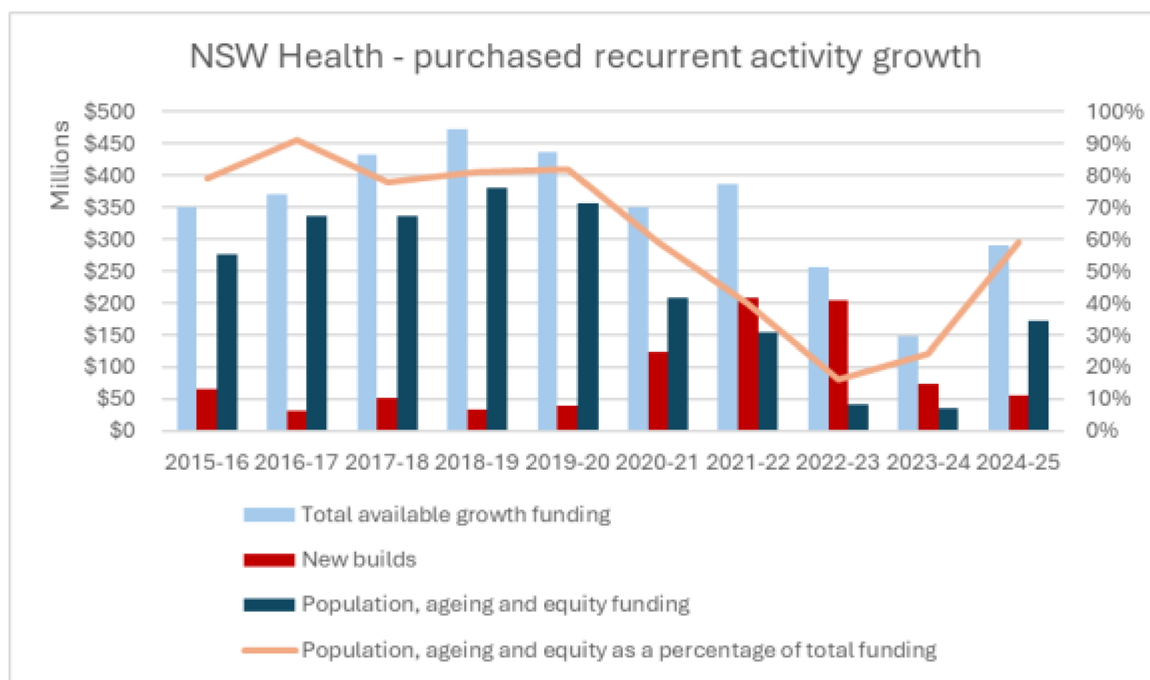
d. Impact of commissioning of new facilities. The recurrent costs to fund the operational requirements of newly opened hospitals are increasing. Prior to COVID, there were fewer new builds coming on line each year and the additional activity and associated cost was able to be absorbed within the budget. However, the increase in the capital program from 2019-20 onwards, which includes a number of large new hospital projects, is starting to come on line, bringing with it significant recurrent funding pressure.

In 2018-19, three hospitals were completed, with only one involving a major redevelopment (the Gosford Hospital Redevelopment with an estimated total cost of $348 million). In comparison, in 2023-24 there were four hospital projects completed, with three being major projects worth a total of $2.2 billion (the $869.8 million Randwick Campus Reconfiguration and Expansion, $723.3 million Tweed Valley Hospital Development and $632 million Campbelltown Hospital Redevelopment).

Based on the 2024-25 Budget Papers, there will be a further three hospital projects to be completed in 2025 and nine in 2026.

53. The chart below shows the total available in annual growth funding allocated between new builds and population, ageing and equity (where equity is based on a formula that follows the same principles as the Resource Distribution Formula (**RDF**), which was aimed at providing an indication of equitable shares of resources for Area Health Services prior to the introduction of the NHRA in 2012-13).

54. Prior to COVID, total activity growth funding was higher and the amount required to operationalise new builds was lower. This meant there was more funding available for population, ageing and equity. Since COVID, total growth funding has been lower and, with higher levels of funding required for new builds, the amount remaining for to address population, ageing and equity pressures has been lower.



