Report of

Adjunct Professor Alfa D'Amato
Deputy Secretary, Financial Services and Asset Management and
Chief Financial Officer

Deb Willcox AM
A/Secretary
NSW Health

The Special Commission of Inquiry into Healthcare Funding

1. This report is provided by Adjunct Professor Alfa D'Amato Deputy Secretary, Financial Services and Asset Management and Chief Financial Officer and Deb Willcox AM, A/Secretary, NSW Health.
2. This report is prepared in response to a request from the Special Commission of Inquiry (Inquiry) dated 16 November 2023. It is provided for the purpose of the initial public hearing of the Inquiry and is introductory in nature. NSW Health understands that there will be further opportunity to present more detailed evidence during the course of the Inquiry.
3. The report covers matters from the perspective of the Ministry of Health as system manager rather than purporting to address specific local issues.

Question 1

An overview of the annual Budget process, focusing on the roles of NSW Treasury and the Ministry of Health. That might include:

a. How the total budget is set for health and what (if anything) is it expressly stipulated to cover and/or not cover?

b. How often is the total health budget reviewed and on what basis? What information is taken into account?

c. How long is the budget cycle i.e. how far in advance does an entity know what its budget will be and what period it is to cover?

4. NSW Health operates in a complex funding environment.
5. NSW public healthcare is funded primarily by the NSW and Australian Governments with additional funding received from direct source revenue such as private health insurance payments and individual payments.
6. The quantum of the NSW Health Budget is ultimately a decision for the NSW Government.

NSW Budget

7. The NSW Budget is prepared by NSW Treasury and the Budget Papers provide an overview of the state economy, including the economic and fiscal outlook together with an outline of government priorities, revenue and expenditure.
8. The NSW Budget is handed down in June each year. The Budget Papers contain the Agencies' financial statements for the coming financial year and the NSW Budget projections for the three following financial years.
9. During the development of the NSW Budget, Treasury (via the Treasurer) issues the budget guidelines which set out the process for the upcoming budget. For the financial year 2024/25, this process started in November 2023. This includes discussions across government that encompass:

    a) the State's financial position including future risks, expenditure and revenue.

    b) NSW Government priorities

    c) Portfolio priorities and funding submissions, including supporting documentation;

    d) Urgent issues such as material economic loss, legislative requirements and business continuity.

10. The Cabinet Committee on Expenditure Review (otherwise known as the Expenditure Review Committee or ERC) considers budget proposals as part of the annual budget process. The allocation of budget across portfolios is a matter for the NSW Government.

How the total budget is set for health and what (if anything) is it expressly stipulated to cover and/or not cover?

11. The NSW Health Expense Budget, or headline NSW Health Budget, is fixed by reference to a 'base' level of funding (determined from recurrent levels of previous funding) to which is added any new funding (this could include time limited funding), including for any New Policy Proposals agreed by the government through the ERC process, with growth expressed as a percentage rate increase on the base.
12. In 2023/24 the NSW Health Budget includes an expense budget allocation of $30,952M and a capital expenditure budget allocation of $3,303M to the NSW Ministry of Health. The Agency Budget Paper also identifies an expense budget allocation of $25.6M to the Health Care Complaints Commission and $9.2M to the Mental Health Commission of NSW.
13. Prior to the COVID-19 pandemic, NSW Treasury applied an underlying growth funding approach that set the recurrent expense budget for NSW Health. During the COVID-19 response, one off funding outside of the budget was provided to NSW Health to facilitate the pandemic response.

Expenditure

14. The NSW Budget Papers include Agency Financial Statements which provide recurrent and capital expenditure by agency or cluster, including NSW Health, for the previous and coming financial year.
15. The NSW Budget Papers also include the appropriation bills which enable distribution of the budget allocations to portfolios, including to Health.
16. The budget allocation provides the overarching funding envelope for the delivery of health services. In the Budget Papers, two components are specifically identified- expenses and capital expenditure.
17. The headline expense budget includes technical items such as depreciation, capital expensing and leases impacts as well as time-limited or one-off items. The headline and underlying expense budget are documented in the Budget Papers.
18. The capital works allocation is based on identified projects that include statewide, rural and regional and metropolitan projects. NSW Health's capital budget comprises four components:
    a) New Works (Major Works), which represent new capital projects that have been approved by government during the current budgetary cycle.
    b) Work-in-Progress (Major Works), which relate to the continuation of agreed work approved in previous budgetary cycles.
    c) Leases, which represent contractual arrangements including all lease renewals, additions and remeasurements.
    d) Minor works, which are a component of the budget allocated for unspecified minor works projects that are capital projects with an estimated total cost greater than $10k but less than $250k.
19. NSW Treasury classifies all capital projects with an estimated total cost of greater than $250k as Major Works.

Revenue

20. NSW Health revenue budget includes:
    a) Appropriations

b) Acceptance by Crown Entity of Employee Benefits and Other Liabilities

c) Sale of Goods and Services (Sales and recoveries of pharmaceutical supplies, Ambulance transportation, Fees for medical and clinical services, facility fees)

d) Investment Revenue (Bank account interest and unit price movement from TCorp Investments)

e) Grants and Contributions (National Health Reform Agreement Funding and other Commonwealth Grants)

f) other (GST Refunds, iCare Insurance Refunds, Rental Income).

21. Each year the revenue budget is increased to reflect changes in prices set by independent authorities and changes in Commonwealth funding.

