# Special Commission of Inquiry

# into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Thursday, 30 November 2023 at 10.00am

(Day 004)

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| Mr Ed Muston SC | (Senior Counsel Assisting) |
| Mr Ross Glover | (Counsel Assisting) |
| Dr Tamsin Waterhouse | (Counsel Assisting) |

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning. Yes, Mr Muston.
2
3 MR MUSTON: Good morning, Commissioner.
4
5 I think the first thing we need to do is, there is an
6 update to the tender bundle, can I hand up to you what is
7 described as a further index to volume 7 and I tender the
8 documents listed there, for present purposes, at least, the
9 most important of which is document A53,
10 [MOH.9999.0005.0001], which is the joint report of Mr Alfa
11 D'Amato and Ms Deb Willcox.
12
13 THE COMMISSIONER: Those exhibits just have the number
14 already allocated to them.
15
16 **EXHIBIT #A53-A65 BULK TENDER OF DOCUMENTS MARKED A53 TO A65**
17 **AS IDENTIFIED IN TENDER LIST**
18
19 MR MUSTON: Thank you.
20
21 That, I think, brings us to today's evidence, which is
22 to be given as a joint session again by Ms Willcox and
23 Mr D'Amato.
24
25 Ms Willcox is probably still bound by the affirmation
26 she made two days ago, but Mr D'Amato might need to --
27
28 THE COMMISSIONER: Are we saying your name, correctly,
29 sir, is it D'Amato?
30
31 MR D'AMATO: D'Amato.
32
33 THE COMMISSIONER: That's the only error he'll make all
34 day.
35
36 **<ALFA D'AMATO, sworn: [10.03am]**
37
38 **<DEBORAH WILLCOX, on former affirmation: [10.03am]**
39
40 MR MUSTON: Can I just start by making sure I've got
41 a proper understanding of the evidence that has been given
42 over the last two days, Ms Willcox, at least insofar as
43 you're concerned.
44
45 I gather from the evidence that has been given that
46 there are, in essence, three important objectives that the
47 health system needs to be pursuing, no doubt amongst

1 others, but three important objectives, and they are,
2 first, an increase in focus on preventative health care; is
3 that right?
4
5 MS WILLCOX: Correct, yes.
6
7 MR MUSTON: Just in relation to that, to make sure we're
8 all dealing with the same thing, could you just give me
9 your very rough definition of what preventative health care
10 comprises?
11
12 MS WILLCOX: Yes, certainly. When we talk about
13 preventative health care or health promotion, we talk about
14 those services or activities that go to maintaining the
15 health and wellbeing of individuals in an attempt to avoid
16 them developing disease or requiring hospitalisation for
17 injury or otherwise.
18
19 Health promotion activities - and certainly health
20 prevention - goes to areas obviously important in
21 population health protection, such as vaccination, and
22 health promotion activities go towards management of
23 obesity, diet, exercise, falls prevention. So it's quite
24 a broad house, but in the main, it is about trying to
25 maintain the health and wellbeing of the population.
26
27 MR MUSTON: Thank you. So when we refer to preventative
28 health throughout the day today, it may be taken that that
29 broad house is what we're referring to.
30
31 MS WILLCOX: Thank you.
32
33 MR MUSTON: That's the first objective. The second
34 objective, as I understand it, is an increased delivery of
35 care in the community.
36
37 MS WILLCOX: Yes.
38
39 MR MUSTON: And that, in a way, is a role which has
40 traditionally been primarily played by the primary health
41 sector; is that right?
42
43 MS WILLCOX: Correct, and probably historically also
44 through home nursing and community nursing. That's
45 probably, too, a longstanding community-based activity.
46
47 MR MUSTON: The objective there is to deliver care in a

1 way which, as best as possible, avoids hospital
2 presentation, unless it's absolutely necessary.
3
4 MS WILLCOX: That's correct. Our objective always is to
5 ensure a person gets the right level of care at the right
6 place at the right time, and for many people, care in the
7 home or a community setting is appropriate, when it's based
8 on clinical judgment.
9
10 MR MUSTON: But there will still remain, obviously enough,
11 a need to deliver acute care in a hospital setting?
12
13 MS WILLCOX: Indeed.
14
15 MR MUSTON: The aim is to ensure that the people who are
16 presenting and receiving that care are only those who
17 genuinely need it?
18
19 MS WILLCOX: That's a perfect characterisation.
20
21 MR MUSTON: In terms of the way in which health care
22 across the board is delivered, the third objective which
23 I've drawn from the evidence is the need to move towards
24 allocative efficiency in the funding or as a driver of
25 health spending.
26
27 MS WILLCOX: That would be correct. The term "allocative
28 efficiency" is an approach that goes to drive equity of
29 access across our populations and communities as opposed to
30 a technical formulation of what sort of funding is
31 required.
32
33 MR MUSTON: Would I be right in my understanding that that
34 essentially means we need to be driven by a need to produce
35 the best health outcomes, allocative efficiency, as opposed
36 to technical efficiency, which is the most cost-effective
37 delivery of services and activity where it's delivered?
38
39 MS WILLCOX: Yes, that's correct. The approach is more
40 towards volume than outcome.
41
42 MR MUSTON: I certainly don't suggest that the evidence
43 that has been given over the past two days tells us that we
44 should not also be focusing on technical efficiency --
45
46 MS WILLCOX: Indeed.
47

1 MR MUSTON: -- where activity is required, but in terms of
2 the overall funding package, I gather, the objective is we
3 ought be trying to use that money to produce the best
4 health outcomes possible as our key objective.
5
6 MS WILLCOX: Yes, indeed.
7
8 THE COMMISSIONER: You reach a point where gains in
9 technical efficiency are pretty hard once you're highly
10 technically efficient.
11
12 MS WILLCOX: That is true. We're constantly, in the
13 system, looking for ways how we can increase our
14 efficiency. Some of those things go to, which Mr D'Amato
15 will no doubt talk to, some of our corporate back of house
16 activities, as tight as you can possibly gain, so you can
17 maximise your investment at the front for clinical care.
18 But there probably is at some point a limiting factor.
19
20 MR MUSTON: Having made sure my understanding of the
21 evidence that has been given so far is correct, I should
22 probably move to this next point, which is just to identify
23 Mr D'Amato, your role within NSW Health. You are the
24 deputy secretary financial services and asset management.
25
26 MR D'AMATO: That's correct.
27
28 MR MUSTON: That's a role you have held since April 2021.
29
30 MR D'AMATO: That's correct.
31
32 MR MUSTON: I think you have been working broadly within
33 the health sector since at least March 2009 according to
34 your CV.
35
36 MR D'AMATO: Yes, that's correct.
37
38 MR MUSTON: I won't invite you to tell us or to list all
39 of your previous experience in the New South Wales health
40 system, but I assume that the recent experience which is
41 described in the CV, which is at [MOH.9999.0006.0001],
42 accurately reflects that history and experience.
43
44 MR D'AMATO: That's correct.
45
46 MR MUSTON: Coming back to these three important
47 objectives that we've identified from the evidence given so

1 far, those objectives need to be pursued against the
2 background of the challenges that the two of you have
3 identified in paragraphs 77 to 92 of your joint report,
4 which is at document [MOH.9999.0005.0001], commencing at
5 page 16. Perhaps if that could be brought up.
6
7 We are dealing with the answers that you have given to
8 question 6 there. I don't need you to go through them in
9 detail but there's just a couple that I wouldn't mind
10 hearing you develop. The first is do you see paragraph 87,
11 at the foot of that page, where you refer to one of the
12 challenges being faced by the health system and the funding
13 of health going forward being the introduction of new
14 technologies. Could I just ask you to develop that a
15 little bit? What are the technologies, first of all?
16
17 MS WILLCOX: The evolution of specialised technologies is
18 moving very rapidly, and there are new drugs and tests and
19 procedures that are, as I say, evolving constantly in the
20 health system.
21
22 We want to provide the very best care to our patients
23 and give them the opportunity to receive the latest
24 treatments and drugs and technologies to maximise their
25 recovery or wellbeing, but some of them come at a very
26 large cost and we need to make sure that our processes
27 within the ministry, working with our clinicians and other
28 partners, are such that we can make an appropriate judgment
29 call about what the system is able to provide.
30
31 Our role is to provide services to the entire
32 community, and there are examples where, for instance, some
33 of these ground-breaking medications can be in the millions
34 of dollars for an individual patient. That's not to make
35 a judgment that that individual is not worth it; it's just
36 to give some perspective on the quantum of some of these
37 new medications and some of the technologies - as to what
38 their value is.
39
40 MR MUSTON: What is the process around decision-making in
41 terms of a new treatment? Let's say there's a new
42 treatment that has become available which is revealed to be
43 very effective, but it's also very, very expensive. What's
44 the process internally in terms of decision-making as to
45 whether to offer it through the public health system?
46
47 MS WILLCOX: We have an expert group that is designed to

1 assess what's coming forward so that we can make a judgment
2 on the evidence and the outcomes associated with
3 a particular device or medication.
4
5 There are Commonwealth pathways as well. But for us
6 internally, we look at the evidence, what is the
7 appropriateness, is there a research context from which
8 this new drug or technology has come forward? We want to
9 evaluate it against the priorities of the system as well,
10 whether that be value-based health care, priority
11 conditions, such as dementia, heart disease, whatever the
12 key conditions that we know to be creating the greatest
13 impact on the system, so there is a reference back to some
14 of those priorities in order to support a decision or not.
15
16 MR MUSTON: Dealing with that decision-making process, to
17 what extent does the cost of the particular medication or
18 treatment factor in to that decision-making? I think
19 a moment ago you told us that some of them can be up to
20 $1 million per patient. That's a large amount of money.
21
22 MS WILLCOX: Yes.
23
24 MR MUSTON: How does that $1 million per patient factor
25 figure into decision-making about whether or not to offer
26 the treatment through the public health system?
27
28 MS WILLCOX: It's obviously a complex ethical question.
29 The circumstances for which that may arise have been fairly
30 infrequent, it would be fair to say. In the most recent
31 times, both Mr D'Amato and I have been involved in two
32 patients who required, or were indicated they required,
33 a very expensive medication, they were at end stage of
34 their condition and had exhausted all other treatments, and
35 a decision was made to fund those particular medications
36 for those individuals.
37
38 We could only but suspect there will be more of this
39 over time, and so we're working with the Commonwealth
40 around this, who are partners in the funding for some of
41 these new technologies and treatments that are coming on
42 board.
43
44 The main group of things that come forward to us for
45 consideration ultimately end up in the pathway of not
46 agreeing to because the evidence is not in, or the
47 requisite value is not apparent, or they may be things that

1 then we decide to fund as part of a statewide service, so
2 things like CAR T cell therapy may be one example, where
3 there's a lot of evidence, a lot of research, agreement
4 within the ministry and with the appropriate clinical
5 advice, and that is now factored in to a service agreement
6 with a funding approach.
7
8 MR MUSTON: We might come back to the way the funding
9 approach works but, for present purposes, I gather the
10 reason that the new technologies or the emergence of new
11 technologies is a challenge to the funding of health is
12 because they can be very expensive.
13
14 MS WILLCOX: Yes.
15
16 MR MUSTON: So they make delivering health care more
17 expensive in individual patient cases than it once was?
18
19 MS WILLCOX: Indeed.
20
21 MR MUSTON: Could I ask you to turn over the page to - do
22 you see there paragraph 90? That is another challenge that
23 you've identified, which is the impact of capital
24 investment on recurrent funding. At the end of the
25 paragraph there, you refer to a significant future capital
26 pipeline.
27
28 MR D'AMATO: That's correct.
29
30 MR MUSTON: I'll come back to just how all of that impacts
31 from a budgeting perspective, but can I just ask at this
32 stage, what is the significant future capital pipeline that
33 you're referring to in paragraph 90?
34
35 MR D'AMATO: Sure. As documented in the budget papers,
36 the government has announced a pipeline of capital for
37 health of around 13.8 billion, and this is in one of the
38 documents that was published in September. Included in the
39 13.8 billion, there is an amount that has been established
40 for new works or new announced capital projects that will
41 be delivered within the next four years, as well as
42 projects that will be completed, that were previously
43 announced but that will be completed in the four years
44 coming.
45
46 As well as, if you want, new buildings, in the
47 13.8 billion we need to acknowledge there's also a spend

1 for ICT, for instance, IT programs, so we have a big
2 investment in single digital patient record, which is also
3 captured as capital spend.
4
5 So that is what is the pipeline, and to just mention
6 what we have estimated in regards to that pipeline and the
7 impact of those that are due to be completed within the
8 next four years, we expect to see around 800 additional
9 inpatient beds coming on line in 2025/26, and our estimate
10 is that to operate this additional capacity we will require
11 around 220 million. That's estimated only starting from
12 1 July.
13
14 So we know that there are different assumptions that
15 we need to test between now and then, but we are keeping
16 always a close eye. We always focus on what is in the
17 forwards and risks associated with the financial impact on
18 the recurrent side of our budget.
19
20 MR MUSTON: So again, to make sure I have understood it,
21 the pipeline involves some projects which are not bricks
22 and mortar projects?
23
24 MR D'AMATO: That's correct.
25
26 MR MUSTON: Like the single patient record?
27
28 MR D'AMATO: That's correct.
29
30 MR MUSTON: That's an IT project. But also traditional
31 bricks and mortar projects like building a new hospital
32 facility or upgrading an existing hospital facility?
33
34 MR D'AMATO: That's correct. And I just want to stress
35 that both will have an impact on our recurrent - even IT
36 projects will have an impact on our recurrent operating
37 expenses, mainly because of the nature of the new IT
38 programs which are all as a service.
39
40 MR MUSTON: The last one I wanted to ask you very quickly
41 about was if you look at paragraph 91, I just wonder, you
42 see there you've said:
43
44 *There is a strong need for more equitable*
45 *sharing of risk and cost across the*
46 *Commonwealth and NSW in provision of health*
47 *services.*

1
2 What do you mean by that?
3
4 MR D'AMATO: The main risk that we want to highlight in
5 this paragraph is the fact that there is a delay between
6 the data collected to inform the national efficient price,
7 which is data collected from all our hospitals in ABF
8 terms, and all other hospitals, ABF hospitals, across the
9 nation, and provided to an Independent Health and Aged Care
10 Pricing Authority once a year.
11
12 What the delay is, is around three years. The data
13 that informed this year's national efficient price would
14 have been informed from data that was from three years ago,
15 which probably barely accounted for COVID cost and barely
16 reflected the inflation impact that we are witnessing right
17 now. So that is a risk that we called out several times
18 with IHACPA, and the challenge is that it's difficult for
19 them to collect across the nation all this data in a timely
20 fashion so they can inform the national efficient price,
21 but there is a risk.
22
23 MR MUSTON: I will come back to the way the Commonwealth
24 delivers its funding, but just so I can make sure I've
25 understood what you've said, the challenge that you're
26 identifying there is, in effect, the fact that the way in
27 which the Commonwealth's contribution to the funding of
28 health care is quantified involves an assessment of past
29 delivery and the cost of delivering services in the past,
30 and that's failing to keep up, potentially, with the
31 ever-increasing cost of delivering those services?
32
33 MR D'AMATO: That's correct.
34
35 MS WILLCOX: I might add, Mr Muston - and Mr D'Amato may
36 wish to elaborate - the other risk around it is what's in
37 scope, and as we see the change in the population needs and
38 the profile of disease, and to your earlier comments about
39 prevention and community-based care, the scope of those
40 things that fit within the IHACPA model is narrow,
41 potentially, there's a narrowing of that which creates
42 a risk for us in terms of what the state then needs to
43 fund.
44
45 MR MUSTON: Maybe I'll ask you to develop that a little
46 bit further. Is part of that the fact that the second of
47 our objectives, delivering health care outside of the

1 hospital setting in a way that ideally prevents hospital
2 presentations or minimises hospital presentations, is
3 traditionally the domain of the Commonwealth funded primary
4 health sector?
5
6 MS WILLCOX: Correct.
7
8 MR MUSTON: And is the scope creep that you are talking
9 about there referable to the fact that, as the state
10 expands its services or adjusts its services to secure that
11 objective through its own spending, it is, in effect,
12 picking up care which would traditionally have been
13 delivered through a Commonwealth funded aspect of the
14 health service?
15
16 MS WILLCOX: In part, but possibly the more significant
17 area is that as we work to try and ensure people, as
18 I said, get their care at the right place - and not always
19 is a hospital the right place - we have adapted our models
20 of care and our ability to care for people in the community
21 through virtual care, home monitoring, self-management,
22 a whole raft of things, in order to ensure people stay out
23 of hospital.
24
25 It's not, strictly speaking, in a GP practice,
26 although that relationship with the GP and primary care is
27 critical, but we have made a positive move to try and avoid
28 people coming into hospital, and we find ourselves sort of
29 straddled, I guess, between the acute services of the state
30 system and primary care. So there's a growing portion in
31 the middle where the risk potentially sits that we would
32 like to work with our colleagues in the Commonwealth to see
33 how we can get a more equitable sharing of that financial
34 cost.
35
36 MR MUSTON: And so again we'll come to activity based
37 funding in a moment, but is the issue that you've just
38 described the fact that the way in which the Commonwealth's
39 contribution through activity based funding is measured, by
40 the coding and recognition of activity, doesn't actually,
41 at the moment, recognise that activity which is delivered
42 outside of the hospital setting that you are expanding into
43 in order to achieve the second of those objectives?
44
45 MS WILLCOX: Yes.
46
47 MR D'AMATO: That's right, you are correct. I think the

1 core issue is again the delay from the independent
2 authority to recognise innovation in the service delivery,
3 if you want, because this agency is tasked to determine the
4 scope of services in then attracting, if you want,
5 Commonwealth contribution. This service can be delivered
6 from block funded service, those small hospitals, as well
7 as ABF hospitals.
8
9 But that fact is that when we step into innovative
10 solutions, as Ms Willcox described, it's challenging for us
11 to attract immediately, if you want, the additional funding
12 from the Commonwealth, because we have to go through
13 a process to demonstrate that these are services that
14 otherwise would have been provided in other settings, being
15 hospital settings, or already deemed to be in scope for the
16 Commonwealth. So that's the challenge for us. There is
17 a gap, if you want; there's a challenge in the process in
18 us accelerating some of this innovative service delivery.
19
20 MR MUSTON: There are two buckets, as it were, a bucket
21 which is traditional primary health care delivered through
22 the Medicare system. There's a bucket which is traditional
23 hospital based health care delivered traditionally in
24 hospitals, funded in part by the state and in part by the
25 Commonwealth, but as you expand your services to keep
26 people out of hospital, there is a gap between those
27 buckets that you've identified, which means the state, to
28 provide those services, is meeting the full cost of them
29 unless and until such time as an agreement is reached with
30 the Commonwealth to change the way the funding of the
31 hospital-based treatment is measured to, in effect, pick
32 that up.
33
34 MS WILLCOX: Yes, that's a correct characterisation,
35 Mr Muston. There are about five significant innovative
36 models of care that have been developed in the state system
37 in recent times that Mr D'Amato was referring to, RPA
38 virtual being one, the frailty collaborative commissioning
39 work that was undertaken in Northern Sydney.
40
41 Our colleagues in the Commonwealth understand the
42 technical barriers around this and we work closely with
43 them, but it did take a considerable period of time and now
44 the Commonwealth, based on the evidence, have agreed to in
45 part fund those particular innovations. But I guess it
46 just reinforces the point that the pace at which the
47 innovation and evolution of care is happening in the

1 system, the technical part of the system and the funding
2 part of the system can't keep up or move at the same pace.
3
4 MR MUSTON: I should probably ask this now: do you
5 perceive that that delay between the technical innovation
6 and funding catching up with it is actually preventing
7 innovation from occurring?
8
9 MS WILLCOX: I think our clinicians on the ground just
10 naturally continue to innovate, so I think it would have no
11 impact on their desire to constantly look and see what they
12 can do to improve care.
13
14 I think we progress regardless, is what I would say.
15 We've done many, I think, really clever and insightful
16 innovations in care, just even in the last couple of years
17 and certainly through COVID, it really stands out. So
18 I don't think it hampers us. It's more an issue probably
19 for people like myself and Mr D'Amato to make sure that we
20 can work with our Commonwealth colleagues and see if we can
21 secure the appropriate funding. But I don't think it stops
22 us all collectively believing that we need to keep evolving
23 and progressing and innovating.
24
25 MR MUSTON: Mr D'Amato.
26
27 MR D'AMATO: I think that is absolutely right. What it
28 does, though, is it at times prevents us from scaling
29 innovative solutions statewide, because we have to go
30 through this iterative process to determine whether we have
31 an opportunity to then access additional funding, and it
32 might take two years, and then to determine whether we can,
33 if you want, expand across the state.
34
35 THE COMMISSIONER: Does that mean there is some innovation
36 that seems to work really well - let's call it RPA virtual,
37 it doesn't matter what it is - but because of the long
38 period of time of dealing with the Commonwealth to secure
39 funding for it, there's a delay in expanding something that
40 you might already think, "This is going to work and it
41 should be scaled out"; it's the delay? As you said, it's
42 not the delay in the clinicians working towards innovation;
43 it's the delay in expanding it until you can make sure it
44 can be paid for.
45
46 MS WILLCOX: That's correct, yes.
47


*Transcript produced by Epiq*

1 MR MUSTON: That's probably a useful point for us to move
2 into the funding arrangements. You've told us in a very
3 high level at paragraphs 4 and 5 of your report that health
4 operates in a complex funding environment - that's probably
5 an understatement - and that the New South Wales public
6 health care is funded primarily by the New South Wales and
7 Australian governments with additional funding received
8 from direct source revenue such as private health insurance
9 payments and individual payments.
10
11 Can I just ask you at a very general level at this
12 stage to explain what those key funding sources are?
13 I understand what you tell us there, that there's the
14 Commonwealth Government, there's state government and then
15 there are the other sources like private health insurance,
16 but what are the actual mechanisms by which that funding is
17 provided? Start with the Commonwealth.
18
19 MR D'AMATO: Sure. So the appropriation, being the state
20 funding component of our budget which reflects around
21 60 per cent, includes normally - and this is what is
22 documented in the budget papers - the capital component,
23 the spend, and the recurrent component.
24
25 MR MUSTON: Just pausing there, the Commonwealth
26 contributes to both the capital and the recurrent component
27 of the funding?
28
29 MR D'AMATO: The Commonwealth, through the NHRA,
30 contributes only towards recurrent, only towards operating
31 expenses.
32
33 MR MUSTON: Let's start with the Commonwealth contribution
34 to the funding. We've heard about the ABF funding. How is
35 the Commonwealth contributing to the funding of health care
36 in New South Wales?
37
38 MR D'AMATO: So the main vehicle is through the NHRA, the
39 National Health Reform Agreement. Through that vehicle
40 there are two main drivers. There's either ABF or it's
41 through a block funded arrangement.
42
43 The block funded arrangement can further split into
44 two components, such as small hospitals, or it can be a
45 different block funding arrangement such as teaching,
46 training and research; it could be specialist services like
47 mental health, forensic mental health. These are