D. ALLOCATION OF THE NSW HEALTH BUDGET

55. The total 2024-25 NSW Health expense budget is $31.9 billion (excluding capital expenditure). Of this, $26.2 billion or 82 per cent is provided to LHDs and SHNs (including NSW Ambulance).

56. NSW Health is only able to allocate funding within the funding envelope provided by NSW Treasury. NSW Health budget allocation methodology consists of four key parts:

    a. Base Annualised Budget - Health Entities are required to review and confirm their initial budgets for the forward estimates period. This includes Forward Estimates information, collation and preparation of all submitted line-item adjustments, review, endorse and process all approved line-item transfers, notification to Health entities on their submission and finalisation of Budget Supplementations impacting Forward Estimates. This confirmation process sets the starting point for the proceeding budget year. In effect, each District is made aware of their opening budget over the forward estimates.

    b. Escalation - Each Health Entity's budget includes specific escalation factors for budgeted goods and services depending on individual categories or contractual arrangements. Examples of individual escalation factors include Blood & Blood Products and S100 drugs. Salaries and wages escalations are aligned to Central Government decisions for all employees including senior executive roles remunerated in line with the *Statutory and Other Offices Remuneration Act 1975*. The composite escalation rate is based on the standard escalation rates and the proportion of funding in each expense category and will vary across Health entities.

    c. Activity Growth - The target volume in each Health Entity's Budget Schedule includes activity targets set for Activity Based Funded Facilities, Small Hospitals and Specific Initiatives. Each Health Entity is provided with activity growth that is negotiated through the purchasing process. As the table of purchased activity growth above shows, the purchased activity includes adjustments for population and equity, where equity growth allocations are determined on a needs index formula which resembles the RDF. The decline in funding for activity growth over the last three years has made the allocation process challenging.

    d. Specific Initiatives – Funding for new or specific initiatives, including savings and/or efficiency dividends applied to NSW Health, in the current year are included in the initial budget allocation. For instance, the 2024-25 Service Agreements contain funding for the Response to the Special Commission of Inquiry into the drug 'Ice', additional Paediatric Allied Health Practitioners and a range of Community Mental

Health enhancements. The specific initiative amounts may be allocated across both ABF and Block funding based on advice from policy units within the Ministry of Health. I

57. Between 2011-12 and 2024-25 LHD budget increased by between 69.5 per cent and 109.9 per cent, with South Western Sydney LHD growing at 109.9 per cent and Nepean Blue Mountains LHD growing by 104.6 per cent. Budget and population data from 2011-12 to 2024-25 indicates there is some correlation between budget growth and population growth, which suggests that the budget allocation methodology does account for population and equity impacts.

58. NSW Health Pillar Organisations, consisting of Health Education and Training Institute, Clinical Excellence Commission, Agency for Clinical Innovation, Cancer Institute NSW and Bureau of Health Information, together with the NSW Ministry of Health operate on a traditional salaries and wages and goods and services model along with additional funding for new initiatives that are to be delivered. Escalations for wages are consistent with applicable industrial agreements.

59. There are three Health entities providing intra-Health services – HealthShare NSW, eHealth NSW and NSW Health Pathology. These organisations act on a cost recovery basis for the services they provide to the system.

60. NSW Health entities and branches within the Ministry of Health may request additional supplementary funding from the Finance Branch within the Ministry of Health at any stage via submission of an approval brief and business case for new or urgent projects that are critical to manage unexpected events, unique one-off pressures, industrial decisions or urgent minor works and equipment demands.

61. Historically the Ministry of Health creates and processes around 500 budget supplementation briefs per year that may include funding allocation letters to one or multiple Health entities. Release of budget supplementations are primarily driven by the nature of the allocation and associated preparatory development work required by Ministry of Health branches and the health system. Models of care and service delivery development strategies vary by initiative and have different allocation drivers. Some apply across all Local Health Districts and Networks such as workforce incentives while others are specific to a location or serve as statewide hubs such as for IVF services. The allocations are issued only when briefs and plans have received both Executive and Chief Financial Officer (**CFO**) approval.

