OFFICIAL

Special Commission of Inquiry into Healthcare Funding

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SUBMISSION TO NEW SOUTH WALES SPECIAL COMMISSION OF INQUIRY INTO FUNDING OF NEW SOUTH WALES HEALTH BY KEN BARKER, PSM.

WHAT FINANCIAL MANAGEMENT PRACTICES WOULD I CHANGE (not in any priority)

- Early issue of annual allocation letters.
- Ministry to provide monthly written feedback on LHD Finance reports, with feedback to go to Board Finance and Performance Sub Committee and quarterly to Audit and Risk Committee.
- Ministry to be proactive (ie visits to LHDs) where monthly finance reports are a concern and LHD responses to matters raised are either unsatisfactory or not showing any evidence that results are improving. (Boards should be advised if such visits are to occur.)
- Cash management responsibility to be transferred back to LHDs and other entities.
- Revenue budgets to be incentive based.
- The previous Savings/Loans policy used by the Department with LHDs be reintroduced to provide flexibility and accountability for initiatives to rectify budget pressures. (NB This may require endorsement by Treasury)
- Ministry and LHDs to haver a deep dive into the operation of the TMF with the intention to restoring the various incentives/disincentives that existed previously. (Treasury may need to be consulted on the outcome of any deep/dive)
- Consideration be given to the restatement of a Resource Distribution Formula (RDF), so all LHDs are able to receive a fair share of Government funding and the annual status if introduced be circulated to all Chief Executives.
- Districts under financial pressure be encouraged to consider structural reform initiatives especially if coupled with major capital projects.
- A ban be placed on consideration of any public/private partnership which involves the delivery of public NSW Health services unless the arrangement allows for the Minister/Secretary the power to terminate such a partnership if the provider makes financial or other demands greater than that provided to the District in which they are located. Current arrangements should use such principles to ensure that such providers do not have growth greater than the LHD in which they are based and any growth is consistent with throughput.

OVERVIEW

This submission is a private submission and is not representative of the views of any professional or other health body, nor private body or company, public company nor any government agency (including NSW Health entities) that Ken has been involved with.

Ken's relationship with NSW Health and its previous iterations go back to 1985 when he joined the Department of Health in a role which would now be something akin to Deputy Chief Financial Officer. Around 2 years later Ken was appointed to a role akin to Chief Financial Officer which he held until his retirement in 2009. During this time Ken served 11 Ministers and had 9 Departmental Secretaries.

Since then Ken has been a member of 3 Health Boards (all terms now completed) and 2 Local Health District Audit and Risk Committees (Completes 8 years with Mid North Coast on 31st October, 2023) and commenced as Chair of Southern NSW ARC from 1 July, 2023. Copies of this submission are provided to the Chief Executives of both these LHDs).

Ken has around 38 years of continuous involvement and exposure to the financial challenges facing NSW Health and its controlled entities with the purpose of this submission is to provide some financial history and suggestions for future improvement. The history is based upon Ken's

recollection and any confirmation could be through 2 sources NSW Health/Department of Health/Ministry of Health Annual Reports and/or financial files held by the Ministry. (NB in the early 1990's in response to Government savings targets the Department closed its Library and transferred all documents to the Royal North Shore Hospital Library with library access for officials possible through the North Sydney Council Library (was when Health had its Head Office at Miller Street, North Sydney).

FINANCIAL MANAGEMENT/ACCOUNTABILITY STRUCTURES OF NSW HEALTH.

Over the period of time that Ken has had a relationship with Health various terms have been used to cover the entities and this paper may use terms that did exist. For clarity they are

- The Ministry of Health was The Department of Health during the course of Ken's employment
- Local Health Districts (LHDs) were called Area Health Services (AHSs)
- NSW Health is a generic term that is used to cover all entities (ie currently Ministry, LHDs and all other entities such as Healthshare, eHealth)

Structures from around 1985 until 2023

In 1985 each public hospital had its own Governing Board, Chief Executive and various support staff. For reporting purposes to the Minister, NSW Health had established around 8 Rural Regional Offices (eg Lismore. Newcastle, Goulburn) with 3 for the Sydney Metropolitan area (Paramatta, Rozelle and North Ryde). The Ambulance Service was its own separate operational and funded service.