22. Australian Government contributions represent an important component of revenue budget for NSW Health.

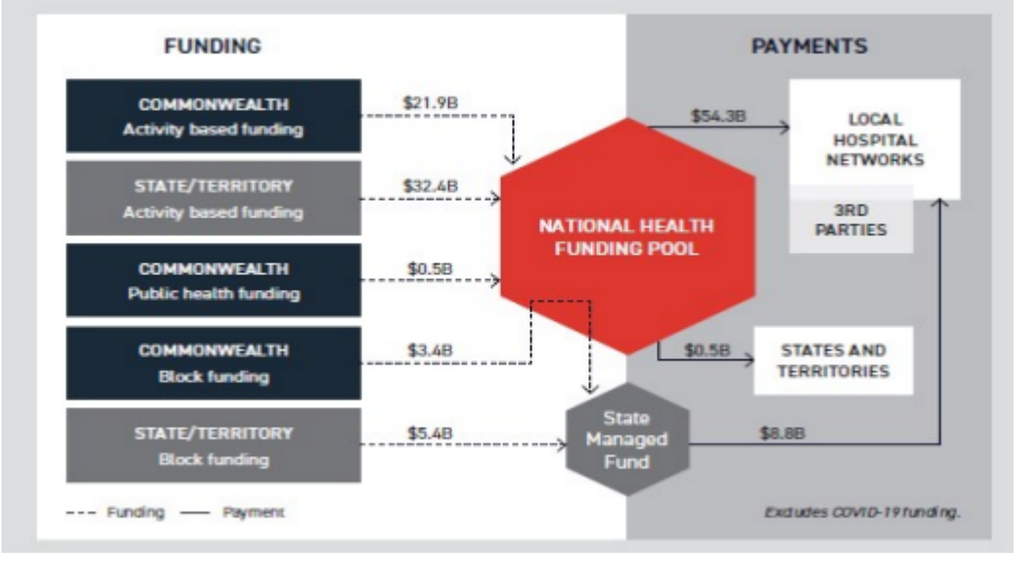
23. The majority of Australian Government funding provided to NSW is through the funding payments made under the National Health Reform Agreement (NHRA). There are three key components of this funding:

a) Activity Based Funding

b) Block Funding

c) Public Health Funding

24. The Administrator of the National Health Funding Body calculates and advises the Australian Government Treasurer of the quantum of national Commonwealth funding to be paid each year. The funding payments flows are outlined below, noting this reflects national payments.



Source: Administrator National Health Funding Pool, National Funding Flows and Payments Annual Report 2022-23

25. The Australian Government also provides funding for health services through a range of time limited national partnership agreements, including for some public adult dental services, palliative care including in aged care facilities, mental health, comprehensive cancer treatment and vaccines.

How often is the total health budget reviewed and on what basis? What information is taken into account?

26. The NSW Health Budget is reviewed as part of the annual process in developing the NSW Budget. Discussions on policies or priorities are not confined to a single financial year.

27. NSW Health is in constant dialogue with NSW Treasury on a range of budget issues, including budget performance and potential New Policy Proposals. The 2023/24 Budget process includes a formal two phase process for submission of New Policy Proposals that encompass new and emerging risks, legislative compliance and business continuity.

How long is the budget cycle i.e. how far in advance does an entity know what its budget will be and what period it is to cover?

28. The budget cycle is annual. In December each year, the NSW Treasurer publicly releases a half-yearly review of the NSW Budget which contains revised projections over the budget and the three following financial years (forward periods) and explanation of any significant variations.

29. NSW Health entities are made aware of their annualised amount (base) through internal processes. The distribution of the growth and funding of any new initiatives is negotiated through the Service Agreement process between the NSW Ministry of Health and health entities.

Question 2

How is the component of the health budget that is allocated to Local Health Districts (LHDs - including Specialty Health Networks) distributed between them? Are similar considerations applied for all LHDs and do they know what these are in advance? How are the budgets determined for entities other than LHDs, i.e.: state-wide services, shared services and the pillars?

30. The Ministry of Health as system manager recommends the annual allocation of the NSW Health Budget across NSW Health entities, including to the Local Health Districts (LHDs) and Specialty Health Networks (SHNs).

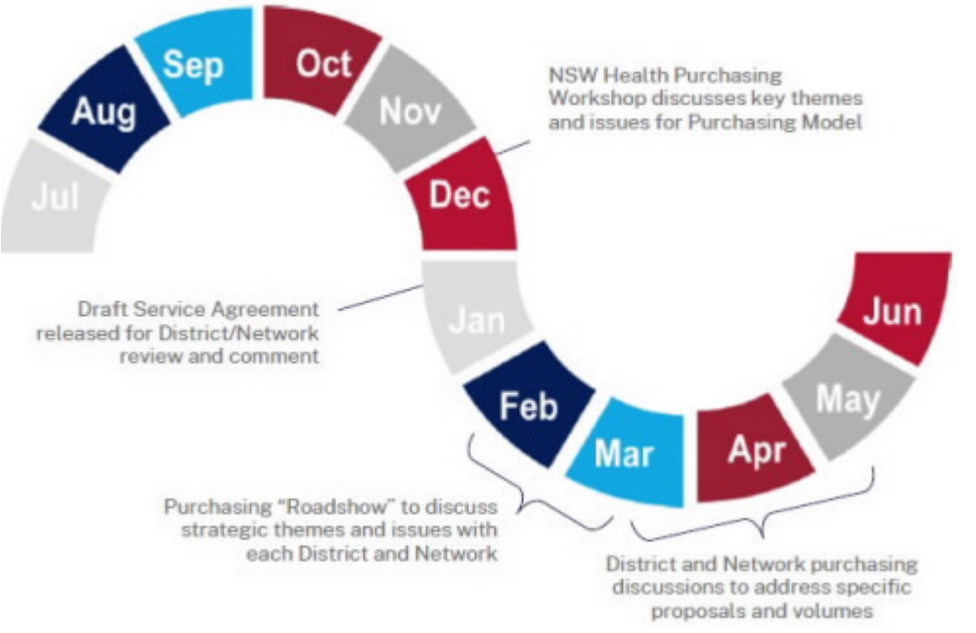
Local Health Districts and Specialty Health Networks