62. The Ministry of Health has amended the Budget Supplementation process to Health entities in 2023-23 and 2024-25 to:

    a. Provide greater budget certainty. Efforts have been made to increase the amount of budget being allocated up front in the initial Service Agreement in June so Health entities can better plan service delivery for the budget year and patients benefit from receiving service enhancements sooner.

    b. Streamline administration and improve transparency. Budget Supplementations have been batched into tranches that provide Chief Executives with a summary of all allocations and a total of the tranche to their Health Entity.

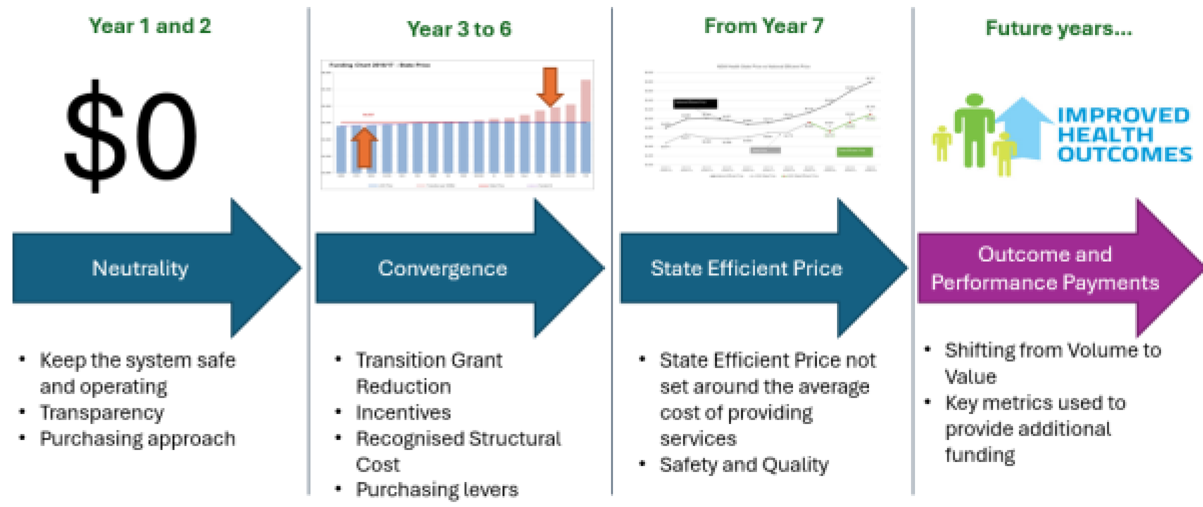
    c. Reduce the number of tranches from four in 2023-24 to three in 2024-25 (October, March and June) to build further impetus to release the bulk of funding before the end of the calendar year of the budget.

    d. More clearly linked Budget Supplementations to Health's strategic objectives, Service Agreement Key Performance Indicators and service measures. The traditional funding allocation letter and attachments has been replaced with a Funding Summary template that succinctly presents key information including, purpose of funding, rationale and expected outcomes.

    e. Focus the health system on measuring outputs and outcomes of Budget Supplementations to staff and patients rather than inputs. This is a change for some areas of the health system to better measure the impact of new programs and policies rather than rely on dollar or staffing inputs. Health entities requested this change to reduce input level reporting and permit more local level autonomy in service delivery. In the longer term, shifts to outputs and outcomes reporting is expected to afford Health entities greater flexibility to evolve their service configuration to meet changing community needs over time. In the near term this should facilitate flexibility of service delivery in rural and regional areas or in specific instances where service need or workforce requirements means service configuration is different from metropolitan or statewide norms

Evolution of ABF and the impact of COVID-19 pandemic

63. NSW Health adopted a Roadmap to the implementation of ABF and recognised there would be various distinct stages to the process. This is demonstrated in the diagram below



64. In the initial stage (neutrality), the aim was to ensure that LHD/SHNs were no worse off through the introduction of ABF. This was achieved as follows

a. Base level activity was paid at the agreed NWAU times the lower of the LHD/SNN's PAC or the State Price.