In addition to oversighting the public hospitals in their Region the Offices provided community and public health services plus had direct control over Schedule 5 Hospitals which mainly provided mental health, developmental disability and aged care services. Around 1985 the Richmond Report which was reforming how mental health and disability services were to be provided by moving suitable patients from the Schedule 5 hospitals to the community had commenced.

Cash accounting was in operation (ie no balance sheets or accruals) and cash was provided by the Department to the Regions who then allocated it to the various public hospitals and the Regions used their portion for the various Regional expenses including the Schedule 5 Hospitals. The Department used the Hospital Fund to move cash from Treasury to the Regions and then the Hospitals. This Fund had 3 main revenue sources being The State contribution, the Commonwealth contribution and Lottery/Poker Machine Taxation Revenue (clearly a Government commitment when they were introduced to fund hospitals). A separate Fund existed for the Ambulance Service.

My recollection is that the Minister approved budgets for each Region, but the relevant Regional Directors either approved Hospital budgets or made recommendations to the Minister.

Hospitals and funding shortfalls were an issue then. Of interest is that around 1984/85 the Government engaged a former Auditor General of NSW (Jack O'Donnell) to review funding issues associated with teaching hospitals. This review identified a number of reforms and improvements which together with other measures were introduced over the next 5 to 10 years.

A pilot program was occurring in the by the Northern Metropolitan Region of the concept of area health services, so that instead of funding each public hospital, a bundle of funding and accountability for more than 1 hospital plus other related services was made (eg community health).

Around 1986/87 the Government then identified a number of Area Health Services (AHS) to be established, but from memory did retain the Regional Offices. The AHS's all had their own Board and non clinical administrative staff. Ministerial approval for each AHS budget was required.

Post 1988 the number of AHS's were consolidated to a similar number to that now in place and the Regional Offices were closed with staff mainly transferred to the Department, obtaining employment in an AHS or taking a redundancy. My recollection is that Governing Boards remained in place.

Around 1992 the Government determined that responsibility for Disability Services would transfer from Health to Community Services. This resulted in the transfer of staff, funding and responsibility for dedicated Fifth Schedule Hospitals which provided Disability Services and Disability Group Homes.

Whilst NSW now has Local Health Districts (LHDs) which I believe was in response to the Commonwealth moving its funding from a block grant to the States to case weighted funding directly linked to public hospital activity, the principle of LHDs reporting directly to the Ministry (was Department) has not really varied for over 30 years and is a model that I believe is worthy of maintaining.

FINANCIAL ACCOUNTABILITY OF LOCAL HEALTH DISTRICTS

In the late 1980s and until my retirement a number of factors came together which resulted in changes in policies in how the AHSs were funded and held accountable.

These in no particular sequence either due to timing or importance are as follows

- Introduction of accrual accounting by Treasury both for the Department and all its controlled entities (ie LHDs)
- The Auditor General taking responsibility for all external audit functions of LHDs. Previously the Department was audited by the Audit Office and each LHD engaged their own auditor. The decision by the Auditor General allowed for the standardisation of audits and the identification of potential system wide deficiencies.
- The introduction by Treasury around 1990 of a Savings/Loan policy for the Consolidated Fund appropriation budget for all Departments. This arose from a Parliamentary Public Accounts Inquiry into "End of Year Spend Ups" which identified that as Departments got closer to 30 June that if they assessed that they would not use of their Appropriation they would find ways to spend it, rather than loose it. The Government in response then allowed for unspent funds to be carried forward on a once off basis so it could be used to benefit the relevant Department in the following year. However if a Department used more Appropriation than approved it would have to repay that sum in the following year. The principle recognised that budgeting is not a perfect science and having Operating results equal to budget is highly unlikely. This principle was fully implemented across all areas of the Department (including the LHDs. For reasons I do not understand Treasury (during the term of the last Government) and then Health cancelled this policy and returned to the policies of the 1980s and before. Whilst Treasury's latest decision applied to the Ministry, whether the Ministry had no choice but to then vary LHD funding arrangements in respect of Appropriation cash is not known. (ie was it done because they had no choice or they choose to).
- To improve the monitoring of LHDs we established 6 control points/initiatives
    1. When issuing budgets and/ or budget variations the impact for the current year and annual was stated as they did vary (eg if an Nurses obtained an award increase from 1 October the impact in the current year is 9/12 of a full year budget). By