1 determined based on historical costs.
2
3 The bulk of the payment, being from the Commonwealth
4 under the NHRA, is around 8.2 billion for this financial
5 year. Of that, 7 billion is related to activity based
6 funding activity. In setting this 7 billion, the
7 Commonwealth takes into account three aspects: one is the
8 base, and this is all documented in the National Health
9 Reform Agreement; then to the base adds what is then
10 reflected to be the price changes, and this is determined
11 from the national efficient price, which we all
12 contribute - we, as in all states and territories,
13 contribute - data on an annual basis; and then the final
14 part is the volume.
15
16 The volume reflects what we, as each individual state
17 and territory, provide to the administrator of the health
18 funding body on a yearly basis, normally around March, as
19 a high-level estimate, and then we update end of May what
20 is going to be the activity throughput that we are
21 targeting to deliver in the following financial year.
22 These are --
23
24 MR MUSTON: The activity that you are reporting on is
25 treatment delivered in hospitals and out of hospitals to
26 the extent that it is captured by the existing codes that
27 have been identified as things that the Commonwealth will
28 contribute towards the funding?
29
30 MR D'AMATO: That's right. It will be activity deemed to
31 be in-scope, and as we mentioned before, the Independent
32 Health and Aged Care Pricing Authority will determine the
33 scope of services.
34
35 MR MUSTON: So in relation to that, am I right in assuming
36 that the ABF side of the funding is primarily driven by and
37 directed towards the funding of hospitals and expansion of
38 scope in and around hospitals to provide what is
39 essentially acute care?
40
41 MR D'AMATO: Yes, acute care, definitely. I think that
42 it's fair to note that the second area of funding is
43 directed towards what we call "non-admitted patient care",
44 so there could be activity delivered from hospital
45 settings, providing it is of a clinical intent, or it could
46 be provided from other settings, so it could be from
47 a community health centre, if it is a nurse --

1
2 MR MUSTON: What sort of care would that be? What's an
3 example of that?
4
5 MR D'AMATO: It could be nurse-led clinics, it could be
6 allied health clinics. It could be hospital avoiders. It
7 could be hospital in the home, perhaps, if it is under
8 a certain model, where the nurses or teams are sitting
9 perhaps outside the hospital as a footprint, and delivering
10 care to patients in their home.
11
12 MR MUSTON: To the extent that you have previously been
13 able to negotiate with the Commonwealth Government about it
14 contributing towards the payment of those services through
15 the identification of a code that captures them?
16
17 MR D'AMATO: Yes. I think that the other components to
18 reflect on is that the activity based funding is based on
19 a classification. We call it streams. Whether it's acute
20 settings, whether it's sub-acute, mental health or
21 non-admitted, they each have a particular classification,
22 so that then the services can be described in an homogenous
23 way and therefore then funded according to a price, that is
24 set by the independent authority.
25
26 MR MUSTON: So in relation to preventative health that
27 we've talked about, to what extent, or in what way, is the
28 Commonwealth contributing to the funding of preventative
29 health in the state?
30
31 MR D'AMATO: In terms of prevention, the way it has been
32 described, particularly in regards to elements around
33 health promotion, there is not a direct funding link to the
34 activity based funding. Through the National Health Reform
35 Agreement we do receive around 160 million a year for what
36 is described in the budget papers, the Commonwealth budget
37 papers, as "public health", and some of these funds will go
38 towards supporting some of these interventions.
39
40 MR MUSTON: Is that delivered as block funding?
41
42 MR D'AMATO: That's correct.
43
44 MR MUSTON: Is that block funding tied to the preventative
45 health measures?
46
47 MR D'AMATO: It does contribute towards the health

1 promotion and public health, yes, but there has been an
2 historical arrangement that there is - if you want, despite
3 the fact it is capturing in the payment that flows to us
4 through the National Health Reform Agreement, there is no
5 formula or no opportunities for us to renegotiate that
6 amount.
7
8 MR MUSTON: But I guess my question is: having received
9 that amount, are you bound by the agreement to spend it on
10 preventative health or is it just contributed to the
11 overall budget?
12
13 MR D'AMATO: It's contributed towards the overall budget.
14 But we spend more than what we receive from the
15 Commonwealth on preventative health. Around 4 per cent of
16 our budget is spent on public health, health promotion,
17 screening, so on.
18
19 MR MUSTON: So that 4 per cent is contributed to by the
20 $100 million you have told us about that the Commonwealth
21 gives you as a block for public health?
22
23 MR D'AMATO: That's right, yes.
24
25 MR MUSTON: In terms of preventative health, I think,
26 Ms Willcox, you referred to vaccination or immunisation
27 programs.
28
29 MS WILLCOX: Yes.
30
31 MR MUSTON: Is that captured by that block or is that
32 contributed to by the Commonwealth in any way?
33
34 MS WILLCOX: There is program funding, but, Mr D'Amato,
35 it is probably one for you.
36
37 MR D'AMATO: Yes, that's probably a bit of a complex area
38 because there is a national partnership agreement in
39 regards to immunisation and vaccination, so depending on
40 which program we're talking about, there will be some
41 elements that the Commonwealth might be involved directly
42 with us, so essential vaccine is one of these programs that
43 come to my mind. These arrangements are renegotiated on
44 a regular basis, but again, it depends on which
45 intervention we're talking about. Normally, it would be
46 most likely outside the National Health Reform Agreement.
47

1 MR MUSTON: So entirely separate to the National Health
2 Reform Agreement there may be separate agreements,
3 depending on the particular vaccine we're talking about?
4
5 MR D'AMATO: That's correct.
6
7 MR MUSTON: I guess two examples that we're all familiar
8 with are the COVID vaccine and the flu vaccine.
9
10 MR D'AMATO: Yes.
11
12 MR MUSTON: Are they captured by an arrangement with the
13 Commonwealth outside of the National Health Reform
14 Agreement?
15
16 MR D'AMATO: Yes, the COVID vaccine most definitely.
17
18 MR MUSTON: Is that something which is being paid for
19 entirely by the Commonwealth or contributed to by the
20 Commonwealth?
21
22 MR D'AMATO: Probably that one has been paid on an
23 arrangement established by the Commonwealth. To determine
24 whether we recover the full cost it's a bit difficult,
25 because obviously we went through this high demand for
26 vaccine. At that point we received 50 per cent of the cost
27 that we incurred in delivering those vaccines, but now that
28 it is becoming a bit more normal, we're yet to determine
29 whether we get the full cost recovery, but I can mention
30 that the impost on our budget is not as extreme as it was
31 during the COVID.
32
33 MR MUSTON: One other little question about preventative
34 health care screening programs, I assume they're part of
35 preventative health care?
36
37 MS WILLCOX: That's correct, yes.
38
39 MR MUSTON: Are there arrangements with the Commonwealth
40 dealing with screening programs?
41
42 MS WILLCOX: Yes. Do you want to --
43
44 MR D'AMATO: Yes, this is another one similar to the
45 essential vaccine. It really varies. It could be cervical
46 screening that we do regularly, it could be bowel screening
47 that - we have an NPA for specific increase in those

1 screening programs, so it varies.
2
3 MR MUSTON: Let me take it away from those programs for
4 a minute and get back to these more general preventative
5 health measures, the lifestyle change and trying to shift
6 what I think were described yesterday as the social
7 determinants of health. Is the Commonwealth's contribution
8 towards that aspect of the state's efforts confined to this
9 $100 million public health payment or are there other ways
10 in which the Commonwealth contributes to that?
11
12 MS WILLCOX: My understanding is the state block funding
13 that is provided to the local health districts for health
14 promotion would be the funding utilised to employ staff, to
15 create clinics and programs and classes in community health
16 centres across the state, to enable people to participate
17 in activities that would go to the preventative health and
18 wellbeing. As I mentioned, weight management, smoking,
19 exercise, falls prevention and the like are principally
20 conducted by our health promotion staff who work in the
21 local health districts.
22
23 MR MUSTON: To the extent that the Commonwealth might be
24 contributing to other aspects of social determinants that
25 are important - for example, housing and education I think
26 were referred to - does health have visibility of that? Is
27 there any coordinated approach taken?
28
29 MS WILLCOX: There are a number of cross-agency forums,
30 for instance, in mental health, where we have other
31 agencies as a part of those discussions, so housing is an
32 example; our colleagues in community and justice; regional,
33 where we would discuss activities that are occurring across
34 government that may impact on the mental health of our
35 consumers and what things other agencies can contribute,
36 because whilst the health system provides care for people
37 with chronic and enduring mental health, there are many
38 other features, as you've outlined, that impact on
39 a person's wellbeing. So that's one example of
40 a cross-agency jurisdictional group that would look to see
41 what those other contributors are.
42
43 MR MUSTON: So the other source of funding I think that
44 you referred to as the private health insurance - how does
45 that find its way into the public health system?
46
47 MR D'AMATO: That goes straight to the bank accounts of

1 the LHDs and contributes towards supporting the expense
2 incurred to treat those patients.
3
4 MR MUSTON: Patients we're talking about are patients who
5 are privately insured, they present at hospital and --
6
7 MR D'AMATO: Elect to be treated as private
8
9 MR MUSTON: -- elect to be treated as a private patient?
10
11 MR D'AMATO: That's correct.
12
13 MR MUSTON: At that point, the funding of the treatment to
14 that patient is delivered how?
15
16 MR D'AMATO: So the funding - I think it's fair to
17 establish that there is a cost, and that is the cost. Then
18 the funding source varies. So for a particular private
19 patient - say in this particular case - instead of
20 receiving funding, with the funding source being the state
21 or the Commonwealth, there will be three components.
22 There'd be a component which is the private health
23 insurance, that it is the accommodation component that we
24 will be billing the private health insurance. Then there
25 will be a lesser contribution from the Commonwealth as well
26 as a lesser contribution from the state.
27
28 MR MUSTON: What's the form of the Commonwealth
29 contribution there? Is that ABF funding?
30
31 MR D'AMATO: That's correct. So, again, establishing the
32 cost ultimately remains the same. When it comes to, say,
33 dividing the bill, it's spread in three ways: there is
34 a Commonwealth contribution that is attributed through the
35 ABF component, and for the Commonwealth, in this case
36 through the national weighted activity units, there is
37 a discount applied relative to each individual DRG that
38 estimates what would have been otherwise the contribution
39 from a third party, so that there is no duplication of
40 funding.
41
42 MR MUSTON: Again to try and capture what I think you have
43 said, a patient who comes in as a private patient is given
44 the same treatment as they would obviously if they were
45 a public patient. As to meeting the cost of that care, the
46 private health insurer will contribute money to the LHD?
47

1 MR D'AMATO: Yes.
2
3 MR MUSTON: The Commonwealth will contribute money
4 referable to the activity that was delivered to that
5 patient but at a discounted rate?
6
7 MR D'AMATO: That's correct.
8
9 MR MUSTON: On the assumption that a contribution has been
10 received from the private health insurer, and whatever is
11 left is picked up by the state?
12
13 MR D'AMATO: That's correct.
14
15 MR MUSTON: So you've said that that funding goes direct
16 to the LHDs. In terms of the Commonwealth funding that
17 we've been talking about, the ABF funding and the block
18 funded payments from the Commonwealth, do they go directly
19 to the ministry or do they go to the state and then form
20 part of the consolidated revenue from which the health
21 budget is drawn?
22
23 MR D'AMATO: So the chart under item 24 illustrates at the
24 national level - the national level, the funding flow in
25 respect of the NHRA.
26
27 MR MUSTON: Just one moment. Perhaps if we could go to
28 paragraph 24 so we can all see the chart. We'll just make
29 sure we have the same thing. That's the chart you're
30 talking about?
31
32 MR D'AMATO: Yes, that's right.
33
34 MR MUSTON: This explains to us the way in which the
35 funding flows. Could you talk us through that?
36
37 MR D'AMATO: Yes. So on the left-hand side you see there
38 are five boxes, and these are the main funding sources.
39 The top box, being the Commonwealth activity based funding,
40 illustrates the dotted line to what is called the National
41 Health Funding Pool. That means the Commonwealth will pay
42 into that pool based on our advice, our targets. So if we
43 say to the Commonwealth, "Next year we're going to deliver
44 2 million NWAUs", then the administrator determines, based
45 on the national efficient price, the Commonwealth
46 contribution, an amount of cash to be paid to the National
47 Health Funding Pool.

1
2 Then we will contribute a balance, a share - in this
3 case, at the moment, from memory, the Commonwealth
4 contribution rate is around 39.7 per cent, so we will
5 contribute the balance of the funding that we set aside for
6 activity based funding for our hospitals. It goes into the
7 National Health Funding Pool.
8
9 Then there is the public health component, the
10 Commonwealth again, which goes straight into the National
11 Health Funding Pool. Then there is a component of the
12 Commonwealth block funding in that case, it could be small
13 hospitals, it could be teaching, training and research, it
14 could be CAR T therapies - which will go straight into the
15 pool. Then there is a component, which is the last
16 component, is what we deem that we want to pay directly to
17 our LHDs.
18
19 On the right-hand side we see then the cash outflow,
20 and from the National Health Funding Pool, based on our
21 targets and our instructions agreed with the Commonwealth
22 and actually documented in the service agreements that are
23 published online by each individual district and network,
24 the payment goes straight into the local hospital. In this
25 case they refer to "local hospital networks", because
26 that's the language adopted at the national level in the
27 National Health Reform Agreement. But for us, it would be
28 the local health districts, which will receive payments for
29 the ABF component to their bank account.
30
31 MR MUSTON: Just to make sure I've understood it, there
32 essentially seem to be three different levels of funding
33 discussions that are happening. There is a discussion
34 between the state and the Commonwealth about the
35 Commonwealth's contribution?
36
37 MR D'AMATO: Yes.
38
39 MR MUSTON: There is a discussion between the health
40 ministry and the state --
41
42 MR D'AMATO: Yes.
43
44 MR MUSTON: -- or treasury, about the overall health
45 budget; and then there is a discussion between the LHDs and
46 other entities within health and the ministry about their
47 respective budgets?

1
2 MR D'AMATO: Perhaps I suggest another way of looking at
3 that is there is a conversation between the ministry and
4 treasury in regards to the expense budget, and that is also
5 informed from several conversations in regards to funding
6 sources. So when we determine the budget for the following
7 year, we will take into account the growth level that we
8 expect to receive from the Commonwealth; we will take into
9 account the changes in prices from the patient fees and
10 also the rate of utilisation and conversion of privately
11 insured patients; and we'll take into account the balance
12 being what the state will have to contribute towards what
13 we expect to fund the following year.
14
15 MR MUSTON: You've told us a little bit about the state
16 budgeting process. It is an annual cycle, the budgeting
17 process for health?
18
19 MR D'AMATO: Yes.
20
21 MR MUSTON: So these are discussions that happen between
22 the ministry and treasury in order to identify the funding
23 envelope for health?
24
25 MR D'AMATO: Yes.
26
27 MR MUSTON: What is the timeline? In a practical sense,
28 what happens? The budget is delivered, has just been
29 delivered. Between now and when the next budget is
30 delivered, what happens?
31
32 MR D'AMATO: It's probably best if I describe under the
33 normal environment where a budget tends to be delivered
34 in June, the process will start around December, January,
35 February, depending on the urgency, if you want, and the
36 way that treasury is organised. This particular financial
37 year, being contemplated, 2024/25, and the process started
38 just a week or 10 days ago.
39
40 The process starts from the point that the treasurer
41 writes to the minister inviting the minister to put
42 forward, if you want, what are called new policy proposals
43 that are relevant to the following financial year.
44
45 Under this current environment, the minister will
46 liaise with the ministry. The ministry has an internal
47 process, we determine our priorities, we cost our

1 priorities, we take into account the activity growth, cost
2 escalation, we take into account the population changes and
3 the like to determine what is, if you want, required for
4 the following year.
5
6 Now, in previous years, we had an arrangement whereby
7 treasury had earmarked an envelope so we knew what was, if
8 you want, available, and that was before COVID. Through
9 that process, we're always able to understand locally how
10 to prioritise, and we always have to prioritise in terms of
11 volume growth, cost escalation, and cost escalation
12 including wages and the like.
13
14 MR MUSTON: Pausing there, and maybe I have misunderstood
15 one of the steps, but could I ask you to look at
16 paragraph 29. Do you see there is a reference to health
17 entities being made aware of their annualised amount - the
18 base?
19
20 MR D'AMATO: Yes.
21
22 MR MUSTON: At what point in the process is that base
23 identified relative to when new policy proposals are put
24 forward? Is it before?
25
26 MR D'AMATO: Treasury captures all this information into
27 their accounting system, their financial management
28 information system, which is called Prime. So we have
29 a sense of what is available in the forward, but that's
30 managed by treasury. What I'm referring to in this
31 particular paragraph is what we make available,
32 information-wise, to the districts.
33
34 So this process is an annual process where not only we
35 make available this information into the entities, so every
36 district has available the access to this information, we
37 also invite districts to review and update this
38 information. What we mean by that is that if there are
39 changes that need to be made between, say, what we call
40 line items, say a goods and services item, you know, that
41 is expected to cost less in the future years than others,
42 then districts can move between these two items, provided
43 they stay within the same envelope.
44
45 This communication normally goes out from my office to
46 the chief executives and the director of finance of each
47 health entity and provides them with a timeline in respect

1 to when they have to provide the information back to us.
2
3 MR MUSTON: Just pausing there, that information that they
4 are providing back to you is informing what you are going
5 to treasury with?
6
7 MR D'AMATO: That's right. That information is informing
8 the service agreements process between the ministry and the
9 health entities. That is because we're not asking the
10 district to tell us what their cost pressures are; that is
11 a process that is outside what we call the forward
12 estimates. So this process is documented and it runs in
13 parallel to the purchasing negotiations.
14
15 MR MUSTON: When you say "purchasing negotiations", we're
16 talking about purchasing activity?
17
18 MR D'AMATO: Correct.
19
20 MR MUSTON: From the LHD?
21
22 MR D'AMATO: That's correct. That would inform the
23 negotiation with treasury and vice versa.
24
25 MR MUSTON: In your discussions with treasury, they
26 identify for you, do they, a base figure, which is
27 essentially what you received in the last budget; is that
28 the usual starting point?
29
30 MR D'AMATO: The normal starting point in regards to
31 determining growth - so the new money - is on what they
32 call the underlying budget. So the underlying budget will
33 capture all things that have been approved in the past that
34 are ongoing in nature. So if there is an award change,
35 say, an increase - like this year there was an increase to
36 our employee-related costs above what we normally would
37 have expected - that is then factored in and annualised
38 and, therefore, becomes the new opening balance, if you
39 like, for the future year, where they apply. Before COVID
40 we used this methodology where there was an agreed amount,
41 so we had some certainty.
42
43 MR MUSTON: Maybe it's useful to go to the chart at
44 paragraph 37 at this point. I think this is what you're
45 describing for us. So what you start with is the baseline,
46 which is essentially what it would have cost you as at
47 today to deliver the services you were approved to deliver

1 last year?
2
3 MR D'AMATO: This reflects the negotiations in regards to
4 activity targets. So it does really focus on then what
5 we'll inform the Commonwealth with and what we'll also use
6 to determine what is the amount of growth that we need from
7 the envelope, if you want.
8
9 MR MUSTON: When you say it focuses on activity, when we
10 use the term "activity", are we essentially referring to
11 the ABF calculation?
12
13 MR D'AMATO: That's correct, yes. So this starts with the
14 previous financial year targets, being the activity targets
15 that were documented in the previous service agreement.
16 Then there are adjustments in regards to growth relative to
17 equity, ageing of population, which varies across different
18 individual districts; then there is this process whereby
19 they make some adjustments in regards to the purchasing
20 adjustors where, for instance, there could be an increase
21 for certain aspects that we want to encourage, whether it
22 is data quality - in the past we had additional funding for
23 data quality - which is not related to an increase in
24 activity, as in NWAUs, it is just an amount that we pay as
25 part of this process of negotiating.
26
27 Then there are also penalties applied if there are
28 increases in activities that strategically we want to
29 discourage - so unplanned re-presentations and the like,
30 unplanned re-admissions.
31
32 Then the last factor is the new builds, for instance,
33 which is related to the commissioning of new hospitals or
34 statewide services, so that's what we call supra LHD
35 services, as well as statewide services - it could be other
36 specialised services, which relates to services that are
37 not necessarily accommodated through the normal ABF
38 process, so we would then pay an additional amount.
39
40 MR MUSTON: So you will pay an additional amount or you
41 would ask treasury to pay you an additional amount?
42
43 MR D'AMATO: All this information is then factored in in
44 what's available from treasury. So if in the past it was
45 around 5 per cent, say, 1 billion, 1.1 billion, from that
46 envelope we would have taken out what is relevant to or
47 related to cost escalation, and normally it would have

1 been, you know, 2.5 per cent for wages. In previous years,
2 before COVID, there was also an amount that would apply to
3 inflation, 2.5 per cent. We're always taking into account
4 certain items of contracts that have specific indexations,
5 and then the balance will be available for purchasing
6 activity through this process, and then providing
7 additional funding for highly specialised services. And
8 when we didn't have - I don't want to use this word, but
9 there is a bit of a bottleneck of opening new hospitals, we
10 were able, through that envelope, to afford those who
11 planned to commission new hospitals.
12
13 MR MUSTON: This is the discussion you're having with the
14 LHDs and the specialty health networks?
15
16 MR D'AMATO: Yes.
17
18 MR MUSTON: Can I ask this question about it. Other than
19 the purchasing adjustors that are seeking to disincentivise
20 bad outcomes, is there any consideration as part of that
21 process for the overall outcomes achieved by the delivery
22 of the activity, from a patient perspective?
23
24 MR D'AMATO: In terms of the outcomes, I guess,
25 probably there would be a time frame which is longer than
26 12 months, and given this process really focuses on
27 activity and the deliverables for the next 12 months, it's
28 a bit difficult. I think there are certainly outcomes and
29 features on top of this process where we invest in
30 preventative care. In 2022/23, for instance, we invested
31 around $12 million for e-cigarettes, or prevention towards
32 e-cigarettes. I know that they seem small amounts but
33 they're still amounts that contribute towards the
34 prevention, and they sit on top of this.
35
36 So a normal service agreement would be informed by
37 cost escalation, the activities that have been negotiated,
38 and then other new initiatives, and the new initiatives
39 would be related to Brighter Beginnings as well, The First
40 2000 Days.
41
42 MS WILLCOX: If I could add that the narrative within the
43 service level agreement also identifies areas for emphasis,
44 for instance, value based health care. There are, as you
45 are aware, a number of key performance indicators
46 throughout the service agreement, and whilst some of those
47 are process measures, some of them are deliberately