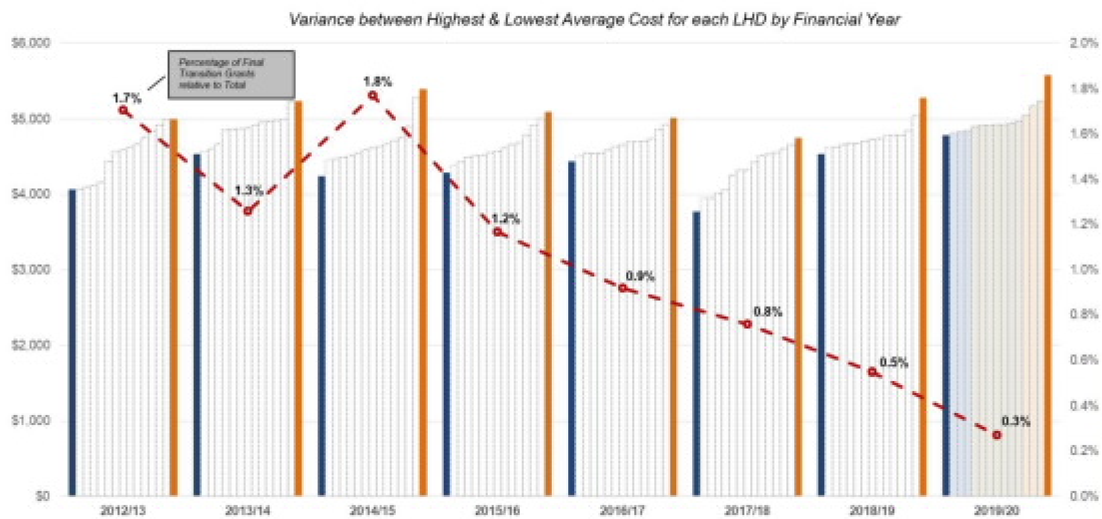
b. Activity growth was paid at the agreed NWAU times a percentage of the State Price (reflecting a marginal cost).

c. Where base level activity was funded above the State Price, a Transition Grant equal to the difference between the PAC and State Price was provided.

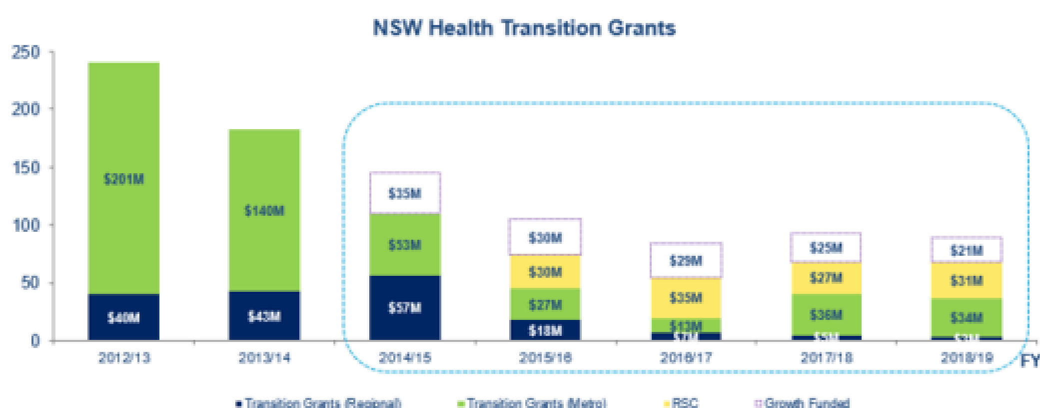
d. Where a LHD/SHN received a Transition Grant, they were required to fund up to 50 per cent of their activity growth from these funds to improve technical efficiency and lower their average cost per NWAU.

65. The next stage involved convergence of the average cost per NWAU for ABF towards the State average for all LHDs and SHNs. There has been a clear convergence towards the State average cost of ABF service provision over the years of transitioning and implementing the NHRA.