maintaining the 2 budgets in both the Department (which at a Departmental level reconciled to Treasury), LHDs understood the base budget for the following year. This assisted in their management of their District.

2. Timely issue of budgets. One of the findings of the O'Donnell Review was that budget management of hospitals was made more difficult that it should be due to budgets not been advised until around November/December. (5 to 6 months after the financial year had started). To address this much effort was internally driven in the Department including to work with Treasury/Government to finalise the Health Budget so that the Minister (who is required to approve the Appropriation distribution) is in a position to make the relevant decisions which should allow for budgets to be advised on/close to State Budget day. This also requires the various Policy areas of the Department to have determined any priorities if growth funds are available (Growth would cover additional operating costs of new capital works, expansion of existing services, populations/service demand growth., government commitments). The year I finished at Health, budgets issued on 16 June (14 days before the year started) to all AHS's.
3. The creation of a Staff Profile which required by Award Grouping (eg Nursing, HSU) for LHDs to identify how fte between the various industrial classification in that award were budgeted. The budget included not only the number of fte but also the base annual award a rate and oncosts. In aggregate the total value of the profile should equal the Employee Related budget for the cash funded items. This could then be used to ensure when an award pay scale was varied funding would be provided in line with the staff profile. The other use of the Profile was to compare actual staff to Profile or funded staff when a LHD was reporting budget difficulties in the Employee Related area.
4. The standardisation of the Monthly Finance Report from each LHD to the Department (around 4 A4 pages) and providing a response back to each LHD before the next report was due. This enabled monthly written dialogue both ways, noting telephone discussions, meetings and visits (including with CEs) were a regular occurrence so that both the Department and Ministry had a common understanding of the issues and action required.
5. Cash is King. Accrual budgeting and reporting includes a number of non cash entries which due to external factors can distort the management skills of the LHDs executive team (eg depreciation, asset revaluations). All LHDs had full responsibility and accountability for the management of Operating Cash which comprised 3 main sources (Government funds provided by the Department on a weekly basis, Private patient revenue (Mainly those who elected to use their private health insurance, motor vehicle accident patients and Department of Vetrans Affairs patients) and Sale of Goods and services (eg car parking fees, rent for use of floor space such as a café). When cash based expenses such as payroll, creditors and VMOs were over budget normally creditor payments would be delayed. To monitor this a kpi was established which monitored the timely payment of creditors. This was part of the monthly report and if creditors became concerned they contacted the Department. If a problem was identified the LHD would be subject to closer review by the Department as this was an indicator of overspending. In some instances it was temporary and in others reflective of poor expenditure control or a significant increase in service demands. Resolution was either by the LHD taking appropriate action or seeking a repayable advance/loan from the Department. An advance was

provided where agreement existed it was short term and would be resolved by 30 June. An interest bearing loan was provided from the Department where repayment would be in a forward year and this was dependant upon an agreed strategy for repayment to occur. (This policy was based on the Treasury savings/loans policy) Strategies included structural reform, realignment of back of house and/or front line services, improved revenue or procurement practices.

6. Revenue Incentive. Health economists in reviewing relevant data sets relating to private health insurance levels could identify where opportunities may exist for LHDs to increase their share. To ensure this was successful stretch budgets were not set so the LHDs had the opportunity to exceed and retain the benefit of surplus revenue or assist in retiring any loan.