1 included to start to shift the outcomes of patients. So if
2 we think about in mental health, in renal supportive care,
3 there are a number, as we add these KPIs to shift the dial
4 so to speak, in terms of the level of emphasis and
5 priority. That's just one mechanism.
6
7 MR MUSTON: The KPIs obviously seek to drive performance,
8 but is the achievement of those KPIs something which is
9 factored in to your assessment of funding of the LHDs?
10
11 MS WILLCOX: Most are not directly on funding. There are
12 some - perhaps I should let Mr D'Amato talk to those - but
13 the process with the LHDs in terms of an iterative process
14 around their performance against these KPIs is something
15 that occurs routinely throughout the year. So it's not
16 sort of get to the end of the financial year and see there
17 are major variants; we have these discussions ongoing.
18
19 MR MUSTON: Perhaps my question, a question for you,
20 Mr D'Amato, is the KPIs are included in the service
21 agreements with a view to, at least in some areas, driving
22 health outcomes. Is the potential cost associated with
23 achieving those health outcomes something that is factored
24 in to decisions about how much funding the LHDs should
25 receive through this process that you have outlined for us?
26
27 MR D'AMATO: Look, I think that - probably, if I may, I'll
28 just step back. Ultimately, this process is related to
29 allocating the new money. So it's fair to say that in
30 certain settings, we pay more, additional - we provide
31 additional funding for delivering care in rural settings,
32 for instance, and that is part of the base and we don't
33 penalise them because they are inefficient in terms of, you
34 know, the state efficient price.
35
36 In fact, I think it is important that we note that we
37 support the ABF model, the technical efficiencies, which
38 accounts for around 67 per cent of the district's budget,
39 by providing not only the block funded component to small
40 hospitals but, we also provide the additional adjustments,
41 if you want. I know this is probably not directly related
42 to the outcomes, but it certainly supports maintaining, if
43 you want, the service provision in certain areas that
44 otherwise we wouldn't be able to deliver.
45
46 MR MUSTON: We'll come back to them, but I think my
47 immediate question is, as best as I can understand the

1 process, the funding of LHDs is driven predominantly by an
2 assessment of the activity that they are generating?
3
4 MR D'AMATO: Yes.
5
6 MR MUSTON: And in doing so, you're looking to ensure
7 technical efficiency by the LHD in the delivery of that
8 activity?
9
10 MR D'AMATO: Yes, that's correct, predominantly.
11
12 MR MUSTON: And the LHDs themselves no doubt are striving
13 to achieve the greatest possible technical efficiency in
14 the delivery of their services?
15
16 MR D'AMATO: Yes.
17
18 MR MUSTON: Because I assume the LHDs don't have an
19 enormous surplus in their budgets to work with?
20
21 MR D'AMATO: Well, it is challenging. It is challenging
22 now, coming off COVID. I have to admit that obviously
23 during COVID all our cost base has been disrupted and the
24 reality is that we are still, you know, navigating this
25 transition period, if you want, but yes.
26
27 MR MUSTON: So a challenge for the LHD is delivering the
28 activity that it needs to deliver through its hospitals in
29 a way that can be contained within the funding envelope
30 that they have had made available to them?
31
32 MR MUSTON: Yes.
33
34 MR D'AMATO: Yes, I acknowledge that.
35
36 MR MUSTON: That does, I suggest, direct a focus on trying
37 to deliver that activity as cost-effectively as possible.
38 You are nodding, I take that as a yes?
39
40 MR D'AMATO: I think it is challenging, yes.
41 I acknowledge that, and it perhaps goes back to some of the
42 comments or some of the elements we discussed before: the
43 delay in updating the national efficient price; the delay
44 in reflecting the true costs of delivering care now and
45 therefore, you know, this environment which is relatively
46 tight and also, as I mentioned, in our transition out of
47 COVID.

1
2 But in regards to the technical efficiencies, yes, ABF
3 drives technical efficiencies, but I think we need to
4 acknowledge that, where we can, we do try to adjust or
5 mitigate some of the risks or the unintended consequences
6 of a pure ABF model.
7
8 For instance, in the growth component, which is the
9 first step, we do really take into account ageing and
10 population changes, rather than pure activity, because
11 otherwise it will create an incentive for anyone to do
12 activity for the sake of doing activity, and coming back to
13 us and saying, "Give me more money because I have done more
14 activity." That's not exactly what we encourage. What we
15 encourage is to be demonstrating growth pegged to changes
16 in population and ageing, and in particular equity. That's
17 probably the area where we try, and we continue to try, to
18 mitigate some of the risks associated with the limitations
19 of ABF.
20
21 MR MUSTON: I will come back to the equity, ageing and
22 population column in the diagram, but at the moment, the
23 LHDs are not being incentivised for reducing activity, are
24 they?
25
26 MR D'AMATO: I think the incentive is - for instance, in
27 the purchasing adjustors when we say "unplanned
28 re-admission", there certainly is an incentive not to do
29 unplanned re-admission, so we're looking at driving the
30 behaviour that has the best outcome for the patients
31 because in that case, they will be penalised.
32
33 MR MUSTON: But the unplanned re-admissions, I assume, and
34 correct me if I'm wrong, that's dealing with, in effect,
35 poorly delivered care which results in a re-admission of
36 a patient, that if that care had been delivered well, would
37 have been avoided; is that a correct understanding?
38
39 MS WILLCOX: It may be but sometimes there are unintended
40 things that occur. It may not be due to bad care. It
41 could be due to some unforeseen circumstance that someone
42 needs to come back into hospital. There could be social
43 reasons why they're not going to manage at home and need to
44 come back. So I wouldn't necessarily characterise it
45 always as "bad care", but there may be other factors at
46 play.
47

1 MR MUSTON: Perhaps a fairer way to put it, the purchasing
2 adjustors aren't rewarding LHDs for delivering preventative
3 and community-based care which prevents people from
4 actually having to come to hospital in the first place, to
5 the extent it's not picked up by the ABF model?
6
7 MR D'AMATO: Look, I think it's fair to say, the
8 purchasing adjustors, as other components through this
9 process, are addressing some of the limitations of ABF but
10 not all of it. I think that is probably --
11
12 MR MUSTON: Can I come back, then, just walking through
13 the timeline of the ministry's negotiation with treasury.
14 You start with an identification of your baseline, much as
15 the ministry does with the LHDs?
16
17 MR D'AMATO: That's correct.
18
19 MR MUSTON: Treasury will identify for you a baseline?
20
21 MR D'AMATO: Yes.
22
23 MR MUSTON: Which is driven largely by activity that has
24 been --
25
26 MR D'AMATO: No, it is largely driven by historical
27 appropriations. So there is a composite of any NPPs that
28 were approved in the past that might be ongoing in nature,
29 could it be related to preventative health, will be in the
30 base, as well as obviously activity, and admittedly the
31 activity and the acute form the biggest part of our budget.
32
33 MR MUSTON: The baseline is effectively - and maybe I'm
34 putting it over-simply - what it cost you to deliver the
35 services that you have been delivering historically,
36 adjusted to take into account any new policies which have
37 been added to that - again, historically --
38
39 MR D'AMATO: Yes.
40
41 MR MUSTON: -- and further adjusted to take into account
42 the cost of delivering those services today. So if there
43 was, for example, an award change consistent with what you
44 told us earlier, and that resulted in an increase in the
45 cost of your staffing to deliver, that would be built in to
46 your base?
47

1 MR D'AMATO: Yes, that's right.
2
3 MR MUSTON: So what then gets added to that base is
4 growth?
5
6 MR D'AMATO: Yes, that's correct.
7
8 MR MUSTON: And in terms of identifying the growth, the
9 first question, what does it comprise, the growth? What
10 are the things that are taken into account to build the
11 growth?
12
13 MR D'AMATO: Historically, the approach was based on
14 a consistent, if you want, level of growth, which is around
15 the 5 per cent. There is a chart under item 69 that
16 illustrates the concept up to COVID. The only reason
17 I want to stress "up to COVID" is after COVID, I think it
18 is something that we need to work with treasury, and that's
19 what we're doing at the moment, in determining what is the
20 appropriate growth in the forward years.
21
22 MR MUSTON: I am going to come back to the chart at 69,
23 but just at a very high level so I understand the concept,
24 growth, the growth figure is calculated by who in the first
25 instance?
26
27 MR D'AMATO: Treasury. That's an agreement that was
28 struck before my time where there was an approach whereby
29 they wanted to create certainty for both parties at the end
30 of the day. Also treasury knowing how much they have to
31 set aside for health, given that we have the largest
32 recurrent budget, is probably providing them some sort of
33 certainty.
34
35 MR MUSTON: So treasury is internally doing their own
36 modelling to work out what they anticipate growth on
37 existing service and policy delivery will look like?
38
39 MR D'AMATO: Yes.
40
41 MR MUSTON: After that, and we'll come to it in a moment,
42 there's a discussion about new policy proposals?
43
44 MR D'AMATO: Mmm.
45
46 MR MUSTON: But is there any negotiation between ministry
47 and treasury about that growth component, after treasury's

1 provided you with its assessment of growth?
2
3 MR D'AMATO: I think the negotiation comes around the
4 margins in determining whether a new NPP should be then
5 funded from the envelope, the growth component, or should
6 be funded on top of it, and normally it is around the
7 materiality of the new NPP that we need to consider.
8
9 MR MUSTON: Taking a step back, before we get to the NPP,
10 we've got, at the moment, just our baseline.
11
12 MR D'AMATO: Yes.
13
14 MR MUSTON: To that has been added a figure for growth,
15 which has been identified, as I understand your evidence,
16 by treasury in the first instance?
17
18 MR D'AMATO: Yes.
19
20 MR MUSTON: Is there any negotiation between the ministry
21 and treasury about the accuracy or appropriateness of that
22 growth figure that treasury has identified?
23
24 MR D'AMATO: We did have a few reviews of the growth level
25 before COVID, and particularly around the COVID - at the
26 end of COVID, and these are cabinet documents, but, you
27 know, we do tend to study in details what are the cost
28 drivers, and that's where we pick up the population, the
29 age and workforce challenges, we pick up the new builds, we
30 pick up the new technology, and I'd say again, to go back
31 to the original document, this was kind of used to test
32 whether the growth rate before COVID was appropriate.
33
34 The reality is the other aspect that this is normally
35 tested against is the intergenerational report from
36 New South Wales treasury, where they normally tend to
37 project, over the next 40 years, the growth in different
38 portfolios. Health normally is the one that typically -
39 according to the latest review of the intergenerational
40 report is one of the portfolios expected to grow the most
41 over the next - in the long term. The growth rate, from
42 memory, is around 6.3 per cent.
43
44 So working in this kind of environment where we have
45 the 5 per cent, 5.2, or 4.9, we always assume a degree of
46 efficiency is there to be achieved as part of the envelope.
47 That's how we use the intergenerational report, the growth

1 level. My only concern is that, going forward, we don't
2 know where the growth level is, and I think that's where we
3 work concurrently with treasury to determine the forwards.
4
5 MR MUSTON: Do you make your own internal assessments of
6 what growth will look like?
7
8 MR D'AMATO: Yes, absolutely.
9
10 MR MUSTON: Do you get any indication from treasury going
11 forward as to what their figure or its figure for growth
12 will be?
13
14 MR D'AMATO: Yes, we always work very closely with
15 treasury. We partner with them. They have an input in our
16 analysis as well as we have an input in their analysis.
17
18 MR MUSTON: So treasury has given you some forecasting of
19 what it anticipates is going to look like going forward
20 over the next five years?
21
22 MR D'AMATO: That's correct.
23
24 MR MUSTON: And further?
25
26 MR D'AMATO: Yes, we have a system that gives us the
27 outlook for the next 10 years, but we normally focus on the
28 forwards, being the budget year and the next three years,
29 so for the next four years. Then what we normally do with
30 our treasury colleagues, we review the forwards and
31 document some of the risks as well, and obviously the new
32 build, the pipeline, is one that we document in that
33 process. We meet with treasury every fortnight, so that's
34 how we escalate any risks.
35
36 MR MUSTON: So your own estimate of growth presumably
37 includes some assessment of what it will cost to deliver
38 health in new hospitals?
39
40 MR D'AMATO: Yes, that's correct.
41
42 MR MUSTON: In upgraded hospitals?
43
44 MR D'AMATO: That's correct.
45
46 MR MUSTON: You have given some evidence about the
47 800 beds in the pipeline.

1
2 MR D'AMATO: Yes.
3
4 MR MUSTON: Presumably your assessment, or forecasting of
5 growth, includes an assessment of what it might cost to
6 deliver care through those 800 beds?
7
8 MR D'AMATO: Absolutely.
9
10 MR MUSTON: What about the increased costs associated with
11 these novel and new treatments that we've been talking
12 about? Is that something that's factored in to projections
13 about growth?
14
15 MR D'AMATO: Yes. We do that, and - to the degree that
16 these have been approved and are available and there are
17 agreements in place where we know the accurate cost, if you
18 want, of this treatment, or that there is also a funding
19 source from the Commonwealth, for instance. So that's
20 where we normally approach treasury in regards to the
21 CAR T treatment, that is also included in the national
22 efficient cost and receive 50 per cent from the
23 Commonwealth. That's what we normally do.
24
25 I think that in regards to the new technology, there
26 is a long spectrum between the time someone identifies
27 a new technology or a new intervention and it gets
28 approved, just through the process, there are clinical
29 trials as well involved in that, to the point that, "Now we
30 scale it and therefore we need a significant investment."
31
32 MR MUSTON: At what point in that long spectrum do you
33 start to at least foreshadow as a possibility that cost as
34 a future cost to the health service in New South Wales?
35
36 MR D'AMATO: Normally we would do that at the point where
37 our Office for Health and Medical Research is involved, and
38 at that point we would probably have more clarity in
39 regards to what's in the pipeline to then start
40 entertaining a conversation with treasury. I think before
41 we put something on our radar, we need to have some sort of
42 accurate costing. If we're talking about two patients,
43 I don't think that - at this stage we can probably manage
44 within our resources, but if you're talking about some of
45 the current CAR T gene therapy that costs us around
46 $30 million a year, that certainly we flag with treasury
47 way earlier. In fact, we flag these at the moment we start

1 negotiating with the Commonwealth.
2
3 MR MUSTON: In relation to the CAR T treatment, I'm
4 presuming that it went through the committee process,
5 Ms Willcox, that you spoke of?
6
7 MS WILLCOX: Mmm-hmm.
8
9 MR MUSTON: Obviously you are not looking at potentially
10 funding CAR T treatment at a time when a very clever
11 scientist is innovating in their laboratory, but by the
12 time it actually is sufficiently developed to come to the
13 committee for the committee to be thinking about whether or
14 not to deliver it as a form of care, you are, at that
15 point, looking at the potential horizon from a funding
16 perspective, and factoring it in to your growth forecast?
17
18 MR D'AMATO: Yes, so at that point and probably after that
19 point - because the committee might take a while to decide
20 whether it's going to be a go or no go. Once there is
21 a decision close to being made, that's when they start
22 coming towards our end and we're able to have involvement
23 with the development branches in determining and
24 forecasting the costs, and these could be things that, with
25 treasury, might be negotiated as time limited funding
26 because we're not a hundred per cent sure of the quantum,
27 ongoing quantum.
28
29 MR MUSTON: Perhaps just so I can try and wrap up this
30 issue around ABF, can I ask you to go to paragraph 93 of
31 your report, which is on page 18, if that helps.
32
33 You tell us there, consistent I think with what you
34 have already told us, that ABF is not designed to deliver
35 allocative efficiency. You indicate that it has broad
36 benefits to the system including transparency. Are there
37 any other benefits that ABF funding brings to the system?
38
39 MR D'AMATO: I think efficiencies should not be discounted
40 as a benefit because we eventually will be able to treat
41 more patients as a result of becoming more efficient.
42 I acknowledge the limitations and I'm not advocating one
43 way or another, but I do think that given what we see in
44 regards to the average cost of treating our patients, we
45 actually decrease our cost base or, you know, we become
46 more efficient purely by providing more care to more
47 patients and the like.

1
2 MR MUSTON: By which you mean more technically efficient,
3 delivering that care in the most financially efficient way?
4
5 MR D'AMATO: Yes. We treat more patients, too.
6
7 MS WILLCOX: It enables us to really understand the
8 elements that are contributing to the cost of care. So in
9 a local health district, when you are looking at your
10 activity and seeing where you might have variation, you're
11 seeing higher costs in areas than you would otherwise
12 expect, it enables you to have a discussion with your teams
13 and clinical staff to understand what is going on in the
14 background.
15
16 Some of those things might be technical components,
17 but some might be around length of stay, things like that,
18 that can be contributing to cost. So it enables discussion
19 to be had with your clinical teams and amongst the
20 executive to really understand the way you're approaching
21 an episode of care or a particular element of care, versus
22 what the ABF component would suggest you should be.
23
24 MR MUSTON: So is your point essentially that the
25 mechanics of the ABF system have, as a serendipitous
26 benefit, the collection of a lot of data, which is very
27 useful in terms of understanding and delivering, as best as
28 can be delivered, the health care that is being provided to
29 the community?
30
31 MS WILLCOX: I think that's right, yes, thank you.
32
33 MR D'AMATO: I think the essence is about benchmarking and
34 the ability to benchmark is predicated on the quality of
35 the data.
36
37 MR MUSTON: You do tell us at paragraph 96 - I think
38 I told you I would come back to this, so I will - that the
39 ABF model contains some adjustors to try and accommodate
40 the fact that the cost of delivering care to particular
41 parts of the population is higher?
42
43 MR D'AMATO: Yes.
44
45 MR MUSTON: How does it do that?
46
47 MR D'AMATO: So the formula that is applicable for

1 patients that fall into these categories, if you want,
2 includes an adjustment, which means that if a patient is
3 being identified as an Aboriginal patient, an Indigenous
4 patient, being treated in a particular facility, that
5 particular episode of care is funded at a higher amount
6 than it otherwise would have been. So just to give you
7 a sense of how material that component is, for 2022/23,
8 that loading or adjustment was around $40 million across
9 the state - 45.
10
11 MR MUSTON: So in relation to that, am I right in assuming
12 that the weighting or the particular percentage of
13 weighting is something that's allocated as part of the NWAU
14 process?
15
16 MR D'AMATO: That's correct, yes, and it's based on the
17 data collection of the local districts. So they need to
18 collect the information, then accurately report it and,
19 most importantly, on top of these types of adjustments,
20 there are also adjustments in the DRGs. So the DRGs -
21 where we collect information, the clinical information, the
22 medical records - inform the coding of a particular
23 treatment. The DRGs are applicable for inpatient settings,
24 and there can also be adjustments in each individual DRG to
25 acknowledge whether the patient had co-morbidities, for
26 instance, to then be paid more as a result of additional
27 complexities that had to be taken into account.
28
29 MR MUSTON: So all of the states, in gathering their
30 ABF activity data, contribute that to a central body that
31 makes an assessment of it, it uses that data in the
32 serendipitous way we've talked about to assess the cost or
33 make an assessment of the cost of delivering care to
34 particular identifiable groups within the patient cohort,
35 and that central body strikes a percentage weighting to
36 reflect what it determines to be the additional cost
37 associated with the delivering care to those sections of
38 the community?
39
40 MR D'AMATO: Yes, that's correct. There are independent
41 bodies, the Independent Health and Aged Care Pricing
42 Authority, they normally do these through a process of
43 consultation as well.
44
45 MR MUSTON: That's IHACPA, as we've heard --
46
47 MR D'AMATO: IHACPA, that's the one. We participate in

1 reviewing the data as well, because that is done at the
2 national level and it is based on empirical statistical
3 evidence that demonstrates there is additional cost to
4 treat some of these patients or patients with some of these
5 adjustments.
6
7 To give another example, the living in a remote or
8 regional area relates to where the patients reside. So if
9 a patient has been treated, say, even in the city, but
10 lives in the country, it's most likely they're not willing
11 to stay a bit longer, and therefore, instead of penalising
12 because they're just treated as any other patient, they
13 apply an adjustment, so they pay a little bit more. For
14 that particular adjustment last year we paid $100 million.
15
16 MR MUSTON: The assessment of these adjustments is all
17 based on a review of care actually provided in the past?
18
19 MR D'AMATO: Yes.
20
21 MR MUSTON: But the payment of money through these
22 adjustments is also all directed only to care - to activity
23 which is either delivered in a hospital setting --
24
25 MR D'AMATO: Yes.
26
27 MR MUSTON: -- or delivered outside of a hospital but
28 picked up by some code which has been agreed by the
29 Commonwealth to form part of the ABF structure?
30
31 MR D'AMATO: That's right.
32
33 MR MUSTON: In paragraph 97 you tell us about some further
34 adjustments that are made. I want to ask you particularly
35 about the potential need to adjust for socioeconomic
36 factors, including remoteness and culturally and
37 linguistically diverse populations.
38
39 MR D'AMATO: Yes.
40
41 MR MUSTON: Those factors, how are they picked up as part
42 of the ABF funding model?
43
44 MR D'AMATO: I think it's fair to say that we pick these
45 up through two different channels. One is where we
46 aggregate the data and we consult our internal stakeholders
47 where they raise these issues several times, and we provide

1 this feedback to IHACPA to determine whether nationally
2 there is evidence suggesting that there is additional cost
3 incurred to treat some of these patients.
4
5 MR MUSTON: Just pausing there, though, in terms of you
6 feeding it back to IHACPA, IHACPA, if they accept your
7 advocacy, will add a weighting to a particular activity if
8 a patient has been identified as coming from the cohort
9 that you have been advocating in respect of?
10
11 MR D'AMATO: That's correct. So that's what we tried in
12 the past. Unfortunately, we have been unsuccessful but not
13 because we haven't tried. It is more challenging
14 particularly in the culturally and linguistically diverse
15 populations because the data quality doesn't allow us to be
16 able to identify the code properly. You know, to give you
17 an example, how do we select this code? Is it on the
18 country where they were born or the language they speak at
19 home? Let alone the fact that the quality of the data we
20 collect in the information system is not a hundred per cent
21 accurate or there to determine a hundred per cent the code
22 or to select the code.
23
24 MR MUSTON: What you are saying effectively is two
25 difficulties: the first is identifying a particular
26 question that you could ask someone to tick a box and place
27 them into a culturally and linguistically diverse category,
28 for example, is exquisitely difficult - that is to say,
29 asking whether someone speaks a language other than English
30 at home might not necessarily tell you an enormous amount
31 about that person's ability to interact with the health
32 system; but, equally, to the extent that questions like
33 that might inform it, they are not currently being asked or
34 recorded?
35
36 MR D'AMATO: That's exactly right.
37
38 MR MUSTON: So the data that you have around culturally
39 and linguistically diverse populations is very much
40 imperfect?
41
42 MR D'AMATO: I guess that is applicable to the whole
43 nation, not only us. That's the other part we need to
44 contemplate. For this to be a national adjustment,
45 everyone needs to demonstrate that there are cost
46 differentials in treating those patients. At the moment,
47 every time we try, there wasn't enough evidence or robust

1 evidence to suggest that was the case.
2
3 MR MUSTON: Are other general socioeconomic factors like
4 the level that someone has received - am I right again -
5 difficult to categorise?
6
7 MR D'AMATO: That's right. So to mitigate risk, we then
8 have these equity adjustments into our purchasing approach
9 where we have a needs index, if you want, a calculated base
10 on the demographic or the catchment area of the particular
11 LHDs that demonstrates whether the population is
12 under-serviced or over-serviced.
13
14 If they're under-serviced, then that is a factor that
15 we will take into account when we agree what is the
16 additional activity we want to purchase from the district.
17 So that's how we try to mitigate that or accommodate for
18 the limitations of the national ABF model.
19
20 MR MUSTON: That's another, in effect, weighting that you
21 are applying based on an assessment of, what, post code
22 data.
23
24 MR D'AMATO: Yes, that's right. Post code data and
25 socioeconomic information related to the post code data,
26 accessing the services available in the district. So we
27 then provide additional funding in respect to the
28 population, in respect of ageing, to the particular
29 district as a result of that.
30
31 MR MUSTON: Again, the weighting that you are applying
32 through the use of that data is being applied to activity
33 actually delivered?
34
35 MR D'AMATO: Yes, that's right. So to a degree, that is
36 probably the last part that is really related to the old
37 funding model, which is an RDF, a resource distribution
38 formula or a population based formula. That's how we
39 integrated the two approaches.
40
41 MR MUSTON: I note the time, Commissioner, I'm about to
42 move on to another topic.
43
44 THE COMMISSIONER: Yes. We will have to adjourn until
45 noon because your microphone needs to be replaced.
46
47 MR MUSTON: Does it?