31. The Ministry of Health develops annual Service Agreements between the Secretary, NSW Health and the LHD/SHN. The Service Agreements typically contain provisions pertaining to

    a) Legislative, governance and performance framework
    b) Strategic priorities for NSW Health and the NSW Government
    c) NSW Health services and networks
    d) Budget
    e) Purchased volumes and services
    f) Key Performance Indicators and performance deliverables

32. The Service Agreements are made publicly available in line with requirements under the NHRA and are generally released on the same day as the NSW Budget is released.

33. The Ministry of Health engages over an extended period with LHDs and SHNs in the development of the Service Agreements as outlined below.



Source: NSW Health 2023

34. LHDs and SHNs can raise new proposals or service enhancements during this process. A range of matters will be considered such as the proposal's alignment with the NSW Health Future Health Strategy, LHD Clinical Services Plans and other policies, and with

the existing funding model. Proposals are also examined to assess whether the model of care is contemporary and likely to deliver the suggested outcomes.

35. Prior to finalisation of the Service Agreements, the Ministry Executive Meeting (MEM) which brings together the Ministry of Health Senior Executive, considers the Service Agreements in totality including the recommended growth allocation across all of the LHDs and SHNs.

36. MEM's deliberations are informed by discussions undertaken with the LHDs and SHNs as outlined above together with a range of factors, underpinned by data, evidence and modelling including:

    a) activity and performance across service streams

    b) population demographics and population growth

    c) commissioning of any new services including capital projects

    d) provision of any statewide or supra-LHD services provided across LHD/SHN boundaries to provide equitable access. Examples include the state spinal cord injury service, mental health intensive care, stroke (including telestroke), neonatal intensive care and severe burns service etc.

    e) purchasing adjustors to incentivise delivery of value based health care

    f) requests for new proposals or service enhancements

    g) any specific local issues.

37. An overview of this budget development process is represented below summarising the activity targets calculations, which are the LHD's projected volume of activity in the nominated streams for the 12 month period of the Service Agreement.

Source: NSW Health 2023

NSW Ministry of Health, Statewide Services, Shared Services and Pillar Organisations

38. NSW Health Shared Services operate primarily on a cost recovery model through internal cross charges to LHDs/SHNs. NSW Health Shared Services' initial budgets are reviewed and determined as part of the annual budget cycle. Budgets for NSW Health Shared Services are prepared by reference to a number of considerations including:

a) in respect of eHealth

   i. Charges based on service catalogue and published pricing

   ii. Charging linked to consumption with customers receiving regular consumption data.

b) in respect of HealthShare

   i. Cost drivers and pricing methodologies vary according to the characteristics of each service:

      1. Linen Services
      2. Warehousing
      3. Food and Hotel Services
      4. Supply Chain
      5. EnableNSW
      6. Patient Transport Services
      7. Employee and Shared Services

c) In respect of NSW Health Pathology

   i. based on service volumes and usage in accordance with the Pricing detailed in the NSW Health Pathology Customer Service Charter.

39. Health Infrastructure is primarily funded through the delivery of the capital infrastructure program.

40. Ambulance Service of NSW charges patients for emergency attendance and transport to NSW public health facilities. Fees are set by the Independent Pricing and Regulatory Tribunal for eligible patients. Pensioners and Concession card holders are free of charge. In addition, Ambulance Service provides services to other government organisations and privately arranged community events and applies user charges.

41. The majority of the service is Block funded encompassing operations that are not recoverable from transport fees and are built up though traditional budgeting for salaries and wages, goods and services and repairs and maintenance. Capital is a significant expense for Ambulance associated with the operation and fitout of vehicles, Ambulance stations and information technology connectivity.

42. 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 based budget build. Escalations for wages are consistent with applicable industrial agreements.

Question 3

Do any other bodies receive funding out of the state health budget e.g. Non-Government Organisations, research bodies, universities? If so, why and what processes apply?

43. NSW Health funding is provided to a range of entities to complement the range of services and supports provided by NSW Health. This funding is generally directed towards providers of activities that require specialised expertise or knowledge and connection with targeted cohorts.

44. This funding facilitates deep partnerships with other health care providers and with research, education and training providers recognising joint responsibilities and the interconnectedness of the health system.

45. Funding is provided to external entities through mechanisms including grants or supports to medical research organisations, Community Managed Organisations (CMOs) Affiliated Health Organisations (AHOs) and other Non-Government Organisations (NGOs). This support furthers the aim of NSW Health to provide appropriate and safe care to patients across NSW. These providers may dedicate part or all of their operations to the NSW health system.