7. Treasury Managed Fund (TMF). Treasury around 1990 introduced the TMF across the inner budget sector to standardise insurance arrangements for all relevant risks (ie workers compensation, property, motor vehicle and public liability). Prior to this reform most LHDs had their own insurance arrangements. The funding was risk based with actuaries setting a benchmark or funded amount and the actual premium reflective of claims experience. Health had its own pool and for public liability and property held the risk centrally but set an excess so that any claim would result in an excess charge to the relevant District. Workers compensation and motor vehicle was fully devolved so that good performing LHD's would normally have premium lower than budget with the reverse for poor performing Districts. The Fund had hindsight adjustments and for workers compensation regular updates were provided so that each District could assess if positive or negative. Positive resulted in the flow of funds to the LHD and negative the withdrawal of funds. Health generally performed well, Unfortunately in my view due to changes made by Government in the last 4 or so years the risk based principles and profile of the Fund in Districts has now substantially diminished.

8. Resource Distribution Formula (RDF) or Resource Allocation Formular (RAF). This model was used for the majority of my time in Health and it is focused on the level of Appropriation each of the AHS's receive. It was discontinued a number of years ago. The objective of the RDF is to shift resources by comparing population needs with resourcing levels. The shift occurs when growth funds are allocated (Health due to its nature and direct relationship with the population always gets a level of growth funding to increase service provision). The shift is included in the advice to the Minister to approve the distribution of Appropriation (cash) to each LHD and other entities. Health Economists use a number of factors which go into the model (eg population size and age, health status of community, level of social disadvantage, tertiary services provided (to allow for possible exclusion). The outcome is that the model will then identify what each AHS share of cash funding should be. When this is known it can be compared to the level of Appropriation provided and a mathematical and dollar difference is determined. In the distribution of growth cash to intent is to then increase the share of underfunded AHS's and reduce the share of overfunded AHS's (albeit all get some growth). Each year Chief Executives, after the budget decisions had been made and advice issued, would be informed of the RDF movements in that year.

9, Capital Asset Charging. Similar to the RDF, a draft policy was formulated to compare LHDs between their entitlement to Fixed assets (mainly hospitals) and their actual share. The intention was for Districts which were "asset rich" compared to their peers to consider options to reduce assets if a real charge was to be introduced. (ie it was a theoretical policy and unlike the RDF never used). It is something that the Ministry may wish to revisit as it could feed into the RDF model.

WHAT STRATEGIES ARE AVAILABLE FOR HEALTH TO BETTER MANAGE ITS BUDGET.

There is effectively two streams

1.MANAGEMENT INTERVENTION

These are locally the easiest and soft in nature. They involve efficiencies around staff reductions/controls, general improvement of internal controls, improvement in procurement controls, increasing revenue.

2. STRUCTURAL REFORM.

These generally are difficult, may require the concurrence of the Minister and may involve capital expenditure. The principle behind this reform is that the future total operating costs will be less due to the economies of scale achieved from site consolidation. Some examples that I was involved with include -

- When the Commonwealth decided it would no longer operate Repatriation Hospitals and transfer Concord to NSW, Health closed Western Suburbs at Ashfield, and wound down parts of Balmain.
- When the Community took over full responsibility for Aged Care a number of Rural Hospitals were reconfigured as a Multi Purpose Service Centre which provided an aged care service for local people, but also reduced the overall Health cost base. Health also ceased providing in a number of locations Aged Care Services (eg Strickland House at Vaucluse).
- Expansion at a number of major Sydney Hospitals allowed for the closure of others (eg Prince of Wales at Randwick expanded and Prince Henry at Little Bay, Royal South Sydney at Zetland and Royal Hospital for Women at Paddington all closed: Bankstown Hospital expanded with Lidcombe closed, expansion of Royal Prince Alfred linked with closure of Marrickville; John Hunter Hospital at Newcastle linked with closure of Wallsend Hospital plus Royal Newcastle due to the earthquake).
- The introduction of Healthshare, Health Infrastructure and ehealth may be identified as structural reform noting in the main the target is corporate services. However some may argue the reform in certain areas has gone too far and may in fact be a contributor the current financial performance issues.