66. With the convergence towards the State average cost, there has been a significant reduction in Transition Grant funding over the period as seen in the following diagram:



67. During this period, the concept of RSC funding was also introduced in recognition that rural LHDs were potentially disadvantaged using a statewide price informed by average cost. RSC funding was provided to specific rural LHDs to recognise that there was a component of Transition funding that was outside their control. Examples of cost structures funded under the RSC include Patient Transport Services (including Ambulance), Rural Locum loading, Rural nurses allowance, Provision of commercial radiology contract premium (Murrumbidgee LHD), Water treatment cost for Dialysis service (Far West LHD). The evolution of Transition Grants over time is shown in the diagram below:



68. The third stage of the roadmap was the introduction of a SEP in 2018-19. Convergence towards the average cost per NWAU created Transition Grant funding instability as LHDs

and SHNs moved marginally above or below the average from year to year. This was overcome with the introduction of the SEP in which all activity is funded at one price based on a statewide calculation. Additional funding similar to the Transition Grants was provided through a CPA to enable LHDs to address cost structure issues.

69. Implementation of the Roadmap was significantly impacted by the COVID pandemic. ABF is appropriate in a period of relative stability and growth budgets. However, 2020-21 and 2022-23 were highly volatile in respect of ABF activity, cost structures and health service disruption. Of significance were the impact of lockdowns, cancellation of elective and non-urgent surgery, staffing redeployment, wages freeze and the variability of COVID outbreaks across NSW and nationally.

MONITORING OF FINANCIAL PERFORMANCE AGAINST BUDGET

70. The System Sustainability and Performance Division has responsibility for the management of performance in line with the NSW Health Performance Framework.

71. Within an LHD, Executive, Managers and Clinicians are able to manage their ABF and ABM performance, benchmark against peers and address the data.

72. Health Entity performance against budget is monitored via reporting requirements and regular governance meetings, including:

    a. Financial Performance and Strategy Report (narrative)

       Health Entities submit this narrative, describing year-to-date and forecast performance across financial and non-financial metrics, to the Ministry of Health on a monthly basis.

    b. Health System Performance Report

       This report is produced monthly and details LHD and SHN performance against access, safety, financial and equity measures.

    c. Financial Services and Asset Management Performance Meeting

       Each month the CFO meets with Ministry of Health finance executives to review Health Entity performance to budget and key drivers of budget variances and more technical accounting matters.

    d. Senior Executive Forum

The CFO provides an update on financial performance at this monthly meeting attended by the Chief Executives of Health Entities along with the Secretary and Deputy Secretaries from the Ministry of Health.

e. Health Entity Performance Meetings

Each quarter, representatives from the Ministry of Health's Finance and System Sustainability and Performance Divisions conduct a series of meetings with the Chief Executive and Executive of each Health Entity to review performance against key indicators (including financial sustainability, variances to budget and strategies to address any overruns). Health Entities at Performance Level 3 receive support through monthly meetings.

f. Health System Performance Advisory Committee

This monthly meeting reviews performance against a range of metrics including access to care, financial performance, mental health, workforce, quality and safety and Aboriginal health and makes recommendations regarding changes in performance levels (in line with the Performance Management Framework) on a quarterly basis.

g. Health Performance Monitor Meeting and Report

This is the peak governance committee of the Ministry of Health involving the Secretary, Deputy Secretaries and relevant Executive Directors meeting monthly to consider health system performance including financial performance to budget by health entity and consider risks and opportunities.

h. Financial Recovery Plans

Health Entities that are more significantly challenged may be placed on a formal Financial Recovery Plan by the Ministry of Health. Quarterly forecasts and governance meetings on Plan progress are held between the Chief Executive and Director of Finance and the Ministry of Health's CFO and Deputy CFO. Processes, expectations and reporting requirements are set out under section 3.2.7 of the 2024-25 Conditions of Subsidy.

73. In addition, where variances to budget are identified, Health Entities are expected to implement Efficiency Improvement Plans, a formalised process to report realised cost savings.