46. AHOs are non-profit, religious, charitable or other non-government organisations and institutions that provide health services which are treated as part of the public health system under the *Health Services Act 1997*. AHOs include organisations such as St Vincent's Hospital Network, Calvary Health Care, Hammondcare and Karitane. In 2022/23 $817M was provided to AHOs from the NSW Health Budget.

47. AHOs operate under local Service Agreements with the respective LHDs. The exception is St Vincents Hospital Network which is the largest AHO and has a direct Service Agreement with the NSW Ministry of Health.

48. A NSW Health document titled 'Financial Requirements and Conditions of Subsidy' outlines principles to ensure AHOs are treated consistently in relation to escalations, Nationally Weighted Activity Units (NWAU) and efficiency initiatives.

49. Medical research grants support programs which include:

    a) Cardiovascular Research Capacity Program
    b) Commercialisation Training Program
    c) Medical Devices Fund
    d) Translational Research Grants Scheme
    e) Medical Research Support Program
    f) Research and sponsorship programs
    g) Teaching, Training and Research and other locally funded research

50. NSW Health allocates funding to NGOs to deliver community based services supporting health and wellbeing, particularly for vulnerable populations. Aboriginal health, aged care, children, youth and families, chronic care and disability, community transport, drug and alcohol, mental health, palliative care, population health and women's health are among the services for which NSW Health provides funding.

51. NGO grant funding agreements are commonly three years in duration and include a range of service deliverables/outcomes which are monitored on a regular basis. In 2022/23, grants of over $700M were provided to NGOs and other external entities.

52. The provision of funding to NGOs and other grant recipients is administered in

accordance with relevant policy requirements (e.g. NSW Grants Administration Guide and the NSW Health Grants Policy Directive).

Question 4

Provide an outline of the New Policy Proposal (NPP) process and the role of the Expenditure Review Committee (ERC) in determining Health's Budget. How are election commitments and Government announcements funded?

53. All budget proposals require classification into either of the following:
    a) Parameter and Technical Adjustment (PTA) or
    b) New Policy Proposal (NPP).
54. The annual NSW Budget process is designed to ensure that resources are allocated in line with the NSW Government's priorities and commitments.
55. The ERC considers a range of budget proposals across portfolios as part of the annual NSW Government budget process, including proposals with financial implications or risks, such as expenditure and revenue proposals in the context of Government priorities.
56. Generally funding decisions for recurrent and capital proposals, including new proposals, are considered in the Budget process. If a proposal is submitted for consideration outside the Budget process, then it must be demonstrated that the proposal is unavoidable, unforeseeable, genuinely urgent, and cannot be accommodated within existing resources.
57. The PTA process assists the continued delivery of initiatives and legal requirements when:
    a) there is an existing program, service or project,
    b) there has been (or is expected to be) an event outside the control of the agency that directly impacts the program, service or project,
    c) there are clear obligations, Commonwealth agreement or legal requirements, and
    d) ERC or Treasurer approval is required for the adjustment

    Where proposals do not fall within the classification of the PTA, they can be submitted for consideration as a NPP.
58. A NPP is a proposal for a new program that requires funding from the NSW Treasury Consolidated Fund or requires approval for a budget adjustment or may be approved to be absorbed within an agency's existing funding envelope.
59. A NPP can include:
    a) an enhancement of an existing program through an increase in scope, coverage or service levels, including the continuation of time limited programs, or
    b) maintenance or improvement to the performance of a State Outcome/program, outside of the NSW Treasury PTA criteria. This includes requests for additional baseline budget funding.
60. The NSW Ministry of Health discusses and prioritises NPPs against, or by reference to, competing priorities and NSW Treasury funding requirements. That approach ensures strategic alignment of new policy measures with NSW Government priorities and the NSW Health Future Health Strategy.
61. Recommendations are then submitted to the relevant Minister who is ultimately responsible for submitting NSW Health NPP priorities to the Treasurer as part of stage one of the budget process.
62. Election Commitment costings are calculated independently by the Parliamentary Budget Office (PBO) in the lead up to the State Election, with the PBO seeking advice from agencies as required. In considering the cost of the Election Commitment the PBO

costing is reviewed post election by NSW Treasury, including any assessments made by the PBO regarding the agency's ability to absorb commitments within existing budget and/or deliver savings and offsets. The agency provides advice to Treasury for consideration where the agency costing materially differs from the PBO costing.

63. Election Commitments and Government announcements can be funded by a specific source of funding identified by the NSW Government or NSW Health may be asked to identify an internal source of funding for the commitment or announcement.

Question 5

An outline of Health's budget and budget performance over time (including for 2022-23). It might also assist to provide some short analysis of headline and underlying growth, changes in expenses and revenue over time, as well as the Commonwealth's contribution to funding NSW Health services.

64. NSW Health works in collaboration with NSW Treasury each financial year to implement adjustments to the initial budget and to operate within the budget allocated to it by the NSW Government to deliver safe, high-quality and compassionate health care to the people of NSW.