1
2 THE COMMISSIONER: Yes, It does, but it is not your fault.
3 We will adjourn until noon, thanks.
4
5 **SHORT ADJOURNMENT**
6
7 THE COMMISSIONER: Yes, go ahead, Mr Muston.
8
9 MR MUSTON: Can I quickly go back to a topic that we
10 addressed earlier this morning, and that is the treatment
11 of patients in the public hospital who identify as
12 a private patient. I think my understanding of where we
13 reached was that the private health insurers contribute an
14 amount of money; the Commonwealth provides a discounted
15 amount referable to ABF to take into account the private
16 health insurance; and then the balance is covered by the
17 state.
18
19 Can I ask this: is there any amount of money which is
20 contributed through the MBS system in respect of those
21 patients?
22
23 MR D'AMATO: Yes, that will be contributed directly to the
24 doctors that treated the patients as part of the private
25 practice arrangements and they will factor in at times -
26 depending upon the level that the doctors are selected to
27 be working on, there will be different arrangements for
28 them to have drawing rights from the number 1 account.
29
30 MR MUSTON: So just teasing that out, if the doctors
31 who are treating these - let's just call them private
32 patients - are staff specialists, employees of the state,
33 there is an arrangement whereby the funding from MBS is
34 received by the state and - yes? The first point, received
35 by the State?
36
37 MR D'AMATO: So it's received into what we call a trust
38 account, so not necessarily by the state as such. We don't
39 have the right to use any of these funds, but we have
40 a custodial trust of these funds. So at that point, it
41 will be in what we call a number 1 account, and these are
42 reported into our trust.
43
44 MR MUSTON: That's held on trust for the doctors who have
45 provided that private care?
46
47 MR D'AMATO: That's correct.

1
2 MR MUSTON: In relation to people who are not staff
3 specialists but might be VMOs, that money just goes
4 directly to them; is that correct?
5
6 MR D'AMATO: That's correct. They would be doing their
7 own billing, most times, whereas the billing for staff
8 specialists employed by us would be done by billing
9 services.
10
11 MR MUSTON: And the money that is sitting in the trust
12 account - the number 1 account, I think you described it
13 as - how does that get used within the health system, at
14 a very high level?
15
16 MR D'AMATO: A very high level, that forms part of the
17 arrangements for the salaries, if you want, where they have
18 an opportunity to draw out of the number 1 account up to
19 a certain limit, and whatever is left in the number 1 at
20 the end of the year is then transferred to what we call the
21 number 2 account. The number 2 account then is identified
22 in our financial statements, as reported to - not only in
23 the financial statements but also to treasury, and that is
24 what we call restricted financial assets.
25
26 MR MUSTON: So the money comes from the MBS into the
27 number 1 account, and depending on the arrangement with the
28 particular staff specialist, a portion of that can be drawn
29 out by the staff specialist as part of their income?
30
31 MR D'AMATO: That's right.
32
33 MR MUSTON: What's not drawn out of the number 1 account
34 in that way by the various staff specialists whose efforts
35 contribute to it goes into the number 2 account. Money in
36 the number 2 account is used in the health system how?
37
38 MR D'AMATO: Normally in that case it is most likely than
39 not it will be for facilities improvement. So in this case
40 it will be up to the local committees, they're normally
41 chaired by the CEs and clinicians are involved in
42 determining how they want to spend - yes, I'm thinking
43 about invest as well - the money related to what's in the
44 number 2 account.
45
46 MR MUSTON: So the money that sits in the number 2 account
47 which is referable to a group of clinicians in a particular

1 hospital will be spent within that LHD setting, after
2 a process of discussion between the CE of the relevant LHD
3 and the clinicians whose work has contributed to the
4 collection of that money?
5
6 MR D'AMATO: There is a local management committee and it
7 is up to them to determine how to spend the money.
8
9 MR MUSTON: Presumably, the total amount of that money on
10 an annual basis is something which we will all be able to
11 find in annual reports?
12
13 MR D'AMATO: That's correct. If you want, I can have
14 a quick look and identify what is in the annual report.
15
16 MR MUSTON: If it's going to take time - if it is
17 something we can find, I don't think we need to take time
18 on it.
19
20 MR D'AMATO: Yes, it is publicly available.
21
22 MR MUSTON: We were talking just before the break about
23 the way in which weightings are given within the ABF system
24 to account for these equity factors, so socioeconomic
25 factors, if we could use that term collectively. Could
26 I understand how that is done in terms of for the
27 identification of the weightings that you apply by
28 reference to post code data? Can I ask you this: do you
29 think that actually does effectively account for these
30 equity factors in terms of the costs associated with
31 delivering care?
32
33 MR D'AMATO: I think probably it is best if we acknowledge
34 the socioeconomic factors are difficult to be accounted for
35 at this stage, but I think that perhaps if you focus on the
36 adjustments that are in place, such as the patient
37 residence, remoteness, there is an empirical methodology
38 that they use, but I have to acknowledge that is at
39 a national level. This means that normally the test that
40 they run is the best fit in determining the cost of a
41 particular group of patients they have identified using
42 post codes and what they call the Modified Monash Model,
43 then they make that as a reference to the average cost of
44 all other patients and they lift the weight to the point
45 that they can try to identify the best fit for this
46 patient. So I can't say a hundred per cent, it will fit
47 all of them, but I think it does provide, you know, for an

1 adjustment that reflects there is additional cost incurred
2 for treating these patients.
3
4 MS WILLCOX: If I could add to that, Mr Muston, I think at
5 a local health district level the chief executives and
6 their teams have a lot of familiarity with their
7 communities and the types of population they're responsible
8 for delivering health care to and a lot of engagement with
9 those communities.
10
11 I said earlier around the ABF and how it enables, at
12 least with the national weighted activity, and allows us to
13 get underneath and understand if we are below or above
14 benchmark or there's some variation. I think if, when you
15 sit with local health district teams, they're very
16 cognisant of the fact that an individual coming into their
17 care from, let's select a community, a Pasifika community
18 in south-western Sydney, where there may be a contribution
19 of factors that make care more complex - I say that not in
20 a negative way about those communities, people come with
21 their own history, co-morbidities, lifestyle, socioeconomic
22 factors - which may mean when you come into hospital for
23 something, there are other things we need to wrap around
24 you to support you, to get you well, get you home and get
25 you supported back with your family.
26
27 So sometimes these things are hard at a technical
28 level to identify, but when multidisciplinary teams are
29 caring for a person, in the main we look to care beyond
30 just that person's disease but their family and the other
31 things that might impact on their successful discharge from
32 hospital and maintaining their wellbeing back in the
33 community.
34
35 MR MUSTON: These weightings, I think we have already
36 covered, are directed at the additional costs associated
37 with providing the activity and delivering that
38 multidisciplinary care to that particular patient once they
39 have presented in an acute setting.
40
41 MS WILLCOX: These things are done as an episode of care
42 and sort of averaged out, so to speak. They won't
43 necessarily accommodate or take into account all of the
44 things that we might do in a hospital for an individual or
45 in a community health centre, because we will be
46 identifying things that that person needs to be
47 person-centred and to support them to the best we can.

1
2 MR MUSTON: And I guess to take it to its, I hope, logical
3 conclusion, these adjustments are not being applied as part
4 of an assessment of the need to target preventative health
5 care to particular sections within the community which,
6 based on socioeconomic or other factors, might need
7 different levels of preventative care than other sectors of
8 the community?
9
10 MS WILLCOX: I think that's an accurate assessment.
11
12 MR D'AMATO: Yes.
13
14 MR MUSTON: Can I move on to the funding of small
15 hospitals and the way in which they're funded. You have
16 addressed that at paragraph 98 and following of your
17 report. I just want to ask a few quick questions about
18 that. First, as I understand it, there is a threshold of
19 activity below which a hospital is block funded as opposed
20 to funded on the conventional ABF model?
21
22 MS WILLCOX: That's correct.
23
24 MR MUSTON: So if there is a particular level - if
25 a hospital is not, on an annual basis, delivering
26 a particular level of activity, a view is taken that you
27 can't just fund that hospital by reference to the small
28 amount of activity it's doing and instead you'd have to
29 block fund it?
30
31 MS WILLCOX: Yes.
32
33 MR MUSTON: How is that threshold identified?
34
35 MR D'AMATO: So the threshold is determined by IHPA and is
36 set in the national efficient cost determination. For this
37 financial year the threshold has been set similar to what
38 has been done in the past, and there are two thresholds.
39 One is if the hospital is in the metropolitan area and one
40 if it is in a rural area. The threshold takes into account
41 the amount of activity that they are treating in these
42 small hospitals.
43
44 So the threshold for the metro is based on 1,800
45 admitted patient national weighted activity units. So any
46 hospital below the threshold would be treated as a block
47 funded hospital.

1
2 MR MUSTON: Just pausing there, if they are below that
3 threshold and they are block funded, who calculates the
4 block, the sum that that hospital is allocated for
5 delivering services?
6
7 MR D'AMATO: It will be based on the national efficient
8 cost determination. There is a section here that
9 determines the pricing model, if you want, for the small
10 rural hospital, and that is predicated on a number of
11 variables, and there is a fixed component as well as
12 a variable component.
13
14 MR MUSTON: That's the Commonwealth's contribution to it?
15
16 MR D'AMATO: That's right, yes.
17
18 MR MUSTON: In terms of the state's contribution to it,
19 how is the state's contribution calculated?
20
21 MR D'AMATO: We determine the contribution based on the
22 historical cost incurred by the particular districts in
23 delivering the care. So it's all predicated on the cost
24 collection that is submitted by the district to the
25 ministry - that is what is informing the amount.
26
27 MR MUSTON: From the state's perspective, as it's funding
28 its LHDs, to the extent that an LHD has a small hospital,
29 which is a block funded hospital, the way in which
30 the total figure which is provided to the LHD for that
31 hospital is calculated takes into account effectively what
32 it has cost to keep the doors open and deliver services at
33 that hospital historically?
34
35 MR D'AMATO: That's correct.
36
37 MR MUSTON: Are there adjustments then made for growth and
38 inflation?
39
40 MR D'AMATO: Inflation, absolutely, as part of the cost
41 base and cost escalation process. So when we escalate the
42 cost base of districts, we will apply different rates to
43 different line items. So employee-related, based on award
44 changes, we would apply the relevant escalation and we
45 would have included in that; all small hospitals as well.
46
47 MR MUSTON: And a proportion of that funding is received

1 from the Commonwealth?
2
3 MR D'AMATO: Yep.
4
5 MR MUSTON: That's calculated by reference to, no doubt,
6 a very complicated formula?
7
8 MR D'AMATO: That's correct. But the part I need to
9 stress is that the relationship between the funding source
10 and expense is something that we manage at the ministry
11 level. So we set the expense budget, or treasury sets the
12 expense budget for the Ministry of Health and NSW Health
13 and that ultimately is the upper limit of expenditures that
14 we can incur in a year. Then the funding sources are
15 determined by, as we discussed before, these three aspects,
16 being first, own-source revenue, patient fees; second,
17 Commonwealth; and then the balance would be the state. So
18 if there are movements in regards to revenue, the state
19 basically --
20
21 MR MUSTON: Picks them up.
22
23 MR D'AMATO: That's exactly right.
24
25 MR MUSTON: So for the hospital that sits just above the
26 threshold and is ABF funded, I assume that the contribution
27 from the Commonwealth in relation to that hospital just is
28 driven by whatever activity is generated through that
29 hospital?
30
31 MR D'AMATO: That's correct.
32
33 MR MUSTON: The way in which the state funds the LHD to
34 operate that hospital takes into account, I assume, that
35 activity?
36
37 MR D'AMATO: Correct.
38
39 MR MUSTON: Does it take into account the historical cost
40 of keeping the doors open and turning on the lights?
41
42 MR D'AMATO: We do. We do through different mechanisms.
43 One is what we call recognised structural cost. So what
44 that does, it takes into account the fact that the ABF
45 hospitals in rural settings will never become as efficient
46 as ABF hospitals in the metro. There's just not enough
47 volume. So what we tend to do, we do an analysis that

1 identifies all the key cost drivers, that are well above
2 the normal range of costs experienced by all other ABF
3 hospitals, and we provide for this extra top-up, if you
4 want, into the service agreement, the expense budget.
5
6 This recognised structural cost is around $43 million.
7 That is included in the service agreements and it's
8 predominant - actually, it's all in the rural and regional
9 LHDs. So this is for those ABF hospitals where, if you
10 want, the price is not necessarily as accurate.
11
12 Then we also have what we call a cost price
13 adjustment --
14
15 MR MUSTON: When you say the price is not accurate, are
16 you referring to the fact that the money generated by the
17 activity is alone insufficient to keep the hospital
18 operating?
19
20 MR D'AMATO: That's right. And it's unlikely to become
21 efficient in the near future. So as you say, in order for
22 them to operate and keep the doors open, there is no point
23 us driving them to become as efficient. We take into
24 account - and these items will include things like patient
25 transport, will include VMOs, will include some of these
26 items that we know are unlikely to be resolved unless there
27 is a significant change in the market.
28
29 MR MUSTON: The need to use premium labour, is that taken
30 into account?
31
32 MR D'AMATO: Yes, it is taken into account. As I say,
33 basically what we look at is the average cost across all
34 ABF hospitals that would have been factored in to a normal
35 price, because we base the price on an average, relative to
36 an average, and then we take into account all other factors
37 that are well above - and we're talking about three
38 standard deviations above from the cost.
39
40 Then there is another part that we call cost price
41 adjustment, and this is utilised across the board, and
42 again, to acknowledge that ultimately, we will never be
43 able to pay everyone a price and expect them to operate.
44 There has to be a transition period where, as Ms Willcox
45 mentioned, there is an opportunity to use this cost, as you
46 say, as a serendipity, to identify opportunities to perhaps
47 do something differently. Again, we've seen some good

1 results but there's always a bit more work that we need to
2 do.
3
4 MR MUSTON: Can I move on from the smaller hospitals. In
5 paragraphs 101 to 105 of your report, you list a range of
6 initiatives and other projects which are undertaken by
7 NSW Health in an attempt to deal with some of these equity
8 issues.
9
10 The first question I have in relation to them is: how
11 are they funded? Are they funded by the ministry or by the
12 individual LHDs or perhaps project specific?
13
14 MS WILLCOX: They will be a combination of funding
15 sources. Because of the devolved system that we have,
16 local health districts will make submission decisions
17 around priority groups or particular - if there is
18 a prevalence of particular disease in a community and how
19 they wish to attend to providing that care. Some of those
20 things will be locally driven and they will do that within
21 their funding envelope. Others will be more program
22 related, which would have come from the ministry or from
23 the Commonwealth, if we're talking going back to matters of
24 immunisation and national screening.
25
26 MR MUSTON: Can I come back to an example you gave I think
27 earlier of the Pasifika community and particular health
28 needs that have been identified within that community.
29 That community presumably is not confined to a single LHD?
30
31 MS WILLCOX: No.
32
33 MR MUSTON: I take it from your earlier answer that at
34 least one LHD has identified a particular need within that
35 community and done work to reach out to that community and
36 deliver health care in a particularly targeted way?
37
38 MS WILLCOX: Yes.
39
40 MR MUSTON: That's no doubt happened by engaging a whole
41 lot of different groups within the community. To the
42 extent that that might have been done effectively in that
43 LHD, how, if at all, does that address the equivalent
44 problems that might be in an adjacent LHD or perhaps even
45 in an LHD in another part of the state, with respect to the
46 same population group?
47

1 MS WILLCOX: So the clinical service planning that
2 a particular LHD would do would involve working obviously
3 with their clinical teams and their community and having
4 some discussion around what might be the best pathways of
5 care for particular people.
6
7 If we stick with the culturally and linguistically
8 diverse communities, we do have a statewide framework
9 around that, which identifies elements that LHDs should
10 consider. One, for instance, would be making sure that
11 they had somebody working in the area of multicultural
12 health to help coordinate care.
13
14 I think to say that none of these processes are
15 linear, and multicultural health teams would be in forums
16 together and share models of care and work that they are
17 doing in a particular community so they can be shared, like
18 a community of practice, I expect.
19
20 There are other forums where we highlight particular
21 successful models where we've evaluated and seen very
22 positive outcomes in a community, and that might be at the
23 senior executive forum that's held every month in the
24 ministry, it might be through particular branches within
25 the ministry or other forums such as the Agency for
26 Clinical Innovation where networks of clinicians come
27 together.
28
29 To come back more directly to answer your question,
30 I think there has always got to be local engagement and
31 decision-making around what works, but we try to optimise
32 the ability of our teams to share information across the
33 system so that we're not all starting from ground zero
34 every time. And there are particular elements that you
35 know work well that you want to see reproduced. That's,
36 for instance, making sure that you have actually got
37 a community group that you are regularly meeting with, for
38 instance.
39
40 MR MUSTON: This community outreach type work or reaching
41 in to the communities is a means by which you are able to
42 provide preventative health care?
43
44 MS WILLCOX: Yes, it's about connecting with communities,
45 understanding their needs, adopting care to be culturally
46 appropriate and sensitive to their requirements,
47 understanding family and social dynamics and how best to

1 engage and connect, and some of that will be around health
2 promotion activities. It would be about how we then best
3 outline our service models so that when people are unwell
4 and need to come into our care, they feel safe and people
5 understand their needs.
6
7 We talked briefly the other day about trauma informed
8 care. It's about having an understanding of these
9 particular community needs and ensuring that all of our
10 clinicians have an understanding of that in terms of care
11 provision.
12
13 MR MUSTON: You have described the way in which some of
14 these models are discussed by leadership across the LHDs.
15 That, I assume, means that those who agree that it is
16 a good idea, and working, will try to implement it in their
17 own individual LHD with respect to the equivalent
18 population group. In terms of the funding of those
19 efforts, that funding has to come out of whatever funding
20 is being provided to the LHD that happens to be delivering
21 it to their particular population; is that right?
22
23 MS WILLCOX: That's correct, yes.
24
25 MR MUSTON: To the extent that those efforts are not
26 generating activity in the ABF sense, how is the funding of
27 those activities recognised when money is delivered to the
28 LHDs by the ministry?
29
30 MR D'AMATO: I think there a couple of aspects. One,
31 first of all, is to describe an overall funding model to
32 include what we call state only block, and the state only
33 block is about programs that are not subject to ABF, they
34 are not in scope for the Commonwealth funding and therefore
35 we pay 100 per cent for it.
36
37 MR MUSTON: Can I ask you to pause there. In relation to,
38 say, a particular outreach program which has been effective
39 in dealing with the health needs of the Pasifika community,
40 is there a process whereby an LHD has to, in effect, bid
41 for some block funding for the continuation of a service
42 like that, if it's not ABF recognised?
43
44 MR D'AMATO: I think - and chip in any time - that one
45 part to recognise is that at times some of these programs
46 have been developed over a number of years and therefore,
47 you know, have always been covered in the base of the