74. The Chief Executives of Health Entities are also required to certify the full-year forecast variance to budget. In 2024-25, certification is required in Period 4 (October 2024) and Period 9 (March 2025).

75. The end-of-year reporting processes that apply to the Ministry of Health overall and individual NSW Health Entities are guided by Treasury advice, including:

    a. Treasury Policy and Guidelines:

        (i.) TPG23-10: Annual Reporting Requirements

        (ii.) TPG24-03: Agency Direction for the 2023-24 Mandatory Early Close

        (iii.) TPG 24-08 CFO Certification on the Internal Control Framework over Financial Systems and Information

        (iv.) TPG24-17: Agency Direction for the 2023-24 Mandatory Annual Returns to Treasury

        (v.) TPG24-33: Reporting framework for first year climate-related financial disclosures

    b. Treasurer's Directions:

        (i.) TD19-02: Mandatory Early Close as at 31 March each year

        (ii.) TD21-02: Mandatory Annual Returns to Treasury

76. The end-of-year reporting process can be summarised as follows:

    a. Interim (31 March) Statutory Financial Statements are completed, endorsed by the individual Health Entities' Audit and Risk Committee and submitted to the Audit Office for annual audit.

    b. Statutory Financial Statements are completed, endorsed by the individual Health Entities' Audit and Risk Committee and submitted to the Audit Office for annual audit.

    c. The Ministry of Health submits financial information for NSW Health to Treasury. This is broken down into outcomes and reconciles to the Statutory Financial Statements provided to the Audit Office.

    d. Supplementary and other information is provided to NSW Treasury for use in preparing the Total State Sector financial statements.

e. A CFO Letter of Certification is prepared in accordance with TPP17-06 – Certifying the effectiveness of internal controls over financial information.

f. Respond to any Audit Office data collection requirements to allow the Auditor General to prepare a report on Health.

g. For 2024-25 onwards, all reporting Government Sector Finance (GSF) agencies will be required to prepare annual reporting information unless exempt. Treasury are yet to formalise their guidance for 2024-25.

h. Finance teams within both the Ministry of Health and Health Entities will also be responsible for Climate Related Disclosures from 2024-25 onwards.

F. CONCLUSION

77. The existing model functioned relatively well in allocating funding for the delivery of public health services across NSW in a stable growth environment, where there was sufficient funding for additional activity or new initiatives through the purchasing process and new policy proposals.

78. However, this is not the case in the post COVID-19 environment with limited growth funding available and challenges with attraction and retention of workforce, escalation of costs for goods and services and the bringing on line of a large number of new facilities through the capital program.

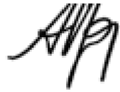
79. The limitations to the existing model have been recognised, and NSW Health has been looking at opportunities to shift the health system in line with the directions outlined in Future Health. This includes consideration of a longer term strategic four year service agreement focused on improving health outcomes to complement the existing one year agreements required by the current national arrangements.

80. The implementation of the current funding model has seen considerable improvement in the quality and breadth of data NSW Health can now collect, report on and analyse. This should be further utilised to inform service and resourcing decisions.

81. Given these ongoing challenges, the Commonwealth, states and territories will need to continue to review the operation of the current funding model to ensure it is able to respond to the changing health needs of the population.

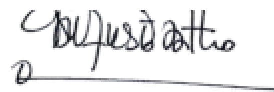
82. This may require consideration of a blended funding model that retains the benefits of ABF but recognises the importance and role of population, equity and the need for

greater investment in prevention, community and out of hospital care. This should be supported by additional funding for purchasing activity and investing in prevention. Internal consultation with Chief Executives of LHDs has commenced to explore options in respect to a blended funding model that incorporates benefits from the ABF funding model and provides certainty of funding for equity and population needs.