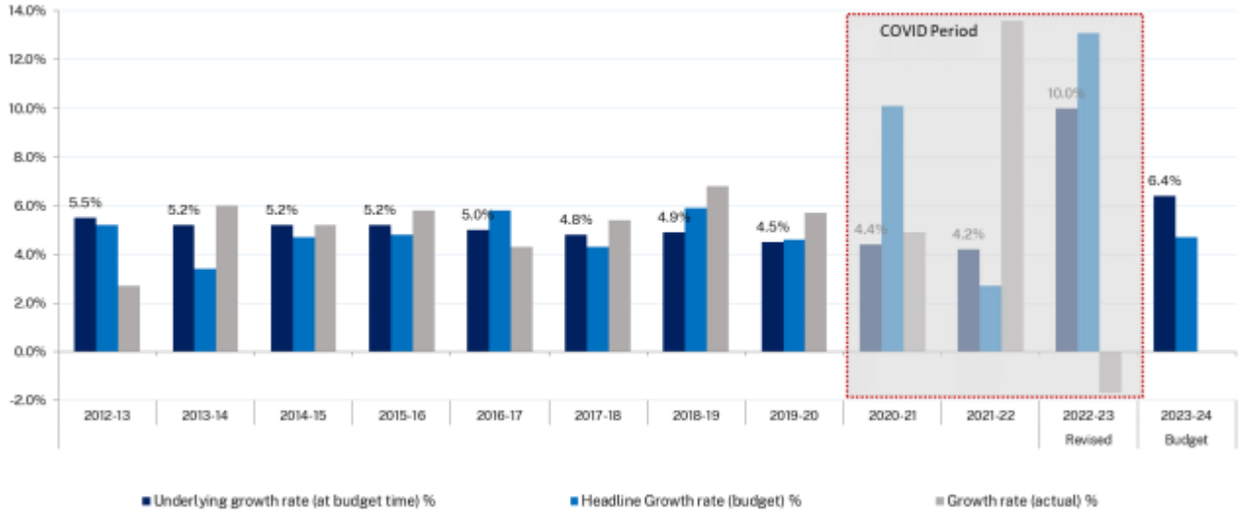
65. Prior to COVID-19 growth of the NSW Health Budget had been relatively stable, reflecting the relative stability of the economic environment during that time.

66. Changes in the NSW Health expense budget are described in the Budget Papers in terms of headline growth or underlying growth.

67. The headline expense budget includes technical items such as depreciation, capital expensing and leases impacts as well as time-limited or one-off items.

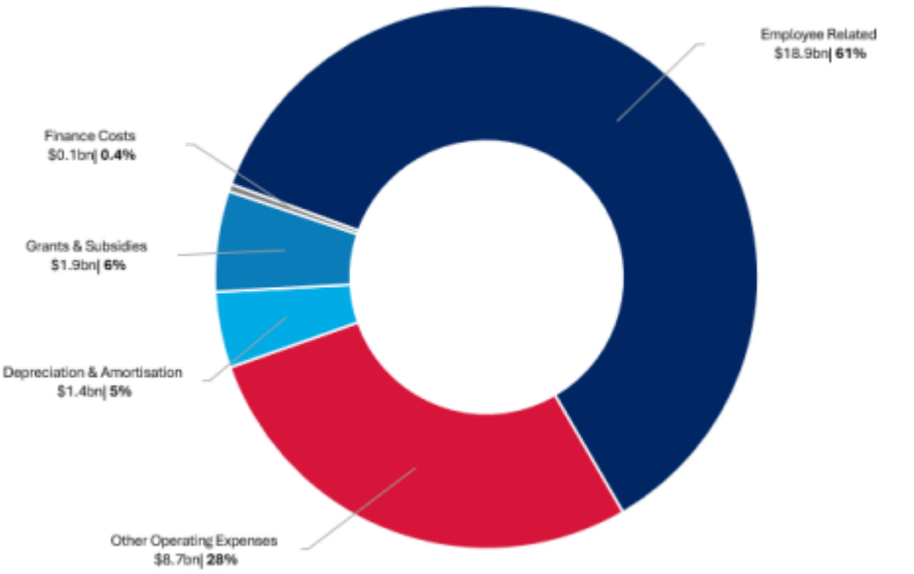
68. The underlying expense budget is equal to the headline expense budget less items such as technical items, time-limited or one-off items.

69. The headline and growth rates from 2012/13 to 2023/24 are shown below, noting the impact on the actual growth in 2022/23 is the result of the recognition of the health worker payment in the prior year.



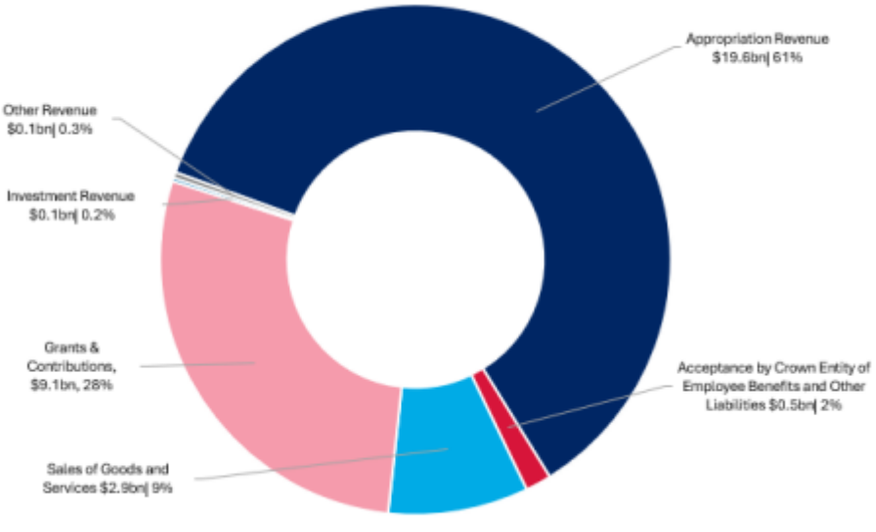
70. The NSW Health Budget comprises an expenditure and revenue budget. These are outlined below by major category for 2023/24.