1 district's funding. Then we normally assess whether there
2 is an additional enhancement as a result of policy
3 decisions - such as a few years ago there was an
4 enhancement in refugee health as a result of policy
5 decisions in bringing more refugees at a particular time
6 from Syria, we received additional funding, we targeted
7 specific areas where we knew they were settling.
8
9 MR MUSTON: Again, pausing there, that's a policy
10 announcement at a ministerial level?
11
12 MR D'AMATO: That's right.
13
14 MR MUSTON: So a policy has been announced that we are
15 going to receive an influx of refugees from a particular
16 location and, coupled with that, we are going to target
17 some funding towards the health needs of that particular
18 population?
19
20 MR D'AMATO: That's correct.
21
22 MR MUSTON: Dealing more here, I think, with the
23 innovation that has developed on the ground in LHDs. For
24 example, I think that - I don't want to keep picking on
25 them, but the one we've been using is the Pasifika
26 community and it sounds like one of the LHDs, at least,
27 have come up with a very innovative way of dealing with the
28 particular and unique health needs of that community.
29
30 MR D'AMATO: Yes.
31
32 MR MUSTON: Do I understand you correctly in saying that
33 if that has grown organically within an LHD, and been
34 funded out of whatever money was available to the LHD, it's
35 effectively taken to just form part of the base?
36
37 MR D'AMATO: That is one option. The other option is
38 there is an NGO involved, and therefore, at that point, it
39 could have been tested for additional funding as a result,
40 you know, new grants being applied for and therefore
41 resolved in that way.
42
43 MR MUSTON: Let's come back to the NGOs, because I want to
44 try to get to the bottom of these programs where the LHD
45 itself, in an innovative way, has developed a new method of
46 delivering care to a community which has a particular need.
47

1 MR D'AMATO: Yes.
2
3 MR MUSTON: Just trying to understand whether, from
4 a budgeting point of view, that LHD is given an allocated
5 amount of money for the continued delivery of that program.
6
7 MR D'AMATO: Yes.
8
9 MS WILLCOX: I think how it plays out at the district
10 level is that the community health teams and the
11 multicultural health teams will be - they are funded as
12 part of the district's budget. If people are coming in to
13 care that can be attributed as non-admitted activity, that
14 would be counted and then reflected in the targets that the
15 finance and purchasing team would consider as part of the
16 normal budget process. But in the main, the activities
17 around community engagement and community health responses
18 that probably go more to the concept of prevention and
19 health promotion would be done within the block budget that
20 the district has in terms of providing community health as
21 part of its overall service.
22
23 MR MUSTON: So there are two separate - there is the ABF
24 generated part of the budget for the LHD, and then on top
25 of that, there is a block of money which the LHD is able to
26 use for --
27
28 MR D'AMATO: To address local priorities.
29
30 MR MUSTON: Does it have to use the money for those
31 purposes? Is it tied money or quarantined money?
32
33 MR D'AMATO: I can't say that it is quarantined. It
34 definitely depends on the local needs. But there is an
35 amount that goes to population health and other aspects,
36 what we call state only block, and each district has an
37 opportunity to prioritise accordingly.
38
39 MR MUSTON: To the extent that the LHD has a particular
40 budget to provide its care annually, if its costs of
41 delivering the acute care increase - and maybe break this
42 into two parts - to the extent that the acute care, the
43 demands of acute care increase, whether or not that
44 increases the recognised activity, that's something that
45 the LHD just has to deal with? There is no way of avoiding
46 the provision of acute care --
47

1 MS WILLCOX: No.
2
3 MR MUSTON: -- on budgetary grounds.
4
5 MR D'AMATO: The other way is valid too. When we have
6 projected a certain level of activity and the districts are
7 not delivering the activity, we do not remove the money
8 from their base.
9
10 MR MUSTON: Let me break it down. First point, level of
11 demand on acute care can increase in a way that does not
12 necessarily result in an increase in activity in an ABF
13 sense?
14
15 MR D'AMATO: Yes.
16
17 MS WILLCOX: Yes.
18
19 MR MUSTON: To the extent that that happens in a
20 particular LHD, the LHD, from within its budget, obviously,
21 needs to deal with it, and that costs whatever it costs.
22
23 MR D'AMATO: Yes, that's correct. But I think we need to
24 be mindful of that cost, because in respect to realities of
25 some of our metropolitan districts where we're looking at
26 the budget, expense budget of around 2 billion, the cost of
27 delivering those services, I don't think they're going to
28 be, if you like, material. I mean, I'm not saying that
29 this is not a valid initiative to pursue, I think we try
30 always to find the right balance.
31
32 MR MUSTON: But I guess my point is, as that funding
33 envelope that they have available at the LHD level is
34 increasingly filled with acute care costs --
35
36 MR D'AMATO: Yes.
37
38 MR MUSTON: -- particularly to the extent that it is not
39 then replenished, at least in futuro, by an increase in
40 activity, the area where that squeeze is going to bite the
41 hardest is in these areas of service delivery which are not
42 acute and are not generating activity; is that right?
43
44 MS WILLCOX: I think that's not completely accurate. In a
45 local health district where you have hospitals and
46 community health centres and you have teams working in
47 community health, we have a corpus of staff that continue

1 to do this work. We don't take from there to fund the
2 other, because we need to maintain these services to the
3 community.
4
5 What we try to do, to Mr D'Amato's point, given the
6 size of the funding, as we've talked about - it is quite
7 different in community health versus our acute settings -
8 there is more opportunity to identify efficiency and to
9 mitigate the financial risk associated with the increased
10 acute activity.
11
12 If you're a large metropolitan local health district
13 for instance, there is much more room to identify, again
14 using the principles around ABF, where one might be able to
15 trim some of the cost to start to bring that pressure down.
16
17 We look at these figures in a local health district
18 day in, day out, week in, week out, and where we're seeing
19 aberrancies or major variations, we very quickly dive in,
20 try to understand what is going on. If we see something
21 that's a sudden shift that we can't explain, then we always
22 come back to the ministry to say, "Hey, we're seeing this",
23 and try to understand what the drivers are for the change.
24
25 So again, these things are not absolutes and it's
26 iterative in terms of the way we approach it. But we have
27 much more opportunity to manage the acute component, and we
28 would leave our community health teams to continue, because
29 it's vital work. But we've got more wriggle room, dare
30 I say, in terms of the acute side of the activity to
31 respond to those pressures. All the hospital avoidance and
32 all the many things that we've talked about over the last
33 couple of days are all in our attempts to contribute to
34 manage that.
35
36 MR MUSTON: So that's dealing particularly with your
37 existing community-based care initiatives?
38
39 MS WILLCOX: Yes.
40
41 MR MUSTON: The ability to generate new ones, am I right
42 in assuming, depends on available funding to divert in that
43 way?
44
45 MS WILLCOX: Yes. Indeed. But also around
46 prioritisation, because things will change and shift. So
47 again, it's not always a sort of surgical approach to stop

1 something in order to start something else.
2
3 There is a devolved management around how we optimise
4 what we need to do in a community through planning, talking
5 with clinicians, talking with the teams and identifying new
6 ways of doing things, if we can't get new money then we
7 look at other ways to deliver the same outcome.
8
9 MR MUSTON: How, if at all, are some of these initiatives
10 dealt with from the perspective of Commonwealth funding?
11
12 MS WILLCOX: In terms of preventative health?
13
14 MR MUSTON: In terms of, for example - we've used the
15 Pasifika community a number of times. To the extent that
16 an LHD identifies a particularly effective way of engaging
17 with a section of its community, and let's build this
18 hypothesis, talk to various other LHD heads at their
19 monthly meeting, and the idea is a great one, and they all
20 start delivering this same model of care to that same
21 section of their population within their own communities,
22 to what extent, if at all, is there an opportunity to
23 extract a Commonwealth contribution to the delivery of that
24 care?
25
26 MR D'AMATO: Probably limited.
27
28 MS WILLCOX: Limited, yes, it would be described. It
29 really goes down to the work with IHACPA around what goes
30 into the cost base and how you extract that information,
31 which Mr D'Amato was referring to before the break. It's
32 an imperfect science of extracting that information to put
33 into a funding model.
34
35 MR MUSTON: So here, I assume, we're dealing with
36 a situation where potentially one of these great
37 initiatives falls between the two buckets we were talking
38 about; we can't quite code it as ABF?
39
40 MR D'AMATO: Yes.
41
42 MR MUSTON: It's not being picked up by the Commonwealth
43 as primary care and it maybe is not strictly primary care,
44 so that bit of it, as I understand your evidence, it's
45 a negotiation with the Commonwealth about expanding the
46 scope of the codes?
47

1 MS WILLCOX: The scope, yes.
2
3 MR D'AMATO: Yes.
4
5 MR MUSTON: What about the extent to which these
6 initiatives that might be developed actually do fully sit
7 within the primary health section which would ordinarily be
8 covered by Medicare, but I'm assuming is not covered by
9 Medicare where it is delivered by the state?
10
11 MR D'AMATO: So normally when we --
12
13 MR MUSTON: First, is that assumption that I have made
14 right?
15
16 MR D'AMATO: There are cases where we then have
17 a situation to address where, you know, the service could
18 probably be delivered - it's most likely to be a primary
19 health service and the lack of primary health care
20 providers kind of force us there, and the reality is that
21 we can't take this to the IHACPA for assessment because we
22 know already they're going to say, "This is primary health
23 care; we're not pricing that."
24
25 So it leaves us with then a bilateral conversation
26 with the Commonwealth in determining whether this is then
27 material to have a conversation with the Commonwealth
28 directly, and that is what we've done in the past, and
29 then, depending on the outcome of these negotiations, there
30 might be an investment from the Commonwealth, or the
31 reality is that they've also tried to assess this in
32 determining the impact on our service. So ultimately this
33 could also be treated as hospital avoidance. If there is
34 the relationship that having that program means that some
35 of this population won't present to a hospital, there could
36 be a case to be made. But, you know, in this case, if you
37 say it's a specific program for a local cohort and it is
38 really primary health care, then it's a bit challenging.
39
40 MR MUSTON: Challenging in the sense that unless the
41 Commonwealth agrees that you are effectively providing
42 primary health in circumstances where it is not otherwise
43 being provided and therefore the Commonwealth will
44 contribute to the funding of it, it's something that the
45 state merely has to pick up?
46
47 MR D'AMATO: That's right. We tried before to approach -

1 and I think we approached also the administrator, where we
2 thought that an opportunity would exist for us to then be
3 funded to deliver services through the current mechanism of
4 the NHRA, but unfortunately, IHPA is limited in pricing
5 hospital services, not all services.
6
7 MR MUSTON: I should, in fairness - as I understood the
8 evidence that has been given over the past two days, it is
9 not an unwillingness on the part of the Commonwealth to
10 provide primary care; it's there are a range of factors.
11
12 MS WILLCOX: There are structural barriers to this, that's
13 correct.
14
15 MR MUSTON: A shortage of GPs, for example --
16
17 MS WILLCOX: Yes.
18
19 MR MUSTON: -- and maldistribution of that GP workforce,
20 as I understand it, means that there are areas of the state
21 which have an acute problem in terms of the delivery of
22 primary care which is not based on decisions about funding
23 but more based on the fact that the way in which that
24 primary care is funded is dictated by the location of the
25 doctor who is delivering the care not by the distribution
26 of the money.
27
28 MS WILLCOX: Yes, correct.
29
30 MR MUSTON: There is one quick issue that I probably
31 should touch on because we have heard a bit about it in
32 some of our discussions and submissions. Could you explain
33 the process of budget supplementation, as between ministry
34 and LHDs?
35
36 MR D'AMATO: Sure. In a regular environment, and what
37 I mean by that, if you take into account - if you remove
38 the environment where we had COVID, budget supplementation
39 relates to items that were considered outside the service
40 agreement process. So in looking at the budget
41 supplementations issued during COVID, we experienced an
42 influx of supplementation that resulted in a significant
43 amount of money being issued on non-ongoing basis. That's
44 what the budget supplementation process does. It really
45 addresses the non-ongoing nature of this funding.
46
47 To give you an example, during COVID, we issued

1 something like, for instance, in 2022/23, $3.2 billion of
2 budget supplementation to the districts, health entities -
3 everyone, not only districts. Of that, around more than
4 $1 billion was just related purely to COVID. Then there
5 were aspects related to technical supplementations and
6 adjustments. This is what we normally do issue through
7 other years, outside the COVID environment.
8
9 MR MUSTON: Does that include what we have heard described
10 as the "winter supplement"?
11
12 MR D'AMATO: That would be one of those, yes, because it
13 isn't ongoing and therefore doesn't fit into the base of
14 the districts, so it will be determined by the chief health
15 officer in saying when to issue the money and how much, and
16 then we issue the amount.
17
18 MR MUSTON: Can I ask you a question about that? It has
19 been suggested in some of the submissions that winter is
20 ongoing in the sense that it predictably occurs. Why is it
21 that that is dealt with as a supplementation each year and
22 not just as, as it were, a recognised hump in the demand
23 upon the acute hospital system which happens every year?
24
25 MR D'AMATO: Look, it is a good question. I think that at
26 times we also need to acknowledge that providing
27 instructions with some additional funding kind of alerts
28 the systems to do something where it is funded, rather than
29 to then, say, go and have a look at what they have set
30 aside for winter preparedness in their local budgets to
31 then determine when to start.
32
33 MR MUSTON: Just pausing there, are you saying - and you
34 might not be - that taking that winter supplementation and
35 using it as a supplementation rather than part of just the
36 bulk funding which is provided to the LHD incentivises the
37 use of that money for its intended purpose, namely, the
38 delivery of increased acute care during the winter period?
39
40 MR D'AMATO: I would argue that is the case.
41
42 MS WILLCOX: If I could add to that, Mr Muston, in terms
43 of how the districts would manage their budgets and
44 activity, the seasonal changes and the phasing of budgets
45 is something. So we know that, come winter - which, you
46 are right, is sort of extending, although with climate
47 change who knows, but traditionally the sort of winter

1 season. But the supplementation is actually also about
2 driving innovative ways of approaching the increased
3 demand.
4
5 So yes, it's a trigger to say, "Yes, winter is
6 coming", but districts do plan and think about what they
7 can do. They learn from the previous year and plan and
8 think, "Well, what could I do differently? Last year we
9 saw a lot of people, for instance, from aged care
10 facilities. Do we want to boost our geriatric in-reach
11 team for the winter months?" Sometimes there is
12 a temporary surge in particular activities that we know
13 really helps when we see that increased demand from
14 flu-like illnesses and respiratory conditions in our
15 emergency departments.
16
17 There might be rapid flu clinics we might stand up for
18 a four-month period where people, instead of going into the
19 ED, can be diverted into a dedicated area where they're
20 looked after. So yes, it's not just a thing to make them
21 do things, it's about thinking around what they would need
22 to do in surge that might actually be an improvement.
23
24 MR MUSTON: Does the fact that this money is delivered as
25 a supplementation rather than as part of the budget that
26 they can be certain of throughout the period make it
27 difficult for them to stand up those little initiatives,
28 taking on the staff, for example, to run a flu clinic
29 somewhere?
30
31 MS WILLCOX: I think the system is well attuned to the
32 seasonal approach to things. As I said, their budgets they
33 tend to phase so that they put more activity in those
34 busier months and then wind it back down as we go into the
35 summer period, although for some of our LHDs that are
36 coastal and high tourism areas, they have to tweak theirs
37 in a slightly different way.
38
39 But I think there is sufficient knowledge and forward
40 planning around these things that if you start thinking
41 about what you are going to need for winter and we know
42 that there is going to be some supplementation, it's
43 a focus and frames it and allows people to do these
44 additional surge activities.
45
46 MR MUSTON: But in managing the LHD, until they actually
47 have in their hot little hands the supplement, can they

1 take on the risk of forward planning, retaining staff and
2 the like?
3
4 MS WILLCOX: It would be not possible to take on staff
5 early if you didn't know that you didn't have funding, but
6 there's a limited, obviously, envelope of money that we
7 have, and we want to ensure that these supplementations
8 then are to manage that risk at that particular time of
9 year, but you are quite right, you can't have a long lead
10 time in terms of some of these activities in relation to
11 staff.
12
13 MR D'AMATO: Can I make a couple more comments in regards
14 to supplementation?
15
16 MR MUSTON: Please do.
17
18 MR D'AMATO: Again, I do want to stress that
19 supplementation has become an issue as a result of the
20 period that we lived in during COVID, where, as a result of
21 the response, we had to manage the funds centrally and
22 direct where the expenses were incurred, whether it was for
23 masks, whether it was for RAT kits and the like.
24
25 MR MUSTON: Pausing there, supplementation is not
26 a creature of COVID, is it?
27
28 MR D'AMATO: No, that's right.
29
30 MR MUSTON: It's a historical feature of the funding with
31 LHDs?
32
33 MR D'AMATO: Yes, that's right. But the point from my
34 point of view we need to understand, before COVID, I'm
35 actually talking about, and it wasn't that many
36 supplementations, and they were always the technical
37 supplementations that were issued to districts in regards
38 to year end adjustments with the movements in the
39 liabilities, and they were things that we would continue to
40 do.
41
42 The other part I also need to acknowledge, at times
43 when we have a new policy and proposal that has been
44 approved by government, and it has been approved in June,
45 we don't have sufficient time to design an implementation
46 plan for the financial year. So that is treated as a
47 supplementation after the service agreement. But that one

1 will eventually form part of the annualised basis.
2
3 I have done some analysis in regards to a particular
4 district where we issued around 100 million in
5 supplementation in 2022/23, and once I removed COVID, once
6 I removed the technical adjustment, the supplementation
7 ended up to be around 24 million. This also is all
8 disclosed in the financial statements. So one by one it
9 determines which ones are COVID-related supplementations.
10 So it is relatively transparent and I totally appreciate
11 the frustration of the districts, because we went through
12 this unusual, you know, period of three years when money
13 was issued on a monthly basis, but that's not the real way
14 of managing the districts.
15
16 MR MUSTON: Could we turn over to paragraph 106, which
17 I think should be on the next page, what you tell us there,
18 which is unsurprising, is that there are many competing
19 demands for the health budget. I assume that is as true at
20 the LHD level as it is at the state level?
21
22 MS WILLCOX: Indeed.
23
24 MR MUSTON: So to the extent that decisions might need to
25 be made about taking on additional staff to deal with
26 a winter surge, the demands mean that there is not
27 sufficient spare money in the budget to do that unless the
28 supplementation has - or until the supplementation has
29 actually been made?
30
31 MS WILLCOX: Yes, that's correct.
32
33 MR MUSTON: Could I just ask you, while we're on
34 paragraph 106, what do you mean when you refer to the
35 consumer expectations, as being a challenge in funding?
36
37 MS WILLCOX: I think --
38
39 MR MUSTON: I should say, you have said it's a challenge
40 in the funding of preventative care.
41
42 MS WILLCOX: Yes. I think it would be fair to say that, if
43 I may make a generalisation, the community in the main is
44 very wedded to their local hospital or their particular
45 service. People form a great affinity for them, and if you
46 want to change the nature of the sorts of care we're
47 delivering, you have to have those conversations with the

1 community.
2
3 There's been significant change since COVID, when you
4 think about all the virtual care that has gone on and the
5 in-reach into homes with remote monitoring and the like.
6 If we want to start to reconfigure how services are
7 delivered, it's really about having those conversations
8 with the community to explain to them and discuss with them
9 what we think might be some other options for care delivery
10 other than just, if I can be sort of simplistic, build
11 another big hospital on the hill.
12
13 MR MUSTON: We'll come back to that.
14
15 MS WILLCOX: That's not meant to be a derogatory
16 statement, it's about people having an awareness and
17 a conversation around needs and presenting other options to
18 community other than what might have been the traditional
19 option of providing care.
20
21 So it's not intended to be a criticism, it's just
22 about the totality of engagement and conversations and
23 prioritising and how we make the best decisions that we
24 can.
25
26 MR MUSTON: While we're on there, if you can go down to
27 paragraph 108, you make the point that the enablers of good
28 preventative care lie outside, or many of the enablers of
29 good preventative care lie outside the health system.
30 Again, I think that's drawing on the social determinants
31 about which we heard yesterday?
32
33 MS WILLCOX: Yes.
34
35 MR MUSTON: To what extent does health and the setting of
36 the health budget take into account or coordinate with the
37 setting of budgets in other ministries with a view to
38 trying to change health outcomes via a whole of government
39 approach?
40
41 MR D'AMATO: There was an approach by treasury utilising
42 what they call outcome budgeting and policy, where the
43 intent was to better connect the investment in different
44 clusters - back then clusters, now portfolios - whereby
45 there was an opportunity to connect investments or the
46 funding decisions in education, justice and health that we
47 piloted a few years ago. I must say, it is challenging and

1 obviously, you know, something that we participated in.
2 Probably the outcome - it will take a few years before we
3 see the material outcome impact, the desired outcome, if
4 you want. But the particular one is called "Stronger
5 Communities", and there was an opportunity to invest more
6 in education and health to then avoid costs in the justice
7 system as a result of it.
8
9 MR MUSTON: So do I take from that that the ability of the
10 current budgetary arrangements to really generate an
11 effective whole of government response to health challenges
12 depends upon high-level policy having been identified by
13 the government of the day?
14
15 MS WILLCOX: That would be one way that it would come
16 about. There is also engagement and connection between
17 officials across agencies. I think Dr Chant yesterday
18 referred to matters around urban planning, where the
19 population health people would be engaging with people in
20 the planning agency to talk about, you know, incidental
21 exercise and greening and being able to walk and transport
22 locations.
23
24 So there is an intersection of those activities and in
25 areas like public housing in particular, we have a lot of
26 engagement with our housing colleagues, and some of this -
27 there will be the larger policy areas like First 2000 Days
28 and Brighter Beginnings, which become a big policy platform
29 across agency for government, but there will also be
30 intersection at a local health district with a particular
31 housing estate, for example, where there would be a coming
32 together of the needs and issues of that community.
33
34 MR MUSTON: The First 2000 Days was a high-level
35 government policy that sat in the umbrella and was to be
36 taken into account in all budgetary considerations across
37 agencies; is that right?
38
39 MR D'AMATO: Across agencies, yes.
40
41 MS WILLCOX: Yes, it was education, Department of
42 Communities and Justice, and health.
43
44 MR MUSTON: To the extent that that has been a successful
45 preventative health strategy, that has been greatly
46 facilitated, has it, by the fact that it sat at that
47 umbrella level?