Alfa D'Amato

14/11/2024
Date

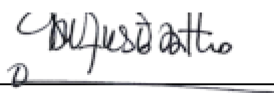


Witness

14/11/2024
Date

Steven Carr

14/11/2024
Date

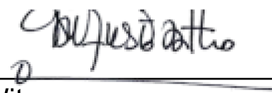


Witness

14/11/2024
Date

Neville Onley

14/11/2024
Date



Witness

14/11/2024
Date

PRICE WEIGHT ADJUSTMENTS FOR 2024-25 (ABF FACILITIES)

Adjustment type	Application criteria	Healthcare setting/ patient category	Price weight (NWAU24)	Change between NWAU23 & NWAU24	Price weight (NWAU23)
Paediatric	• Patients aged ≤17[1] years; AND • Treated by a specialised children's hospital: The Children's Hospital at Westmead, Sydney Children's Hospital or John Hunter Hospital. [1]except Newborns and Other Neonates from MDC 15 – the additional cost is already factored into these AR-DRGs.	Acute admitted: adjustment is AR-DRG dependent and the amount applied to each AR-DRG[1] on a case by case basis.	Refer to *Table I1, Appendix I*	various	Refer to *Appendix J, 2023-24 Compendium*
		Mental health admitted.	112%	unchanged	N/A
		Non-admitted: adjustment is Tier 2 class dependent and the amount applied to each class on a case by case basis.	Refer to *Table M1, Appendix M*	various	Refer to *Appendix M, 2023-24 Compendium*
Patient Residential Remoteness Area*	For outer regional, remote and very remote categories: • The Australian Statistical Geography Standard (ASGS)* is used to classify patients' usual place of residence and locality of hospitals (*www.abs.gov.au* and *Appendix B*). • These adjustments apply regardless of the geographic location of treatment.				
Outer Regional	• Patients residing in an outer regional area. *as per ASGS*	Admitted: (acute, SNAP, mental health) and Non-admitted.	7%	↓	8%
Remote Area	• Patients residing in a remote area. *as per ASGS*	Admitted: (acute, SNAP, mental health) and Non-admitted.	20%	↓	22%
		Emergency.	32%	↑	30%
Very Remote Area	• Patients residing in a very remote area. *as per ASGS*	Admitted: (acute, SNAP, mental health) and Non-admitted.	33%	unchanged	33%
		Emergency.	32%	↑	30%

Adjustment type	Application criteria	Healthcare setting/ patient category	Price weight (NWAU24)	Change between NWAU23 & NWAU24	Price weight (NWAU23)
Indigenous	• Patients identifying as being of Aboriginal and/or Torres Strait Islander origin. *No adjustment is applied if the patient's origin status is not recorded in the PAS. Staff need to ensure they ask every patient to identify their status and make accurate recording of it.*	Emergency; Admitted (acute, SNAP, mental health) and Non-admitted.	3%	↓	4%
Radiotherapy	• Patients with a specified radiotherapy procedure ACHI code in a healthcare record. See *Table D1, Appendix D*.	Admitted (acute or SNAP).	41%	unchanged	41%
Dialysis	• Patients with a specified renal dialysis ACHI code in a healthcare record: (see *Table D1, Appendix D*). • Not applicable to *L61Z Haemodialysis* or *L68Z Peritoneal Dialysis AR-DRG*.	Admitted (acute or SNAP).	24%	↓	26%
Multidisciplinary Clinic	• Non-admitted patient service event where three or more healthcare providers are present during the service event. The healthcare providers may be of the same profession (medical, nursing or allied health) and they may deliver care either individually or jointly within same service event. However, they must each have a different specialty. • Excludes service events assigned to Tier 2 classes *20.48 Multidisciplinary burns clinic; 20.56 Multidisciplinary case conference – patient not present or 40.62 Multidisciplinary case conference – patient not present.*	Non-admitted encounters under Tier 2 classification.	51%	unchanged	51%
Patient Treatment Remoteness – Remote Area**	• Is in respect of a person who receives care in a hospital which is within an area that is classified as being remote.	Admitted (acute, SNAP, mental health) and Non-admitted.	2%	↓	5%
		Emergency.	2%	↓	3%
Patient Treatment Remoteness – Very Remote Area**	• Is in respect of a person who receives care in a hospital which is within an area that is classified as being very remote.	Admitted (acute, SNAP, mental health) and Non-admitted.	34%	↑	32%
		Emergency.	2%	↓	3%