Ministry of Health 2023-24 Total Expenses excluding Losses Budget



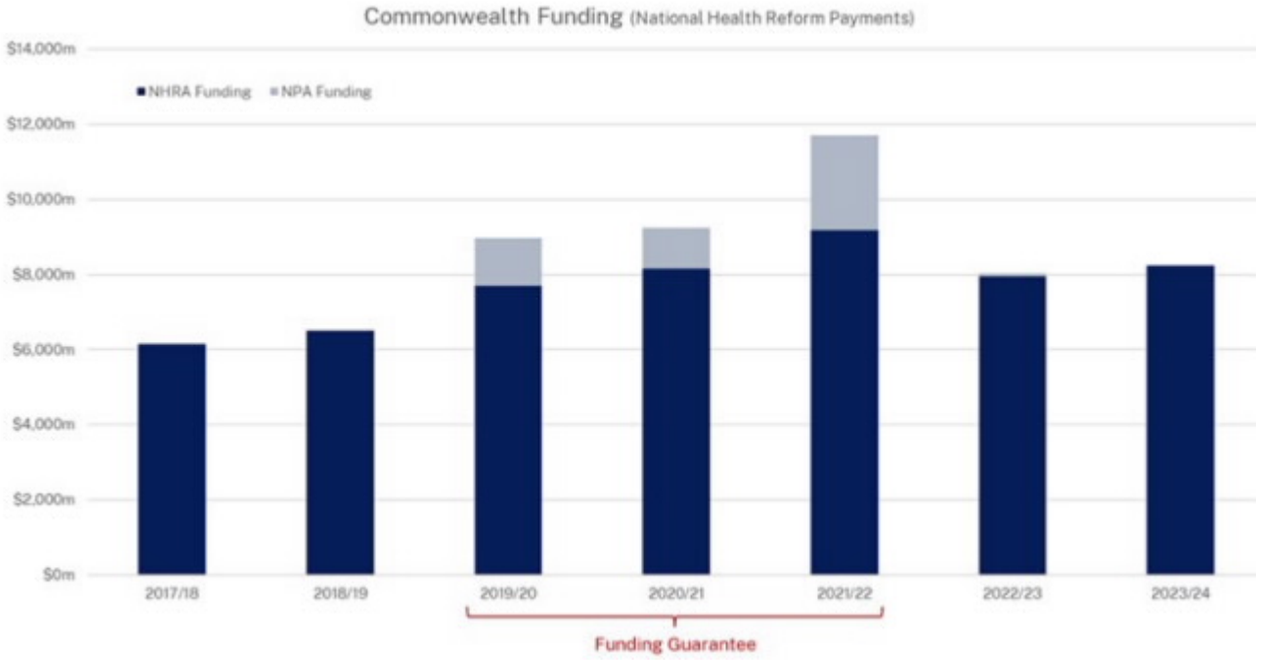
Source: 2023-24 NSW Budget Papers

Ministry of Health 2023-24 Total Revenue Budget



Source: 2023-24 NSW Budget Papers

71. The proportion of Australian Government contributions under the NHRA to NSW Health revenue from 2017/18 to 2022/23 is outlined below. The funding methodology set out in the NHRA is a 'growth funding' model where only growth is funded at a 45% contribution from the Commonwealth while the base is funded at the prior year's Commonwealth Contribution Rate. For 2023/24, the current Commonwealth Contribution Rate for public hospital funding under the NHRA is 39.69%. This is based on Administrator December payment advice using NSW Health's current activity estimates for 2023/24. This could change following the full activity reconciliation after year end.



Source: NSW Health 2023

72. An outline of NSW Health's budget and budget performance is included in the Ministry of Health's audited consolidated financial statements (the financial statements) and published as part of the NSW Health Annual Report each year.

73. The financial statements include the Statement of Comprehensive Income which includes the budget and expenditure, revenue and operating result for the financial year.

74. For the purposes of the financial statements the Ministry of Health (the Ministry or Parent) is the reporting entity, with controlled entities including LHDs and health entities constituted under the *Health Services Act 1997* and collectively referred to as the consolidated entity.

75. The financial statements are supplemented by Notes providing additional information, including a budget review note with reconciliation of major movements between the actual and budgeted net result (Note 43 in the Ministry of Health financial statements for the year ended 30 June 2023).

76. The budget each year represents the initial/original budget of the reporting period. Subsequent amendments to the initial/original budget are not reflected in the budgeted amounts.

Question 6

What challenges NSW Health face in funding healthcare into the future, including the impact of capital works programmes or other fiscal challenges.

77. There are a range of challenges shaped by external and internal factors facing NSW in ensuring the continued delivery of safe, high quality health care into the future.

78. The burden of disease has shifted significantly over the last 20 years with a significant increase in chronic illnesses. Diseases such as type 2 diabetes, dementia and osteoarthritis have been increasing, while stroke, coronary heart disease and lung cancer have decreased.

79. This will be further exacerbated as the population continues to age with 25.2% per cent of the NSW population predicted to be aged 65 or over in 2061. As people live longer, the propensity for co-morbidities and chronic health conditions increases, which drives the need for a coordinated approach to care across the health, aged care, primary care and disability sectors.