1
2 MS WILLCOX: Yes, definitely. Having ministerial
3 leadership and senior executive leadership around something
4 like this - you can't underestimate the value of that and
5 how that is interpreted on the ground with the teams.
6
7 MR MUSTON: So when health approached treasury for the
8 setting of its budget, it was able to say, "Here are ways
9 in which we are achieving this overall policy objective,
10 which is captured by the First 2000 Days program"? So too
11 presumably when education, housing, transport - every other
12 agency that is going to treasury to have its budget set as
13 part of this process would have been required, would it, to
14 have addressed, to the extent relevant, that policy?
15
16 MS WILLCOX: It wouldn't have been all agencies. It was
17 largely the Department of Education, would be our main
18 partner in the element called brighter beginnings, because
19 First 2000 Days sort of spreads across many things that
20 we're already undertaking in the health system and in the
21 Department of Communities and Justice, but the particular
22 program of work around assessment of little ones in early
23 childhood, the four-year-olds, was a joined -up budget
24 proposal between education and health.
25
26 MR MUSTON: Your point is, they are all the agencies that,
27 for example, industry and resources, probably don't have
28 a great deal to contribute to The First 2000 Days?
29
30 MS WILLCOX: Yes, correct.
31
32 MR D'AMATO: It is most likely they would have identified
33 a lead minister and portfolio to bring this to government
34 and we were just participating in this. In this case, it
35 was education. So not all clusters or portfolios would
36 have been engaged.
37
38 MR MUSTON: Could I jump down to paragraph 111, just while
39 we're on this page. You talk about the longer term
40 initiatives and the time frames associated with a lot of
41 preventative health not being consistent or compatible with
42 shorter budgetary cycles. What do you mean? I think
43 I understand what you mean by that, but if you could tell
44 us?
45
46 MS WILLCOX: I think if you think about the budget cycles
47 are annual events and you think about some of the long-term

1 public health and preventative health measures, if you
2 think about smoking, for instance, these sorts of programs
3 are a major change, social change programs in the community
4 and take long periods of time and concerted effort, and you
5 don't necessarily see the outcomes of that on an annual
6 basis when budgets are being framed.
7
8 So it is just the practical reality of some of these
9 larger societal changes, whether it be weight gain,
10 alcohol, drugs and alcohol, smoking - these are
11 significantly long-term investments over time.
12
13 MR MUSTON: I assume the same applies at both the state -
14 the ministry and the LHD level, so the ability of the
15 ministry to persuade treasury to provide funding for some
16 of these longer-term preventative strategies is challenged
17 by the fact that evidence of those strategies'
18 effectiveness is sometimes not available until they have
19 actually been on the ground and paid for, for a long period
20 of time.
21
22 MS WILLCOX: That's true, but some are - the evidence is
23 so strong, if we take smoking, that there is not a need to
24 convince government of things like that because, you know,
25 we all realise very clearly that the evidence is in on
26 that. The most recent one being around vaping, announced
27 by the Commonwealth minister around that, again on the
28 backdrop of the impacts of nicotine, governments have been
29 very swift to act on this vaping issue. Sometimes it can
30 happen quickly.
31
32 MR MUSTON: Some of the submissions we have received point
33 to what is suggested to be an overwhelming evidentiary
34 basis for the problem that dealing with obesity is
35 something which has the capacity to have significant
36 long-term benefits for the health system and for the
37 population. By that one - how does that one feature in
38 this long-term funding strategy?
39
40 MS WILLCOX: First 2000 Days, to go back to that, it would
41 be one policy framework where the issue of being overweight
42 for a mum, you know, and what that means in terms of their
43 ongoing risk to themselves - is but one area. We do height
44 and weight now on children in our hospitals, it is just
45 another practical measure. We do a lot of stuff with
46 schoolchildren through Dr Chant's area, Munch & Move and
47 various other initiatives to encourage healthy eating.

1 I think we have worked with education in terms of what goes
2 into canteens and kiosks. That would be an example of
3 where there would be some cross agency. So it is about
4 targeting these things at multiple levels and wherever
5 there is an interface and an opportunity, it means some
6 would be short term, for instance, if someone is coming in
7 to hospital to have surgery, say a hip replacement or
8 a knee replacement, if their weight was an issue, having
9 a discussion around a program to lose some weight prior to
10 surgery. Again that's a very short term, it is not
11 a population goal but it would be short term to support
12 that person's success at recovery.
13
14 MR MUSTON: How are population goals identified as key
15 policy objectives?
16
17 MS WILLCOX: There is a national preventative health
18 strategy that has been developed across all states and
19 territories with the Commonwealth and sets some priorities.
20 At a state level, certainly Dr Chant's area takes the lead
21 as the head of the deputy secretary for population health,
22 and that would be working with other governments, the
23 evidence, and understanding where the trends and changes in
24 the population's health is going and then designing
25 programs and policies that need to be implemented.
26
27 MR MUSTON: So having identified them, how does the
28 identification of those programs and policies feature in
29 the funding or budgeting arrangements?
30
31 MR D'AMATO: Normally Dr Chant will approach the ministry
32 executives, like every other branch. We put together an
33 internal process to prioritise NPPs or our internal
34 initiatives. We'll go through the relevant approval
35 process, being the minister and then treasurer. If, for
36 instance, some of these initiatives might not be supported
37 by government but we strongly believe they should be
38 supported, like we did in 2022/23 for some additional
39 investment in e-cigarette prevention and e-cigarettes in
40 youth, then we will identify a funding source through
41 either savings or re-prioritising some of the funds that we
42 have available in the particular year to either do more
43 activity in hospitals or --
44
45 MR MUSTON: In relation to that one, sticking with this
46 theme that there are multiple competing forces fighting for
47 the available budget, within health there are two ways

1 within which a particular initiative or key preventative
2 health objective can be funded. First it can be made the
3 subject of an NPP or a new policy proposal, which is
4 accepted by treasury as increasing and results in an
5 increase in the funding envelope.
6
7 MR D'AMATO: That's correct.
8
9 MR MUSTON: Alternatively, if that's not successful, it
10 can - within health, if a decision is made to prioritise
11 it, it can be drawn from the existing funding envelope -
12 yes?
13
14 MR D'AMATO: That's correct, subject to --
15
16 MR MUSTON: With you that means some other demand on that
17 envelope obviously has to fall away, or yield --
18
19 MR D'AMATO: There has to be some trade-offs, yes.
20
21 MR MUSTON: That's probably a convenient time,
22 Commissioner.
23
24 THE COMMISSIONER: All right. We will adjourn until
25 2 o'clock.
26
27 **LUNCHEON ADJOURNMENT**
28
29 THE COMMISSIONER: Yes, Mr Muston.
30
31 MR MUSTON: Can I quickly take up with you the matters
32 addressed at paragraph 43 and following of your report.
33 This is the funding of bodies other than the LHDs. You
34 tell us in paragraph 43 that health funding is provided to
35 a range of entities to complement the range of services and
36 supports provided by NSW Health. Then, down at
37 paragraph 45, you identify what some of those entities are.
38 Can I just go through them and make sure that we understand
39 what we're dealing with. The affiliated health
40 organisations or AHOs, they are privately owned hospitals,
41 predominantly, which are incorporated within the public
42 hospital network; is that right?
43
44 MS WILLCOX: That's correct. There are also organisations
45 such as Karitane and Tresillian which fit the definition of
46 an AHO as well as being an NGO, so they have a sort of
47 hybrid model. But your definition is adequate, yes.

1
2 MR MUSTON: Karitane and Tresillian, they have facilities,
3 do they?
4
5 MS WILLCOX: They have some inpatient services, yes.
6
7 MR MUSTON: My vague memory of those services - that's
8 inpatient services for mothers with new babies, assisting
9 them with --
10
11 MS WILLCOX: Yes, sleeping and feeding and - I only
12 outlined them because they are not like a hospital
13 traditionally, like a Calvary or St Vincent's, that's all.
14
15 MR MUSTON: The bigger AHOs are St Vincent's, which is
16 funded, I think you tell us, directly from the ministry?
17
18 MR D'AMATO: That's correct.
19
20 MR MUSTON: They receive a service agreement from the
21 ministry which is similar to the service agreement that
22 other LHDs receive?
23
24 MR D'AMATO: Yes, that's correct, and they participate in
25 the same negotiations like any other district.
26
27 MR MUSTON: Presumably there are some differences between
28 the way in which St Vincent's interacts with the ministry
29 when compared with the way LHDs interact with the ministry?
30
31 MS WILLCOX: As Mr D'Amato said, they participate in all
32 the same forums that our chief executives of local health
33 districts and networks participate in. We work and act as
34 one system, including St Vincent's. They obviously have
35 a large private hospital as well, which is run by their own
36 board, but in the main, the interactions around
37 performance, engagement on issues, escalation of matters,
38 sharing of information is essentially treated the same as
39 the other LHDs.
40
41 MR MUSTON: Access to the pillar services is available to
42 St Vincent's in the same way as it is available to other
43 LHDs?
44
45 MS WILLCOX: No, not entirely. Certainly in terms of
46 e-health, we don't run or directly support the information
47 and communication technology of St Vincent's Hospital.

1 They run their own. So there would be some back of house
2 activities, such as their food and linen, stuff, that would
3 be for St Vincent's themselves to manage.
4
5 MR MUSTON: Does St Vincent's have access to HealthShare,
6 for example, in terms of food and linen?
7
8 MR D'AMATO: Yes. If they wanted to yes, but that is an
9 option.
10
11 MS WILLCOX: It's an option, yes.
12
13 MR MUSTON: But they don't have to?
14
15 MR D'AMATO: So they access procurement contracts from us.
16
17 MR MUSTON: That's St Vincent's, which is an arrangement
18 directly between the ministry and that hospital, or the
19 organisation that runs that hospital.
20
21 Other hospitals that are classified as AHOs sit within
22 the LHD network?
23
24 MR D'AMATO: That's correct.
25
26 MR MUSTON: So am I right in understanding your report
27 that those AHOs have a service agreement with the LHD in
28 which they are physically located?
29
30 MR D'AMATO: Yes. That's my understanding.
31
32 MS WILLCOX: Yes. So HammondCare is outlined there.
33 That's an example that has an arrangement or a contract
34 with Northern Sydney Local Health District as one example,
35 to deliver palliative care, but they also, I understand,
36 have an arrangement with South Western Sydney Local Health
37 District to provide services.
38
39 MR MUSTON: When you say in paragraph 48 that the AHOs are
40 treated consistently in relation to escalations, national
41 weighted activity units, et cetera, what exactly do you
42 mean there?
43
44 MR D'AMATO: What I mean by that is that within the
45 general ledger we can actually see how much each individual
46 district pays AHOs and we escalate according to the same
47 escalation process we have for all other districts. We

1 escalate the payments made to AHOs in the previous years.
2 What we tend to apply is what we call a composite
3 escalation, because despite the fact that this particular
4 line item will sit outside the employee related, we
5 acknowledge the fact that a component of the grant will go
6 towards paying employee-related expenses that at times are
7 subject to different conditions.
8
9 MR MUSTON: That probably feeds into my next question.
10 How does the local service agreement between an LHD and the
11 AHO operate in terms of the funding received by that LHD
12 from the ministry?
13
14 MS WILLCOX: So where there is a local agreement between
15 a district and, if I give an example of - I will use the
16 HammondCare example - palliative care services, again we
17 would meet regularly with them, look at their activity,
18 quality and safety, staffing issues, matters of concern to
19 them that they wish to escalate, any particular things from
20 the district or any sort of strategy from the ministry
21 through to the district that we wanted to make sure that
22 they were across and participating in or not. So there
23 would be an interface or performance meeting with them and
24 they can escalate matters of finance.
25
26 MR MUSTON: So the activity that's generated in these AHOs
27 is harvested by the LHD and feeds in to the ABF funding of
28 the LHD?
29
30 MR D'AMATO: Yes, that's correct.
31
32 MS WILLCOX: Yes.
33
34 MR MUSTON: And also feeds into the ABF funding of the
35 state through the Commonwealth arrangements?
36
37 MR D'AMATO: Correct.
38
39 MR MUSTON: The next little group of organisations you
40 refer to are the CMOs or the community managed
41 organisations. What are they?
42
43 MS WILLCOX: These are a group of organisations that are
44 principally managed by community or consumers and would
45 have, in some cases, a governing body that would be made up
46 of community members. One of, I guess, the most common
47 areas where we would see CMOs is in the mental health area

1 and there is a peak organisation called the Mental Health
2 Coordinating Council that many of these smaller
3 organisations belong to. They're a very valuable group to
4 the extent that they're usually people with lived
5 experience or carers and they are providing particularly
6 levels of advocacy, support, peer support for consumers in
7 mental health and give us feedback on how we might better
8 improve our models of care delivery. So they are really
9 sort of a reference group in mental health in particular.
10
11 MR MUSTON: You may not have one at hand but do you have
12 an example of one of those groups?
13
14 MS WILLCOX: I do and I've just got to bring - there is
15 BEING New South Wales; I think SANE might fall into that
16 category as well. Yes, there are a number of smaller
17 groups and I could come back to you with some of those.
18
19 MR MUSTON: The next group or last group on the list is
20 the NGOs, so the non-government organisations. How do they
21 fit into the ecosystem?
22
23 MS WILLCOX: So there are significant number of
24 non-government organisations that provide a combination of
25 services or advocacy or support to communities. Some have
26 had a very long history within NSW Health, but there is
27 a process of application whereby NGOs come forward to
28 indicate that they want to be funded by the ministry to be
29 part of the health system.
30
31 We go through a process of ensuring that the services
32 and the activities they intend to provide go through
33 a probity process, there is a Grants Administration Guide,
34 but at a policy level we work with the relevant branches to
35 make sure that the things that that NGO is going to do or
36 provide align with the direction of the ministry. That is
37 a process, as I said, we draw on the expertise of the
38 branches, so again, if I hark to mental health, that would
39 be a discussion with them and some assessment around the
40 role that a group might play.
41
42 MR MUSTON: Is it a similar process that applies in
43 relation to the CMOs in terms of decisions around funding
44 them?
45
46 MS WILLCOX: Yes, probably the quantum of funding that's
47 provided is smaller, hence the obligations that you might

1 put on one of those organisations may be less. They would
2 certainly still be appropriately procured and monitored,
3 but not at the scale that you might see a large NGO, such
4 as a Lifeline or Family Planning NSW, who are really
5 providing quite significant amounts of service to the
6 community.
7
8 MR MUSTON: In terms of decisions around funding CMOs and
9 NGOs through the grants process, is there consideration
10 given to the extent to which the use of those funds or the
11 funding of those organisations collectively advances
12 overall objectives of health?
13
14 MS WILLCOX: There is an NGO Advisory Committee that
15 I chair across the district where members of our - NGO
16 members are on that group, where we would discuss strategic
17 priorities for the system and how NGOs may contribute to
18 that.
19
20 There is not an overarching statewide approach to
21 capture all NGOs, but there certainly is at a program level
22 a cohesiveness around how we engage, who we might bring in
23 to the funding pool. Again, mental health is an obvious
24 example. With the mental health branch we've had very good
25 line of sight of all of the NGOs that are operating in that
26 space. They would interact with them. There would be
27 evaluation of work they are doing, and again we would seek
28 guidance from mental health around the performance or
29 otherwise of an NGO that's operating in that policy space.
30
31 MR MUSTON: In terms of the three - I don't say this
32 necessarily critically - objectives we started with,
33 increasing focus on preventative health, just for example,
34 the first one, there is no process whereby someone or some
35 group takes a look at a high level and says, "To what
36 extent is our collective spend on CMOs and NGOs furthering
37 this objective?", for example.
38
39 MR D'AMATO: We tend to do it when we have to implement -
40 we consider that as part of the implementation strategy
41 related to the specific initiatives. Probably a good
42 example is the Ice inquiry and the recommendations from the
43 inquiry. In implementing those recommendations we are
44 investing in NGOs as an extra opportunity to reach those
45 communities. That's how we do it. We do it probably by
46 stream, so drug and alcohol, HIV and other streams that we
47 already have well established, rather than have

1 a comprehensive strategy across all the different NGOs.
2
3 MR MUSTON: I understand that identifying particular
4 streams of work where there is seen to be an immediate
5 need, and through those streams you have identified NGOs or
6 CMOs that are able to provide service in those areas. Is
7 there any collective examination at a higher level of the
8 way in which, following all of those streams down their
9 respective courses leads to the successful pursuit of
10 overall health objectives statewide?
11
12 MR D'AMATO: In my experience, there is. This is
13 basically vested with each individual branch. So NGOs are
14 really supporting all different policy areas. One could be
15 drug and alcohol, one could be HIV, one could be mental
16 health, as we mentioned. Therefore, the evaluation
17 component is then within the division or branch. The
18 mental health will determine whether some of the NGOs, you
19 know, are performing according to the agreements, whether
20 it needs to be continuing, or where there is additional
21 investment coming from new NPPs that could be utilised as
22 a mechanism to implement those strategies.
23
24 MR MUSTON: Is there a measurement taken or an evaluation
25 made of the overall outcomes of the grants in terms of
26 health outcomes for the population that they are directed
27 towards?
28
29 MS WILLCOX: Yes. There are annual reviews done with the
30 NGO partners and then a three-year review also, and that
31 annual review gives us an opportunity to track progress
32 where we might need a shift in emphasis. But because they
33 are not a homogeneous group, having one overarching sort of
34 state way of saying, "You're all doing what you need to do"
35 is a little tricky, hence why we take a program approach
36 and let those policy leads in those particular branches
37 give us the advice around the performance.
38
39 MR MUSTON: So the feedback that you get from the NGOs,
40 for example, presumably is around delivery of the service
41 and the KPIs that have been built in to the grant
42 arrangements?
43
44 MS WILLCOX: Yes.
45
46 MR MUSTON: Do they tend to focus on the actual KPIs
47 around the delivery or do they focus on KPIs around overall

1 health outcomes for the population that those services are
2 being delivered to?
3
4 MR D'AMATO: It is a bit of a balance.
5
6 MS WILLCOX:: It is a bit of both, yes. I think there
7 would be a fair emphasis around delivery to ensure that the
8 funding being provided is being acquitted to the services
9 that we require, but particularly in mental health and
10 child and family health, there are some key outcomes that
11 we would be aligned with those organisations to be in
12 pursuit of achieving.
13
14 MR MUSTON: It might be difficult to deal with at a high
15 level, but how are those outcomes being measured?
16
17 MS WILLCOX: The outcome measures would come from the
18 policy areas, because as they seek to engage with an NGO or
19 determine that they want to actually go out to the
20 non-government sector, perhaps to provide a grant in order
21 to pursue a particular outcome, as I say, these are things
22 that would come from the population health or the policy
23 team within the ministry for an identified need, and then
24 go and find a partner he can assist us achieve the outcome.
25
26 MR MUSTON: Can I ask you very quickly about the research
27 grants and support programs you refer to at paragraph 49.
28 There's a range of different programs that have been
29 identified there. Some appear targeted, like the first
30 one, whereas others, like the one at point (d), for
31 example, seem a little bit more general.
32
33 MS WILLCOX: Yes.
34
35 MR MUSTON: In terms of the allocation of funding toward
36 these sort of research grants, is there a focus on
37 particular objectives of health, in, for example, the three
38 objectives we started with, or is it more general?
39
40 MS WILLCOX: The overarching objectives around our Office
41 for Health and Medical Research, who oversees this, is
42 around assisting clinicians and researchers to have the
43 tools and the capability to pursue research. Research and
44 education are integral to all of our health services and
45 our clinicians as part of everything they do, whether it is
46 a quality improvement right through to a major national
47 grant.

1
2 Some of the things here, for instance, if we identify
3 the commercialisation training program, are really about
4 how we can support researchers who are developing
5 innovation, how we can train and support them to understand
6 the process around commercialisation to get some particular
7 thing up and running; the Medical Devices Fund again, there
8 have been a number of things - portable brain scanners,
9 neuromodulation equipment for overactive bladders, a whole
10 raft of things where people are researching and developing
11 clever things and how we can give them some funds to take
12 these things to market and to continue to develop.
13
14 The translational research grants, another one listed
15 there at (d), are far more, I would say, targeted to our
16 clinical teams to enable them to convert their research
17 into something that's actually going to be part of care, so
18 literally translational. And there's very much, then,
19 a focus on things such as value based health care,
20 Aboriginal health, rurality. There are these strategic
21 priorities - future health, the highest level - but
22 distilled down into priority areas for population as well.
23
24 MR MUSTON: Would it be a fair summary to say that in
25 respect of some of the schemes identified in paragraph 49,
26 there is a particular eye given to objectives like the
27 three we started with, whereas with others, they're
28 intended broadly just to facilitate research generally and
29 provide a platform from which people working within and
30 around the New South Wales health system are able to
31 research in whatever area they happen to do their research?
32
33 MS WILLCOX: That's right. We want to generate
34 an environment and give people - I mean, funding is always
35 important, but also training and tools and infrastructure
36 so that they can flourish in an environment to enable
37 New South Wales to progress its research and innovation
38 agenda.
39
40 MR MUSTON: In creating that environment is that to enable
41 people to harness research money from other sources?
42
43 MS WILLCOX: Certainly, and there is no question that
44 access to grant funding - no matter whether it comes from
45 the universities or from Commonwealth, from state - it's
46 not uncommon if someone's been successful, that actually
47 builds momentum for them to work with other teams and

1 collaborate and access grants from other sources.
2
3 MR MUSTON: Can I ask you - and I think this might
4 probably be a question for you, Mr D'Amato - to go to
5 paragraphs 64 to 69. You set out there the process of
6 building the budget. Can I just ask you to explain how
7 that process really works in a practical sense?
8
9 MR D'AMATO: Okay. So in terms of the starting point, as
10 we discussed before, there is a base amount. In the past,
11 historically, we had an indication of new money that was
12 set aside for health, and as you can see from the chart, it
13 illustrates that it was relatively consistent over the
14 years apart from COVID.
15
16 In the past, when we approached treasury conversations
17 and the minister, through the minister through the
18 treasurer and eventually to ERC, the conversations were
19 always around what was going to be delivered from the
20 original envelope and the conversation about new
21 initiatives, whether they were absorbed, if you want,
22 within the envelope or on top of the envelope.
23
24 MR MUSTON: Just pausing there, you have your baseline
25 figure, which is historical?
26
27 MR D'AMATO: Yes, correct.
28
29 MR MUSTON: Possibly adjusted for something like a change
30 in an award or something that means the baseline is now
31 more expensive than it was last year?
32
33 MR D'AMATO: That's correct.
34
35 MR MUSTON: You then have built into that this figure for
36 growth, which I think we've already talked about, where
37 treasury identifies a growth figure through some modelling
38 that treasury has done, and there might be some scope to
39 talk to treasury about that, but maybe not an enormous
40 amount of room for movement?
41
42 MR D'AMATO: Yes.
43
44 MR MUSTON: You then have an ability to build on top of
45 that growth figure an increase in the funding envelope by
46 reference to new policy proposals?
47