Adjustment type	Application criteria	Healthcare setting/ patient category	Price weight (NWAU24)	Change between NWAU23 & NWAU24	Price weight (NWAU23)
COVID-19 Treatment	• Is in respect of a patient who: – is assigned an ICD-10-AM 12th Edition code: *U07.12 COVID-19, virus identified, symptomatic* or *U07.2 COVID-19, virus not identified*; AND – has received care as defined by one of the AR-DRGs specified in *Table E2, Appendix E*.	Acute admitted.	66%	↓	94%
Intensive Care Unit (ICU)	• A patient who spent time in a specified ICU. See *Table C1, Appendix C* for a list of NSW facilities with specified ICUs. • Episodes, in any ICU, coded to *U07.12 COVID-19, virus identified, symptomatic* or *U07.2 COVID-19, virus not identified* or *U07.11 COVID-19, virus identified, asymptomatic.* • Not applicable to any AR-DRG *(P01Z-P68D)* from *MDC 15 (Newborns and Other Neonates)* because the cost of ICU care is 'bundled' in the price weights for these AR-DRGs. See *Table I1*, Column titled *'Bundled ICU'*, *Appendix I* to identify these AR-DRGs.	Acute admitted patient in specified ICU and COVID-19 patients in any ICU.	0.0441/ per hour spent by the patient within an ICU	↓	0.0437/per hour

Adjustment type	Application criteria	Healthcare setting/ patient category	Price weight (NWAU24)	Change between NWAU23 & NWAU24	Price weight (NWAU23)
Private Patient* Service**	• Private admitted patients whose treatment in a public hospital is funded from private health insurance, Medicare Benefits Schedule (MBS) or self-funded. • Price weight discounted by the estimated value of these funding sources listed above. • Adjustments are informed by the Hospital Casemix Protocol (HCP) data set which is reported by private insurance companies.	Acute admitted.	DRG class based (refer to *Table I1, Appendix I*)	various	*Appendix I, 2023-24 Compendium*
		Mental health admitted.	AMHCC class based (refer to *Table K1, Appendix K*)	various	*Appendix K, 2023-24 Compendium*
		SNAP admitted • Palliative	3.4%	↓	4.2%
		• Rehabilitation	4.0%	↓	4.4%
		• Psychogeriatric	1.4%	↓	1.9%
		• GEM	3.3%	↑	3.1%
		• Maintenance (non-acute).	2.9%	unchanged	2.9%
Private Patient* Accommodation**	• Eligible admitted private patients treated in public hospitals. • Adjustment reflects the default benefit payments paid by private health insurers for private patient accommodation in public hospitals. *The adjustment is based on the 2023-24 average default benefit rates for private health insurers by State/Territory which were indexed forward one year by 3.75%.*	Same-day admitted (acute, SNAP, mental health).	0.0478 NWAU per diem x SEP	↑	0.0471 NWAU per diem x SEP
		Overnight admitted (acute, SNAP, mental health).	0.0660 NWAU per diem x SEP	↑	0.0650 NWAU per diem x SEP

**adjustment is not applied if the patient's place of usual residence is not recorded in the Patient Administration System (PAS). It is important to enter patient's usual residence postcode and not accommodation they may be residing at the time of admission (e.g., family member's house). The Australian Statistical Geography Standard (ASGS) 2021 is used in 2024-25 to classify patients' place of residence and locality of hospitals (see: Appendix B).*

***geographical location of the hospital (as per the ASGS) defines this adjustment, not a patient's place of usual residence. The adjustment is not relevant to NSW facilities in 2024-25 because none of the current NSW ABF facilities are in remote or very remote area. See Appendix B for remote area postcodes.*

****Private patient price weight adjustments specifics:*

If the application of the private patient adjustments returns a negative NWAU value, the NWAU value is held to be zero, as negative NWAU values are not permitted for any patients under the funding model. The negative discount in NWAU is offset by the revenue supplied by private health insurance companies for accommodation and Medicare Benefits Schedule (MBS) for diagnostics.