80. The NSW Health funding approach will need to reconsider the changing economic outlook including the assumptions regarding inflation and interest rates which impact provision of goods and services.

81. Rising demand for healthcare services and an increase in complexity and acuity of presentations to NSW public hospitals present further challenges. Presentations to NSW public hospitals continue to increase. The Bureau of Health Information (BHI) Healthcare Quarterly Report found triage category 1 presentations have increased 18% from pre-pandemic levels, while triage category 2 presentations increased 20%.

82. In NSW, it is estimated that two-thirds of the disease burden is associated with conditions that could be managed outside a hospital setting, however difficulties in accessing primary care, driven by poor accessibility and availability and decreased affordability will place further pressure on the public health system.

83. Improved access to primary care services would serve to reduce the demand for low-acuity hospital presentations while also having a significant impact on health outcomes.

84. Demand for access to primary care in Residential Aged Care Facilities (RACFs) has increased due to the rising number of residents with complex and chronic illnesses. To alleviate the problems caused by the thin market of GPs in regional, rural and remote communities, NSW Health has stepped in to develop initiatives to provide more attractive training pathways to increase numbers.

85. Access to quality clinical care in RACFs is critical in preventing unnecessary admissions to hospital. Increasing strain on the aged care sector is resulting in closures of facilities and/or aged care beds, and a general reluctance from providers to take on older people with significant needs, such as those with mental health conditions.

86. Hospitals and emergency departments are often being used as a last resort for older people and those living with a disability when there are no other services available to support them either at home or in the community. Appropriate disability supports in the community are key to enabling safe timely discharge and reduce likelihood of re-admission. In more remote rural communities, LHDs have become the default provider of aged care services.

87. The introduction of new technologies also presents challenges, both in terms of the expectations of consumers to access new therapies and technologies and the costs associated with providing these services.

88. The health workforce supply patterns were disrupted by the COVID-19 pandemic, which has resulted in supply shortage against demand. This supply and demand tension has led to pricing changes for contingent worker supply across the country. All states and territories are competing for a limited supply of medical and nursing workforces

89. Workforce shortages are apparent across a range of clinical specialties, particularly in primary care and regional areas, creating challenges in accessing care. For the medical workforce, a reduced number of GPs has the greatest impact on regional LHDs' ability to provide services. There are also specialist medical shortages particularly in emergency medicine, across all LHDs. Similarly, all regional LHDs have nursing shortages, primarily around the recruitment of nurses with emergency skills particularly required for the smaller facilities. Similar pressures exist for allied health professionals.

90. The impact of capital investment on recurrent funding is significant. New capital builds once completed and operational, can require additional staff and resources putting further pressure on budget. This will further be impacted by the significant future capital pipeline.

91. There is a strong need for more equitable sharing of risk and cost across the Commonwealth and NSW in provision of health services. The National Efficient Price (NEP) does not accurately reflect current costs incurred. In addition, the national activity cap results in NSW bearing the full cost for any activity performed over this cap.

92. The continued impact of the COVID-19 pandemic and associated costs, some of which remain embedded is another stressor.

Question 7

What budgetary measures are there (if any) to promote equity of access to health services for people living in rural/regional areas? What budgetary measures are there to prioritise health services for people with greater or different needs? e.g. ATSI, CALD groups.

93. The NSW Health Budget incorporates ABF, block funding and grants or funding for specific programs or initiatives. The ABF component of the model is not designed to deliver allocative efficiency. However, the ABF model incorporates elements including a range of adjustors to address the differing needs of individuals and communities in accessing health care. The ABF model has brought benefits to the system, including greater transparency in funding, but has limitations.

94. LHDs and SHNs are primarily funded through ABF based on the number and mix of patients they treat. Funding is provided to the LHD where the treatment is delivered. ABF recognises that the needs of some patients are more complex and require more resources than others.

95. Under the ABF model in NSW, health services are funded at a unit price (National Weighted Activity Unit) based on activity agreed in Service Agreements with the Secretary, NSW Health, being the agreements referred to in paragraph 31 above.

96. The cost of delivering a given level of care is higher for some health consumers than for others. Aboriginal and Torres Strait Islanders and those living in remote areas are an example. A higher NWAU weight is added for these consumers to reflect the extra costs. Additional adjustments applied to account for the relative cost of treating patients can include:

    a) Youth (under 17 years old)
    b) Living in a remote or regional area
    c) Receiving treatment in a remote or regional area
    d) Aboriginality
    e) Being in an intensive care unit
    f) Having had COVID-19
    g) Receiving dialysis or radiotherapy secondary to a patient's stay

97. Some health consumers will also consume a greater volume and complexity of health services. To account for this, while moving towards equitable access for all consumers, equity growth is allocated where the per capita consumption of hospital services by the LHD population is lower than the NSW average. This incorporates adjustments to account for the population's age and sex as well as socio-economic factors (including remoteness, Indigenous status and some Culturally and Linguistically Diverse (CALD) populations) that can influence the quantity and complexity of services needed by the population.