1 MR D'AMATO: That's correct.
2
3 MR MUSTON: So there's a process we might come to in a
4 little while where new policy proposal is put up to
5 treasury, once that process is gone through, if accepted,
6 that will result in an increase over and above your
7 growth --
8
9 MR D'AMATO: That's correct.
10
11 MR MUSTON: -- to accommodate that proposal which has been
12 accepted -- there's also parameter and technical
13 adjustments, PTAs, which I might get you to explain to us.
14
15 MR D'AMATO: So the key difference between the two is
16 probably more in respect of whether they are new
17 initiatives that the government will announce as a result
18 of the budget cycle. For instance, a good example of a new
19 policy proposal would have been The First 2000 Days,
20 a brand new policy, brought together a number of
21 portfolios, and we receive additional funding for that,
22 then --
23
24 MR MUSTON: So pausing with that one, The First 2000 Days
25 was put up as an NPP, it had been costed by health, it was
26 presented to treasury who took the view that it was
27 consistent with overarching government policy, it was
28 accepted but no doubt there was some examination of your
29 costings.
30
31 MR D'AMATO: That's correct.
32
33 MR MUSTON: Treasury arrived at its own view about what
34 those costings were, which may or may not have been the
35 same as yours.
36
37 MR D'AMATO: That's correct.
38
39 MR MUSTON: Treasury's ultimate determination of the cost
40 of that policy, which was approved, was then added to the
41 health budget.
42
43 MR D'AMATO: Yes, and I guess the decision ultimately is
44 for ERC, the expenditure review committee. Treasury
45 facilities the process and tests our assumptions but we
46 work very well with them in determining the correct
47 assumptions before we get to the point where ERC makes ae

1 decision. That policy was across a number of portfolios
2 and it was brought to the ERC by the education portfolio,
3 but we participated with the costing related to our
4 initiatives affecting that.
5
6 MR MUSTON: Let's come back to that ERC process. You were
7 going to explain to us what parameter and technical
8 adjustments are.
9
10 MR D'AMATO: Yes, sure. Then in terms of PTA, what we
11 look at more likely than not are things related to
12 increases in revenue and increases matched with the
13 increase in expenses related to a higher utilisation of the
14 high cost rates, which are funded from the Commonwealth.
15 Because of the volatility of the particular item, we tend
16 to exclude it from the underlying growth calculations, so
17 we keep that one as a headline growth, so that we avoid
18 having to go back each year with a top-up. We would rather
19 just keep it outside. That would be subject to a PTA.
20
21 Another good is example is a few years ago when we had
22 to adjust the charges for the NSW Telco Authority, which is
23 another agency inside government that is responsible for
24 providing the telecommunication for ambulance, for
25 instance, and other agencies, so when the charge is settled
26 throughout the year, then we need to make an adjustment, we
27 go to treasury and there will be a PTA.
28
29 MR MUSTON: The PTAs are not a brand new policy area into
30 which health is bravely stepping?
31
32 MR D'AMATO: Yes.
33
34 MR MUSTON: It's not just your modellable growth through
35 increases in activity connected, say, to an increase in
36 population or the like, but, rather, it is volatile items
37 which sit outside the easily predictable that are a further
38 amount which you can put forward to treasury and after
39 a process of negotiation is added to that growth figure?
40
41 MR D'AMATO: Yes. That's correct. And tend to be time
42 limited, too. And there is a policy that is issued by
43 treasury that covers this.
44
45 MR MUSTON: Can I come back to paragraphs 64 to 69.
46 Again, so I understand it, if we look at the graph on
47 paragraph 69, looking at the first period there, we've got

1 an underlying growth rate of 5.5.
2
3 MR D'AMATO: Yes.
4
5 MR MUSTON: I assume that that is what is being added to
6 the base.
7
8 MR D'AMATO: Correct.
9
10 MR MUSTON: That's the figure that treasury has agreed is
11 the growth that they will apply to the baseline?
12
13 MR D'AMATO: Yes.
14
15 MR MUSTON: So that's essentially a 5.5 per cent increase
16 on health's budget from the last budgetary period?
17
18 MR D'AMATO: That's the case, yes.
19
20 MR MUSTON: The next figure there, or the next column in
21 the growth, the headline growth rate, again, could you just
22 explain to me what that one represents?
23
24 MR D'AMATO: Effectively there is a different starting
25 point in calculating the new money, and because the
26 headline would include items that are more volatile, the
27 headline growth could be up or down, outside our control,
28 if you want. It doesn't necessarily relate to what's
29 available for us to spend on the next financial year. So
30 that's the reason we calculate it outside and it is also
31 published in the budget papers each year.
32
33 MR MUSTON: So that figure there is another estimate of
34 growth?
35
36 MR D'AMATO: That's correct.
37
38 MR MUSTON: Which takes into account some volatilities,
39 which are largely excluded in the underlying growth figure
40 that is there?
41
42 MR D'AMATO: That's right. The volatility could also be
43 due to time-limited programs, so when they cease, the
44 headline could look lower only because the prior year
45 included some one-off funding.
46
47 MR MUSTON: What role, if any, does the headline growth

1 rate identified in the graph there have in informing the
2 amount of growth which gets added to health's budget from
3 one budgetary period to the next?
4
5 MR D'AMATO: Look, I think it informs the conversation in
6 regards to what is to be dropped off, as in what are the
7 ceasing programs that we need to consider with treasury,
8 whether there is a reason to extend those programs or just
9 cease them.
10
11 MR MUSTON: The grey column, the last one in that group of
12 three above 2012/2013, that is the actual growth rate?
13
14 MR D'AMATO: Yes, that's right. Once we finalise our
15 budget papers, in the budget papers we would include what
16 we call a projection, because by the time we prepare the
17 budget papers we wouldn't have a final June result, let
18 alone audited results, so we use that to determine then
19 against the previous year, what has actually been the
20 movement at that point in time.
21
22 MR MUSTON: Just in relation to that year - we will deal
23 with that one, 2012/13 - the fact that actual growth was,
24 as it turns out, about half of the underlying growth
25 predicted, didn't mean that that health did not spend the
26 money that it had been allocated through that budgetary
27 process?
28
29 MR D'AMATO: No.
30
31 MR MUSTON: Does that effectively mean that that
32 2.5-ish per cent to 3 per cent worth of growth which was
33 predicted but not experienced, the money that had been
34 allocated to that prediction was used to stretch into the
35 delivery of other services throughout health?
36
37 MR D'AMATO: It also means that there could have been some
38 carry-forwards as a result of some of the policies might
39 have been delayed in the implementation, we would have an
40 agreement with treasury to move the money into other years
41 and - or otherwise also means the previous year, we might
42 have exceeded our projection and therefore, the actual
43 growth would have been lower, which is the case for the
44 particular year. And I also need to state that that year,
45 that's where we'd just started the NHRA implementation, we
46 were just fresh out of area health services into LHDs, so
47 it was a fairly complex year, so I think --

1
2 MR MUSTON: Not a good example to have chosen.
3
4 MR D'AMATO: I was going to go there but --
5
6 MR MUSTON: Let's pick on a different one. Is the reality
7 that at least up until 2019/2020, with the exception of
8 that difficult year, the actual growth has been very close
9 to, if not ever so slightly exceeding, the underlying
10 growth rate that had been predicted by treasury?
11
12 MR D'AMATO: Yes.
13
14 MR MUSTON: I haven't run a calculator across it but it
15 looks like the underlying growth rate across that period,
16 2013/14 through to 2019/20, is in the order of 5 per cent?
17
18 MR D'AMATO: That's correct. I think that's probably part
19 of the treasury policy, they set this long-term average,
20 and the view has been to lower this to what they call
21 a more sustainable rate, which is probably more applicable
22 or maybe more achievable in an environment where some of
23 the economic conditions are stable.
24
25 MR MUSTON: Probably not entirely coincidentally, if one
26 looks from 2013 through to, say, 2020, 2021 even, the
27 actual growth that was experienced looks like it also
28 hovers at around, if you were to identify it as an average,
29 perhaps the 5 per cent mark?
30
31 MR D'AMATO: Yes, that's right.
32
33 MR MUSTON: Obviously the grey box we see there is the
34 period that was affected by COVID where things were
35 abnormal --
36
37 MR D'AMATO: Absolutely.
38
39 MR MUSTON: -- in many respects. No doubt nowhere more
40 acutely, I suspect, than in your field of endeavour.
41
42 Can I ask a few questions about that. In 2020/2021,
43 the underlying growth is pitched at 4.4 per cent. Is that
44 because at the time that prediction was being made, COVID
45 hadn't really arrived yet?
46
47 MR D'AMATO: Yes. Absolutely. But reflecting on the


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1 headline growth, the headline growth would be impacted by
2 time limited funding, and throughout COVID there has been
3 all time limited funding in regards to whether it was the
4 PPE investment, whether it was around masks or other types
5 of expenses that we had to account for, which we didn't
6 really know how long for and the quantum. So there was
7 a one-off amount.
8
9 MR MUSTON: Again, let's make sure I've understood that.
10 2020/21 you have 4.4 per cent underlying growth rate, which
11 is what treasury had, no doubt a year before COVID ever
12 arrived, modelled?
13
14 MR D'AMATO: That's correct, yes.
15
16 MR MUSTON: You have your actual growth, which despite the
17 pandemic - perhaps it related to it in some ways - was just
18 a touch over that 4.4 per cent, so that was the actual
19 experienced growth during that period; is that right?
20
21 MR D'AMATO: Yes, that's correct. Perhaps it's useful to
22 consider that the headline growth had included additional
23 inventory stock, like the PPE that we purchased.
24
25 MR MUSTON: I'll come back to the headline growth, I'm
26 just interested in the actual growth. To what extent was
27 the actual growth in 2020/21 impacted by the fact that
28 a lot of activity was not able to be delivered during that
29 period?
30
31 MR D'AMATO: Let me just rephrase this way. In respect to
32 the actual growth, we need to take into account that the
33 headline growth also included one-off payments for masks.
34 The masks were not necessarily all utilised in that year,
35 and therefore weren't expensed, and therefore the growth is
36 not necessarily reflecting the additional money, one-off,
37 we received to purchase PPE, which was back then I think
38 around 800 million. Part of this was issued in the
39 following years.
40
41 MR MUSTON: If I have understood what you've said
42 correctly, the headline growth figure there is so much
43 larger than in previous years because there was a large
44 amount of purchasing of PPE --
45
46 MR D'AMATO: That's correct, yes.
47

1 MR MUSTON: -- and other perceived essential needs for
2 dealing with COVID, it was not anticipated that they would
3 all be used in that budgetary window?
4
5 MR D'AMATO: That's right.
6
7 MR MUSTON: Instead you probably bought enough masks to
8 last you for five years. So whilst the headline growth was
9 quite high, when it actually comes to counting each of
10 those masks as part of your actual growth, from a budgeting
11 point of view, you spread them over the five years; is that
12 right?
13
14 MR D'AMATO: That's right, yes.
15
16 MR MUSTON: 2021/22, things got shifted the other way.
17 You actually did have, again, the same prediction in terms
18 of underlying growth rate of 4.2. Can I just ask you
19 a question about that: was there an adjustment to the
20 base?
21
22 MR D'AMATO: Yes, there was, a 4.2 was on top of the base,
23 yes.
24
25 MR MUSTON: So did the base change radically as a result
26 of the pandemic?
27
28 MR D'AMATO: I must admit that those years the base has
29 been - there has been significant noise in the base, for
30 two reasons. One is that if you were to consider the
31 activity performed, we actually weren't performing
32 the targets. So that's where the Commonwealth then
33 introduced what they call a funding guarantee, so we'll
34 receive a set amount independent of the activity we
35 delivered, which was --
36
37 MR MUSTON: Coming back to my earlier question, people
38 weren't actually able to attend hospital and have their
39 elective surgery, for example, so the activity that would
40 have been generated by that surgery was not happening?
41
42 MR D'AMATO: Mmm-hmm
43
44 MR MUSTON: In turn there was, in effect, an under - the
45 ABF model at least, produced less revenue than would
46 ordinarily have occurred?
47

1 MR D'AMATO: That's correct. We produced effectively less
2 outputs and for the pure ABF environment it wasn't really
3 working, also because effectively we were also producing
4 for each individual unit of activity at a higher cost
5 because there was a lot of fixed cost to be absorbed in
6 addition to additional costs that we had to introduce for
7 PPE and the like, they weren't really adding much to the
8 productivity.
9
10 MR MUSTON: Coming back to 2021/22, we have about
11 4.2 per cent of growth on what was a noisy but nevertheless
12 relatively stable base.
13
14 MR D'AMATO: Yes.
15
16 MR MUSTON: You then have actual growth which is extremely
17 large, 14 per cent. What is that attributable to?
18
19 MR D'AMATO: That particular year there were two factors
20 that impacted the exponential growth. The main one was
21 that we had to go to cabinet for additional funding
22 in-year, outside the budget cycle. So we received an
23 uplift in the budget to purchase additional RAT kits and
24 other expenses that we incurred that we didn't forecast at
25 the beginning of the cycle.
26
27 MR MUSTON: So that activity was essentially a purchasing
28 activity?
29
30 MR D'AMATO: It was RAT kits, so additional tests,
31 additional PCR tests, there was the establishment of some
32 of the vaccination centres that at the start of the
33 financial year we weren't, let's say, a hundred per cent
34 sure how much it was going to cost, how long it was going
35 to take, let alone all the challenges we experienced. So
36 we went back to treasury and cabinet seeking an additional
37 increase in our expense limit as a result of it.
38
39 MR MUSTON: But this is 2021/22. You don't need to go
40 back to treasury to get your actual growth, do you?
41
42 MR D'AMATO: I needed more money for RAT kits.
43
44 MR MUSTON: So your actual growth exceeded the underlying
45 growth rate that treasury had identified by so much that
46 you needed to go back to treasury to get more funds to
47 cover your actual growth during that period?

1
2 MR D'AMATO: Yes, that's correct.
3
4 MR MUSTON: 2022/23, we then have an underlying growth
5 rate of 10 per cent. So that is your baseline, no doubt
6 ever-increasing baseline, but that's your baseline. Then
7 you have a very significant increase, as I understand the
8 graph, on that baseline funding. So is that, in a sense,
9 10 per cent growth funding which has been added to your
10 base in 2022/23?
11
12 MR D'AMATO: That's correct, mmm-hmm.
13
14 MR MUSTON: What did that relate to?
15
16 MR D'AMATO: So the budget papers for 2022/23 list
17 a number of initiatives. The government initiatives that
18 were funded through that program. That is when we also
19 funded the Brighter Beginnings, for instance. In that
20 particular year, that was around 34 million on recurrent
21 expenses for Brighter Beginnings.
22
23 Then there were a number of other initiatives in
24 regards to boosting the regional workforce, so you might
25 have heard that they introduced an incentive payment for
26 incentivising the workforce in the regions, there was
27 funding that particular year, and that included 210 million
28 only for one year, and 883 over the four years.
29
30 There were a number of initiatives to open new
31 hospitals in that year that were funded. There was an
32 additional investment in IPTAAS, the patient travel and
33 accommodation, of 34.3 million in that year. So this is
34 what is included in the 10 per cent.
35
36 MR MUSTON: To what extent has that 10 per cent impacted
37 on the base and the underlying growth going forward, say,
38 for the next five or six years.
39
40 MR D'AMATO: Some of this was what they called "brought
41 forward growth".
42
43 MR MUSTON: We might need you to explain that for the
44 non-economists in the room.
45
46 MR D'AMATO: If you look at this chart, on the left you
47 see there it's relatively stable, and you can imagine this


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1 chart continuing on the other side relatively stable, and
2 decisions were made to adjust so that they could accelerate
3 some of the growth and bring forward some of this --
4
5 THE COMMISSIONER: 2022/2023 was an election year. Does
6 that have anything to do with that? (No audible response).
7 I'm not sure whether that was a yes or no. I will decide
8 what the answer is.
9
10 MR MUSTON: I'm not sure.
11
12 MR D'AMATO: There were decisions in regards to where we -
13 and we also were coming out of COVID, so there was, if you
14 want, a need to rebalance some of the workforce and so
15 that's where some of the decisions were made. The
16 government then announced the additional 10,000 workforce
17 FTEs.
18
19 MR MUSTON: Just understanding the concept of this brought
20 forward growth, though, does that mean that the
21 5 per cent-ish average underlying growth that we've seen in
22 the graph to the left of the grey box is not going to
23 continue to the right of the grey box in quite the way that
24 one might anticipate it would?
25
26 MR D'AMATO: I think that's a fair assumption.
27
28 THE COMMISSIONER: You mean it's stolen - "stolen" is
29 probably not the right word - taken from future years?
30
31 MR D'AMATO: It was anticipated, brought forward,
32 accelerated with a view that we would probably be bringing
33 on more workforce now so that in the future year we didn't
34 have to increase as much as we had done each year over the
35 last 10 years, in a normal environment.
36
37 MR MUSTON: But an increased workforce potentially drives
38 more activity?
39
40 MR D'AMATO: That's correct.
41
42 MR MUSTON: The pipeline of 800 beds that you told us
43 about a bit earlier drives an increase in activity?
44
45 MR D'AMATO: Yes.
46
47 MR MUSTON: And an increase in activity - again, correct

1 me if my economics is wrong - drives an increase in growth,
2 doesn't it?
3
4 MR D'AMATO: Yes.
5
6 MR MUSTON: Is it right that this period where the
7 pipeline is producing an increase in growth is actually
8 going to be confronted with an underlying growth rate
9 figure which is lower than the historical growth rate
10 figure?
11
12 MR D'AMATO: That's a good assumption.
13
14 MR MUSTON: So the extent to which growth within health
15 will be funded will decrease?
16
17 MR D'AMATO: Yes, based on assumptions, that is most
18 likely to be the case and that is where we are using the
19 NPP process to address some of these future risks.
20
21 MR MUSTON: I might come to the NPP process in a moment,
22 but to what extent does the combination of a pipeline of
23 increased activity and a reduction in the future growth of
24 the health budget combine to impact on the sustainability
25 of the existing funding of health?
26
27 MR D'AMATO: I think as I mentioned in number 64, we are
28 collaborating with NSW Treasury to identify the mitigation
29 strategies at the moment.
30
31 MR MUSTON: So those mitigation strategies, I think you
32 said a moment ago, include trying to utilise the NPP
33 process?
34
35 MR D'AMATO: That's correct.
36
37 MR MUSTON: Could I ask you a few questions about that.
38 You deal with that at paragraph 53. You've already
39 identified for us what the distinction between the PTA and
40 the NPP is. In terms of the NPP process, how is it that
41 the process which you describe in paragraph 54 works? So
42 we're now coming into this ERC process that you speak of in
43 your report.
44
45 MR D'AMATO: So the process that I have outlined a bit
46 earlier has started, and so this week we're preparing
47 a list of priorities to go to the minister's offices, and

1 at that point the minister will make the priority
2 adjustment and that will flow to the treasurer and --
3
4 MR MUSTON: Can I ask you a question about that just so
5 there is no confusion. Health is compiling a list of its
6 priorities --
7
8 MR D'AMATO: Correct.
9
10 MR MUSTON: -- which is going to be put to the health
11 minister, which in turn will be delivered to the ERC?
12
13 MR D'AMATO: The treasurer.
14
15 MR MUSTON: To treasury.
16
17 MR D'AMATO: The treasurer.
18
19 MR MUSTON: Where you refer in paragraph 54 to "NSW
20 Government priorities and commitments", is that the same
21 priorities as you're talking about now or is that
22 a different category of priorities?
23
24 MR D'AMATO: I'd say that that is an overarching guideline
25 and that is also the guideline that was used in this
26 current year's budget, and the budget papers outline what
27 in health was mapped to, if you want, these priorities, and
28 there were two main priorities, essential services and the
29 cost of living. Ultimately, we tried to map our priority
30 to those government priorities to see if there is an
31 alignment to start with.
32
33 MR MUSTON: Again, to make sure I haven't misunderstood
34 it, the current New South Wales Government priorities that
35 are referred to in paragraph 54 are addressing cost of
36 living challenges and essential work?
37
38 MR D'AMATO: Essential services.
39
40 MR MUSTON: And that's because the government has
41 identified them as key policy priorities?
42
43 MR D'AMATO: That's right.
44
45 MR MUSTON: To the extent that you need to fit the three
46 objectives that we started with into that framework, you
47 need to, in some way, try and characterise them as

1 furthering those priorities; is that right?
2
3 MR D'AMATO: Yes, that's right. I think that perhaps as
4 a good example, this year's overview of the budget papers
5 gives a sense how we map our priorities to the government's
6 priorities. They are here called out - rebuilding
7 essential health services, and they list a number of
8 initiatives the government has invested into. There is
9 also improving access to health services, and that is where
10 they describe investment in other areas, in particular in
11 the capital space. So that's how we work to align to the
12 government's priorities.
13
14 MR MUSTON: Okay. There is a discussion with treasury
15 that happens around an NPP. First thing, NPP is formulated
16 internally by? Health.
17
18 MR D'AMATO: Yes.
19
20 MR MUSTON: It is, as best as possible, aligned to the
21 government's priorities and commitments.
22
23 MR D'AMATO: Correct.
24
25 MR MUSTON: Health itself has its own list of priorities
26 which include the three objectives that we've talked about.
27
28 MR D'AMATO: Yes.
29
30 MR MUSTON: That then goes to the ERC?
31
32 MR D'AMATO: Goes to the minister first.
33
34 MR MUSTON: It goes to the minister. The minister takes
35 it to treasury.
36
37 MR D'AMATO: To treasurer. The treasurer.
38
39 MR MUSTON: Just the treasurer?
40
41 MR D'AMATO: At this stage, yes, this year's process
42 required the minister to write to the treasurer with a list
43 of priorities.
44
45 MR MUSTON: Where do we go from there?
46
47 MR D'AMATO: Then we get feedback from the treasury and at