Two areas where corporate structural reform may have gone too far are

- Giving Cash management responsibility to Healthshare. Previously each District had 100% responsibility for cash management. This involved the control of payments to employees and suppliers from the weekly level of cash provided by the Department plus its own discretionary revenue (eg patients fees). The downside was that if cash expenses exceed the cash budget, suppliers were paid late. A benchmark of creditors over 45 days was in place to monitor this (was part of the monthly report) and was one of the indicators which reflected a budget problem and the possible need for a loan, budget recovery strategy or other action.

The Ministry has changed this so that now all LHDs Operating cash is managed by Healthshare resulting in no direct link between budget compliance and cash management. (To me it is as if your bank gives you a credit card, asks you do your best each month to pay it, but don't worry if you cant because the Bank will fund the gap). The resultant issue for the 2022/23 audited accounts I expect will be a number of Districts will have a material difference between Government cash budget and actual which will flow through to a material Net Surplus. The Net Surplus is not a cash result, but is due to the amount of cash for that LHD provided to Healthshare is greater than the approved budget (ie cash provided is over that budgeted). The unrelated issue is that for some LHDs and their Annual Public Meeting questions could be asked as to why are services restricted/not available when they had such a significant favourable result?

- LHD Corporate Services/Administration staff. I understand that some Rural LHDs especially have difficulty in recruiting key corporate staff in areas such as finance, audit, information technology, risk, clinical coding, workforce. Also most Rural LHDs do not have the ability use the Government Pre Qualification panel and engage a third party as most on the Panel are Sydney based and travelling/accommodation costs are involved. It would appear desirable to introduce a Health Corporate trainee program for all LHDs which has a focus on school leavers who wish to undertake a relevant tertiary training program to develop skilled staff for NSW Health going forward.

PRIVATISING AND OUTSOURCING ON THE DELIVERY OF HEALTH SERVICES.

It would be remiss of me not to comment on Terms of Inquiry B iv dealing with this matter.

My involvement includes

1. Being given the Operating budget contract for the soon to be opened "privatised" Port Macquarie Base Hospital and asked to sort it out, which we did (noting the contract was agreed with officials who had a focus on capital works and service planning, not financial management)
2. Having discussions with the then Auditor General about the accounting treatment for the capital costs of PMBH and then seeking a Treasurer's Direction with the annual accounts for the Department then qualified for been in breach of an Accounting Standard. (if we applied the Accounting Standard we would have been breached for not complying with the Treasurer's Direction). This issue was addressed by Treasury in the following year.
3. Working with another senior Executive/Treasury and negotiating cancellation of the PMBH agreement and transfer back to the public sector.
4. Working with a number of 3rd Schedule Hospitals and other Hospitals which are privately operated but provide public services and their related funding issues.

My personal view is that they are normally problematic to deal with if they believe any of their arrangements/agreements with NSW Health are not favourable as the Secretary/Minister normally does not have the power to direct and control (including the Board).

Some may argue that is no different to a LHD which has Visiting Medical Officers and clinical academics, and whilst either of these groups (as can the Health Unions) raise issues ultimately the power of control is with the Minister/Secretary.

Whilst LHDs do have independent Board members as appointed by the Minister and Chief Executives, the Minister/Secretary can where necessarily dismiss either or both (may involve the Governor for Boards) and appoint an Administrator or Acting Chief Executive.

I am not aware such a power exists with any 3rd schedule or privately operated Hospital which provides public services. This would appear to be a governance matter that requires reform so that Boards and Chief Executive tenure of such entities can be terminated by the Minister and/or management of the Hospital be taken over by a person appointed by the Minister where financial and/or service provision is unacceptable.

Ken Barker 31st October, 2023

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