98. The NSW funding model recognises the additional costs related to the provision of services in rural/regional areas in the following ways:

    a) For Small Hospitals: small rural/regional sites are block funded by reference to what they actually cost, as measured by the annual costing study performed in NSW. This is different to ABF facilities that are funded on the basis of activity.
    b) For the larger hospitals: rural/regional sites that are funded by ABF receive additional funding via the Recognised Structural Cost adjustment, which provides a top up on the State Efficient Price to acknowledge the unavoidable costs of running a hospital in rural/regional NSW (such as additional transportation).

c) All acute hospitals (both small and large) also receive an additional loading on the NWAU to recognise the additional costs of treating patients in rural/regional areas. There is an adjustment to both the patient's postcode, and the location of the hospital.

99. This recognises barriers which may be beyond the control of District management in achieving operational efficiencies. These include consideration for Nursing Award regional loadings, VMO regional and remote loadings, patient transport costs and other operational costs unique to the LHD/SHN.

100. The small Rural Hospital funding methodology addresses cost pressures associated with rural and regional service delivery with the provision of a significant fixed cost component in addition to a variable cost component.

101. To better support priority cohorts and vulnerable populations, NSW Health undertakes a range of initiatives, strategies and programs that specifically aim to facilitate access the health care they need, when and where they need it.

102. The NSW Refugee Health Service is a state-wide service, funded by the NSW Ministry of Health to provide a range of clinical services and medical assessments for recently arrived refugees and asylum seekers. Activities also include policy input, research, projects and a range of health promotion initiatives.

103. NSW Health and individual LHDs and SHNs also have a range of multicultural policies and strategies to assist in improving access to prevention, health promotion and clinical care for culturally and linguistically diverse communities.

104. The NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023 aims to improve our systems and processes to promote better health for NSW residents from culturally and linguistically diverse backgrounds. This includes identifying priority health issues and groups of consumers who are at higher risk of poorer health outcomes and responding to these needs.

105. Many of these initiatives are undertaken in partnership with NGOs, CMOs and other providers such as Aboriginal Medical Services and Aboriginal Community Controlled Organisations as these entities have the relationships and expertise in engaging and supporting these cohorts and populations.

Question 8

Are there challenges in funding more preventative care?

106. The primary challenge in funding more preventative care is the many competing demands for the health budget, coupled with consumer expectations of where health funding should be directed.

107. Health systems need to manage the increasing demand and complexity of health needs. This focus can impede the ability to direct funding to preventative care, which often has a less 'immediate' need and a potential longer timeframe for the delivery of improved health outcomes.

108. Many of the enablers for good preventative care lie outside of the health system. These factors impact individual's ability to connect with the health system and their ability to achieve the same health outcomes. These factors include a person's employment, education, housing and social supports.

109. Health related prevention activities span working in partnership with government agencies to support healthy urban design all the way through to secondary prevention in a hospital setting through evidence based medicines and pre-emptive procedures.

110. Because preventative health activities span a range of initiatives, some deliver results quickly, such as smoking cessation and immunisation, while others may yield benefits over many years, such as cross government partnership in supporting urban design and transport that support social engagement and physical activity.

111. For the longer term initiatives, the timeframes are often not compatible with the shorter term budget cycles that drive funding allocations. For some complex health issues funding cycles do not acknowledge that many years may be required to demonstrate a sustained health change.

112. Effective preventative health strategies require considerable engagement, both with individuals and communities and with other partners including other government agencies to effectively address the broader social determinants of health.

113. An example of where this is occurring is the First 2000 Days Strategy. This has required cross agency effort and resources to drive a coordinated evidence based approach to providing the best start for children in NSW.

114. The health system could better undertake preventative activities as part of routine clinical care. Many of these preventative activities would be within the remit of the primary care system, however many patients are unable to access regular primary care due to lack of availability or affordability or the care not being accessible for vulnerable cohorts.

115. Preventative measures are significantly impacted by human behaviour, requiring additional supports for individuals to effectively participate, such as addressing food insecurity and housing needs.

Question 9

Any key savings and financial reform projects currently in progress, including those contributing to the Government's Comprehensive Expenditure Review.

116. NSW Health has a range of key savings and financial reform projects currently underway.

117. As part of the Government's Comprehensive Expenditure Review (CER), NSW Health has also identified a range of savings initiatives and established a governance structure to support the delivery of initiatives.

118. Key elements of the CER include:

a) consolidating corporate and business services,

b) ensuring shared services are considered in future infrastructure investment decisions,

c) establishing a single statewide operating and business model for the planning, coordination and delivery of ICT services across NSW Health.

119. NSW Health is undertaking a system wide Procurement Reform Program to deliver an integrated end-to-end procurement and supply chain system. This program has four key workstreams which are driving greater efficiency and savings across NSW Health. The four workstreams are:

a) New Operating Model to empower the procurement workforce supported by a refreshed procurement policy and new contract management framework

b) DeliverEASE to improve the availability and visibility of medical consumables across NSW hospitals, resulting in faster and more efficient delivery of stock and reduction of waste

c) NSW Medicines Formulary to provide a holistic framework for the procurement, useage and clinical governance of pharmaceuticals

d) SmartChain to create a single integrated procurement and supply chain

120. NSW Health is also undertaking implementation of whole of government savings initiatives, consistent with the rest of the public sector. These initiatives will see reduced spend in the following areas:

a) advertising,
b) consultants,
c) external legal services,
d) labour hire / contractors,
e) travel,
f) senior executive service.

Defined budgets have been allocated to LHD/SHNs with savings plans underway.

Deb Willcox AM
A/Secretary, NSW Health

Adjunct Professor Alfa D'Amato
Deputy Secretary, Financial Services and Asset Management
and
Chief Financial Officer

27 November 2023