1 that point we start working on some of the priorities that
2 they have identified to go to the next stage.
3
4 MR MUSTON: So feedback from treasurer and treasury is
5 what? "You need to adjust this to fit the priorities a bit
6 bitter"?
7
8 MR D'AMATO: It could be also costing, maybe, assumptions.
9 Could be, you know, "We don't think that the assumptions
10 you used to cost this particular NPP are right." So at
11 this stage we just go away and we recalculate or retest our
12 assumptions. Sometimes it'd be just difference of opinions
13 in which case we need to resolve where it is that we can,
14 you know, balance the different viewpoints.
15
16 MR MUSTON: So there are essentially two streams of
17 discussion that are happening. There is a discussion
18 happening at perhaps minister to treasurer level about the
19 priorities and commitments and the way in which this NPP
20 aligns with the government's priorities and commitments?
21
22 MR D'AMATO: Yes.
23
24 MR MUSTON: That's one strand of discussion? I think you
25 have to say "Yes", or "No", as the case may be.
26
27 MR D'AMATO: Keep going. I just want to understand
28 where - because ultimately, it's all aligned. We put
29 forward our priorities to the minister, then obviously we
30 sit down with the minister and decide should that be
31 priority number 1, priority number 2. Then, at that point,
32 the minister will send a letter to the treasurer and the
33 treasurer will feed back to the minister, but the treasury
34 will liaise with us in between.
35
36 MR MUSTON: Once this communication between the minister
37 and the treasurer has happened, then a second conversation
38 starts as between yourselves and treasury around perhaps
39 your modelling of the funding requirements associated with
40 that NPP?
41
42 MR D'AMATO: Yes.
43
44 MR MUSTON: Once those two conversations are happening,
45 and let's assume - you reach a point, do you, where the
46 discussions with treasury land on an agreed or at least an
47 "agreed by treasury" figure as to the costings for

1 a policy?
2
3 MR D'AMATO: That's it.
4
5 MR MUSTON: The policy, once it's been costed, goes at
6 that point to the ERC?
7
8 MR D'AMATO: Yes, it will go to stage 2 or progress to
9 what we call stage 2. At that point, for stage 2, we like
10 to have more modelling done so we have more evidence of why
11 the outcomes, the expected objectives, and they will be,
12 most likely than not - I can't anticipate everything will
13 go to ERC, there might be other things that will go in
14 before, priorities, but that is the course of action.
15
16 MR MUSTON: I'll ask about the modelling: is it modelling
17 just the financial implications of the policy or is there
18 modelling around, say, health outcomes implications of the
19 policy?
20
21 MR D'AMATO: There will be both. It will be actually
22 triangulated, not only the outcomes, there will be also the
23 outputs, impact on revenue, potentially, if any. Obviously
24 the costing will be a critical factor, but, you know, this
25 is all taken into account in determining whether it should
26 progress or not and the merit of that particular
27 initiative.
28
29 MR MUSTON: Presumably to the extent that the health
30 outcomes - positive health outcomes hopefully - produce an
31 impact on costing going forward for the delivery of acute
32 health services, for example, that all gets built in to
33 this modelling process that you have described?
34
35 MR D'AMATO: Yes, that's right. Yes. They might ask
36 questions in regards to whether there are offsets as
37 a result of this particular NPP so that they can consider
38 what it means, whether it is taking the activity out of the
39 acute sector into the community. Yes, so all of this is
40 factored in.
41
42 MR MUSTON: To perhaps put an example to it, you have
43 given some evidence already about the community based
44 delivery of care where it falls between the buckets of
45 activity based funding on the one hand and Medicare funded
46 primary care on the other, and then there may be a need -
47 am I right --

1
2 MR D'AMATO: Yes.
3
4 MR MUSTON: -- to put forward an NPP which addresses as
5 a new policy direction the delivery of care in this way to
6 cover a cost where the activity based funding is not
7 available, the Medicare funding obviously is not something
8 that you have access to, so that's - is that the sort of
9 area?
10
11 MR D'AMATO: Yes, that's right. We will create a package
12 that includes obviously a balanced view of where we want to
13 see the performance of the system, you know, in, say, the
14 emergency department, for instance, what might be required
15 then to invest in hospital avoidance programs and create
16 the right balance and improve the access performance.
17
18 MR MUSTON: To the extent that you've told us about some
19 perhaps ad hoc arrangements with the Commonwealth to
20 contribute funding to some of these programs, where they
21 fall between the buckets or maybe start to fall a little
22 bit more on the primary health side of the bucket, is that
23 arrangement with the Commonwealth struck at this point or
24 does it vary?
25
26 MR D'AMATO: Unfortunately it takes a little bit longer
27 than at this point. We will normally flag with the
28 treasury colleagues there might be an opportunity, and then
29 we assess the risk of increasing the revenue with the
30 expected outcome from the Commonwealth. But at this stage
31 we tend to be conservative and suggest that it is
32 documented; there could be an avenue to access additional
33 funding before we increase our revenue.
34
35 MR MUSTON: Next question: so the NPP, once it has gone
36 through this process, it goes to the ERC, the expenditure
37 review committee. Who populates that committee? Who are
38 the members?
39
40 MR D'AMATO: So the Premier, the Treasurer, the Minister
41 for Finance and Deputy Premier. I can't remember all of
42 the membership, so I might have to get back to you.
43
44 MR MUSTON: I think for present purposes, am I right in
45 interpreting from your answer that it's members of cabinet
46 who are on the committee; it's not a group of --
47

1 MR D'AMATO: Experts.
2
3 MR MUSTON: -- experts in particular areas?
4
5 MS WILLCOX: Officials from the relevant agencies would
6 also be in attendance.
7
8 MR MUSTON: So in the medical space, it's not a group of
9 clinicians and researchers, would perhaps be a fairer way
10 of putting it.
11
12 So in making decisions about the merits of pursuing
13 a health based NPP which has been put forward to that
14 committee, other than to the extent that they are being
15 informed by ministerial briefings and the underlying
16 information that accompanies that proposal, it's not
17 a specialist group with expertise in that area who's making
18 decisions about whether or not to pursue it?
19
20 MS WILLCOX: It is our job to draft these proposals in a
21 way that is able to explain with an evidence base what the
22 service delivery impact will be for the community to enable
23 our ministers and executive of government to make an
24 informed decision.
25
26 MR D'AMATO: I think the evidence that we provide is
27 probably the most critical step, and that's why they create
28 this two-step approach that allows us to focus our effort
29 to provide and prepare the evidence, the business case at
30 times, for those policy proposals that have been identified
31 to go to a next stage.
32
33 MR MUSTON: In paragraph 56 you tell us about the timing
34 of these decisions. So I guess to bring us up to 56, if an
35 NPP meets the approval of the ERC, then that becomes an
36 additional component which is added to the health budget,
37 when the budget is announced. If, between budgetary
38 periods, changes are made which require further funding,
39 you need to go back to government, to treasury --
40
41 MR D'AMATO: Mmm-hmm.
42
43 MR MUSTON: -- in the way you have described in
44 paragraph 56. Is it common that that has to happen?
45
46 MR D'AMATO: Look, in my experience it's probably more
47 related to very unusual circumstance. It could be flood,

1 it could be bushfires, it could be COVID. These are the
2 items that we would take outside the budget cycle because
3 they are outside our control and would really be difficult
4 to project. But particularly because they have
5 a significant impact on our budget, it has to be resolved
6 at that level.
7
8 MR MUSTON: What about as between the ministry and the
9 LHD? So the LHD gets its budget as part of the service
10 agreement. To the extent that there are changes in the
11 experience on the ground of the LHD, to what extent do
12 those changes get recognised in further funding to the
13 extent it's needed? Start with big issues like COVID and
14 floods and bushfires. I assume that's in much the same
15 way?
16
17 MR D'AMATO: Yes, it's very similar, in that what we would
18 do was hold a pool, a central pool. In that case, if it
19 was like COVID, we would have received additional funding
20 from the government. We hold that pool centrally and then,
21 on a monthly basis, we provide additional funding to
22 districts. As I say, that is one of the reasons why the
23 budget supplementation has been an issue over the last two
24 years.
25
26 The reason why we have done that, as I mentioned
27 before, one was because it was very difficult to project
28 where the needs were, and so we were able to stretch, if
29 you want, an envelope that was set by the government as far
30 as we could.
31
32 The other part is that we also needed evidence to
33 provide to the Commonwealth, because there was an NPA on
34 the response to COVID, where the Commonwealth provided
35 50 per cent of certain costs incurred as a result of the
36 response, but we needed the evidence, we needed the
37 invoices, we needed to provide the extra evidence to the
38 Commonwealth that we actually incurred the expense as
39 a result of COVID. So we established the monthly process.
40
41 MR MUSTON: At the LHD level, to the extent that
42 a particular service, perhaps which might not be within the
43 planning or the budgeting of the LHD, for example, keeping
44 a facility open overnight, or something along those lines,
45 is forced upon the LHD by higher powers - perhaps I should
46 be a little bit less coy.
47

1 It has been your experience, no doubt, that there are
2 times when community and political forces drive change
3 within the health system which might not be the change that
4 the LHDs would themselves have made?
5
6 MS WILLCOX: I think yes, it does occur from time to time.
7 I think the views of the community and what they believe is
8 right for their local health service is a legitimate
9 request. But sometimes, it may be a little out of kilter
10 with what an LHD might think is an appropriate service
11 model. There may be financial constraint, as you have
12 alluded to, or maybe that the model that was in place is no
13 longer a safe model.
14
15 For instance, if we talk about maternity services and
16 the number of births reducing in a small regional hospital,
17 there may be a quality and safety issue there where
18 a decision is made but the community will still, rightly,
19 hold the view that they would like to see their maternity
20 services maintained.
21
22 These are the sorts of dilemmas and issues that
23 a local health district chief executive will work with
24 community to attempt to resolve, and occasionally they will
25 require an ongoing commitment for funding that perhaps
26 wasn't factored in. That will frequently lead to
27 a discussion with the CFO to see what sort of support we
28 can be provided or how anything else could be realigned to
29 preserve the service.
30
31 MR MUSTON: That really does get to the crux of my
32 question: first of all, I understood your evidence very
33 clearly yesterday that the need to have regard to the
34 community's needs and desires is critically important in
35 delivering a service like health to the community.
36
37 MS WILLCOX: Yes.
38
39 MR MUSTON: As a result, bringing the community along and
40 clinicians along with you in implementing change is going
41 to be critically important.
42
43 MS WILLCOX: Yes.
44
45 MR MUSTON: To the extent that that has not been possible
46 and a situation emerges where, for example, an emergency
47 department is required to be kept open where the LHD


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1 believed it was not viable to do so, there is a process, is
2 there, whereby further funding is available to the LHD
3 through the ministry to reflect that?
4
5 MS WILLCOX: It would be a negotiation with the ministry.
6 It would require the LHD to put forward a proposal with the
7 costings the workforce required and any other
8 infrastructure needs for something to be commenced or
9 maintained, and then a negotiation with our finance
10 colleagues to work through what, if any, additional funding
11 would be available and how we were going to imagine it.
12 I mean, ultimately if government makes a decision for
13 something to continue, it's our job to work through that in
14 the best way possible to deliver that commitment.
15
16 MR MUSTON: Can I ask you then about election commitments
17 which you refer to at paragraph 62. Would it be right to
18 assume that the election commitments tend to be large
19 expenses?
20
21 MS WILLCOX: There would be a blend. Yes, sometimes they
22 are small commitments to a particular community or group or
23 a particular program, and some are on a significant scale.
24 So there's a variety, I'd say, in range.
25
26 MR MUSTON: So to use the example we gave a moment ago, at
27 the smaller end of the scale it might be a commitment to
28 keep an emergency department open in a small rural
29 hospital?
30
31 MS WILLCOX: Or a commitment for a piece of equipment, may
32 be another example.
33
34 MR MUSTON: At the larger end of the spectrum, it might be
35 a promise to build a new hospital?
36
37 MS WILLCOX: Yes.
38
39 MR MUSTON: Or upgrade all or some part of an existing
40 hospital?
41
42 MS WILLCOX: Yes.
43
44 MR D'AMATO: Or add additional workforce in regions.
45
46 MR MUSTON: Can I ask in relation to those sorts of
47 commitments, first, is there consultation with health about

1 whether or not the commitment aligns with what health sees
2 to be key objectives in delivering health services to the
3 community in New South Wales?
4
5 MS WILLCOX: The principle there is that we would remain
6 at arm's length to those decisions. They would be for the
7 current government or the party out of office aiming to be
8 in government to make those determinations and we would
9 keep at arm's length from those sorts of commitments.
10
11 MR MUSTON: In terms of, just going back to our three
12 objectives that we started with, for example, the way in
13 which that works is there's no discussion with health
14 around whether or not, for example, those sorts of
15 objectives would be best advanced by building the new
16 hospital on the hill that you referred to a bit earlier?
17
18 MS WILLCOX: A group in opposition, we definitely would
19 not be able to provide information other than what's
20 publicly available, and presuming they were getting
21 information from community members and other relevant
22 stakeholders to inform whatever commitments they ultimately
23 determine.
24
25 An incumbent government approaching election would
26 obviously have greater access and understanding of the
27 policy positions and priorities of the ministry, have
28 access to information and briefing material as part of the
29 normal machinery of government. But we would still not
30 have a direct involvement in terms of determining what
31 those commitments are.
32
33 MR MUSTON: Now in terms of the costs associated with
34 those commitments - let's take the example, Mr D'Amato,
35 that you gave towards the end, increasing workforce, for
36 example - am I right in assuming that if the maker of that
37 commitment was elected to government, the additional cost
38 associated with the workforce which is retained is then
39 added to the budget?
40
41 MR D'AMATO: Yes.
42
43 MR MUSTON: The equivalent of an NPP or sits in the same
44 place as an NPP on top of the existing growth figure?
45
46 MR D'AMATO: Yes, look, that's correct. I think we need
47 to take into account that the costings are coordinated by

1 the Parliamentary Budget Office, so it is independent to
2 us. They do liaise with us but it doesn't mean they have
3 to follow our costings, and at times the assumptions vary.
4 But yes, all things being equal, once an election
5 commitment has been costed, then, you know, the
6 determination is made in regards to the costing, that will
7 come with additional funding, noting that as part of the
8 PBO costing there is also costing for savings.
9
10 MR MUSTON: So am I right in understanding your evidence:
11 a commitment is made, the costing of that commitment -
12 let's take the example of the additional workforce --
13
14 MR D'AMATO: Mmm-hmm.
15
16 MR MUSTON: -- is assessed by the PBO?
17
18 MR D'AMATO: The PBO, yes.
19
20 MR MUSTON: Perhaps having sought some input from you?
21
22 MR D'AMATO: Yes.
23
24 MR MUSTON: Would it be right to say that they would
25 ordinarily seek input from you in relation to those
26 costings?
27
28 MR D'AMATO: They normally do, yes, but it doesn't mean
29 that they will follow our assumptions.
30
31 MR MUSTON: So the ultimate figure which is applied to the
32 health budget by reference to that commitment, if it is
33 enacted, is the figure that the PBO has settled upon?
34
35 MR D'AMATO: That's correct.
36
37 MR MUSTON: And that is sometimes different to the figure
38 that you have settled upon?
39
40 MR D'AMATO: Yes, there are discrepancies.
41
42 MR MUSTON: Using the additional workforce example,
43 workforce is workforce and the award is the award, so the
44 difference might not be significant; would that be right?
45
46 MR D'AMATO: There might be assumptions in regards to
47 savings as a result of having additional workforce in

1 regards to reduction of overtime and shifts and the like,
2 that they now experience are not necessarily easy to
3 achieve, but they, according to the assumptions then
4 applied by the PBO, were taken into account in the final
5 costing.
6
7 MR MUSTON: Can I ask this question: has the PBO ever
8 identified a costing which was higher than your anticipated
9 costing?
10
11 MR D'AMATO: I guess I've only been involved in two
12 elections so I can't really comment on the history of the
13 PBO, but there is a report publicly available that
14 considers all the feedback from the different portfolios on
15 the quality of the PBO costing. And at times the PBO also
16 costs items where they deem they can be absorbed by the
17 portfolios, and that was one of the comments that all our
18 portfolios made in regards to some of these assumptions -
19 they could perhaps be tested before being just locked in.
20
21 MR MUSTON: We've thought about the workforce one. In
22 terms of the infrastructure commitments, so building a new
23 hospital or upgrading an existing department in a hospital,
24 the same process applies, I assume: there are some
25 predictions made by the PBO about the costs associated with
26 that project?
27
28 MR D'AMATO: Yes.
29
30 MR MUSTON: That is added in the first part, at least, to
31 the infrastructure budget?
32
33 MR D'AMATO: That's correct.
34
35 MR MUSTON: When we're dealing with that, that's an
36 assessment being made of what it is actually going to cost
37 to build the hospital or to upgrade the facility. And
38 again, there's discussion with your infrastructure
39 colleagues about what the anticipated cost of the build
40 will be?
41
42 MR D'AMATO: Yes.
43
44 MR MUSTON: And ultimately the PBO arrives at a figure?
45
46 MR D'AMATO: That's correct.
47

1 MR MUSTON: That figure is what goes on to the
2 infrastructure side of the health budget?
3
4 MR D'AMATO: That's correct.
5
6 MR MUSTON: Is there any consideration given as part of
7 that process to the operational costs of the new build?
8
9 MR D'AMATO: Not outside of depreciation. So most times,
10 they probably take into account the depreciation impact
11 over the forward and the planning years, in that once the
12 asset is completed, we will start depreciating the asset
13 and that is the only recurrent, if you want, expense
14 consideration.
15
16 MR MUSTON: Would I be right to assume that a new hospital
17 requires staff?
18
19 MR D'AMATO: Absolutely, yes. That's a good assumption.
20
21 MR MUSTON: And electricity?
22
23 MR D'AMATO: Yes, cleaning.
24
25 MR MUSTON: Various other expenses associated with
26 operating a new hospital.
27
28 MR D'AMATO: Yes.
29
30 MR MUSTON: Those expenses presumably continue after the
31 hospital has been built?
32
33 MR D'AMATO: That's correct.
34
35 MR MUSTON: They probably start when the hospital is
36 built.
37
38 MR D'AMATO: Yes.
39
40 MR MUSTON: Are those sorts of costs built in to this PBO
41 process?
42
43 MR D'AMATO: No.
44
45 MR MUSTON: Do those costs get added to the health budget
46 as a result of the implementation of this commitment?
47

1 MR D'AMATO: So far in my experience, what we've seen,
2 that normally doesn't get added to be absorbed within the
3 percentage growth to the underlying base and that's it.
4
5 MR MUSTON: To the extent that one is up and operating
6 a hospital that's generating further activity, then it, in
7 that respect, has a capacity to drive some further growth
8 and some further funding through the ABF system?
9
10 MR D'AMATO: Yes, through the Commonwealth, the
11 45 per cent, that's correct.
12
13 MR MUSTON: But before that happens, there is a period
14 where this expense associated with operating the new
15 facility is not being contributed as an increase in the
16 health budget; is that right?
17
18 MR D'AMATO: Yes, that's correct. I think it's fair to
19 note that, in our experience, when we open a new facility,
20 we tend to see a period where the facility is not
21 necessarily operating at the most efficient level, not at
22 the optimal level, as things need to settle down.
23 Sometimes it takes even one and a half or two years until
24 we operate to the optimum level as some of the referral
25 pathways need to be re-established and, you know, new
26 processes need to be implemented and the like.
27
28 MR MUSTON: We've raised this in the context of election
29 commitments, but how does that work in the context of other
30 new builds which might be announced throughout a period of
31 government?
32
33 MR D'AMATO: So at the moment the processes have been
34 disconnected in that there has been a process in regards -
35 I'm talking in the past - applying for capital funding,
36 which was running in parallel to our normal recurrent
37 funding approach. And maybe it was possible because we
38 were talking about relatively small capital investments -
39 you know, if I think about 2017/18, we were thinking about
40 a capital budget of 1.5 billion; we're talking about
41 3.3 billion at the moment. So that kind of exacerbated the
42 risk or the opportunity for us to have a lead within an
43 envelope and open new facilities because, all of a sudden,
44 we have 800 beds to open, not just one or two facilities.
45
46 MR MUSTON: To the extent a commitment is made throughout
47 a term of government to open or to build or upgrade

1 a hospital, is the situation the same as you have described
2 through this NPP process?
3
4 MR D'AMATO: Yes.
5
6 MR MUSTON: In that there is consideration given - in
7 forward planning - to the capital cost of the build?
8
9 MR D'AMATO: Yes.
10
11 MR MUSTON: But the actual cost of operating that facility
12 is not something which is taken into account as part of the
13 budget envelope or funding envelope that is notionally
14 being made available to health?
15
16 MR D'AMATO: That's correct.
17
18 MR MUSTON: So that additional cost needs to be found
19 where?
20
21 MR D'AMATO: Yes, so at the moment, these additional costs
22 will have to be factored in as an NPP.
23
24 MR MUSTON: And if it's not picked up as an NPP how is it
25 dealt with by health?
26
27 MR D'AMATO: There would have to be re-prioritising
28 initiatives from the base, that would be one option;
29 obviously efficiencies would be another option; or
30 increasing revenue to the extent we can offset these
31 additional costs. These are things that we take into
32 account when we estimate the overall impact of opening new
33 facilities. But the reality is that the cost, because of
34 the nature of the new builds, tends to be much higher than
35 what we would expect from ABF anyway to start with.
36
37 MR MUSTON: I think you've mentioned the pipeline of 800
38 beds. What actually is in the pipeline at the moment in
39 terms of new infrastructure?
40
41 MR D'AMATO: At the moment, in 2025/26, we expect to
42 complete a number of hospitals, and probably the large one
43 expected to be completed by then will be the John Hunter
44 precinct. There's the two kids' hospitals redevelopment
45 and the Nepean Hospital stage 3, I think. St George,
46 Eurobodalla will be another one, Manning hospital. These
47 are the hospitals we're looking at, at the moment. This is

1 only the 2025/26. Then there are others.
2
3 MR MUSTON: So are there others beyond that?
4
5 MR D'AMATO: Yes.
6
7 MR MUSTON: How many".
8
9 MR D'AMATO: I don't have the full list with me but in
10 2026/27, we have estimated that - again, this is provided
11 everything goes according to plan because these facilities
12 could be slowed down as a result of, you know, conditions -
13 things outside our control. But in 2026/27 we're looking
14 at an additional 336 beds, then in 2027/28, 273 beds, and
15 these are only the inpatient beds. Then there's obviously
16 additional capacity for procedure rooms, there would be
17 emergency treatment bays, these are added to those
18 inpatient beds.
19
20 MR MUSTON: You mentioned a moment ago that the way in
21 which the cost of operating those hospitals is brought into
22 the health budget is through the NPP process?
23
24 MR D'AMATO: Yes, they will have to, because at the
25 moment, I don't see how we can absorb the costs of this
26 additional infrastructure pipeline.
27
28 MR MUSTON: So without approval of these NPP policy
29 proposals to fund the operation of these hospitals, what is
30 your view as to the viability of the system?
31
32 MR D'AMATO: Well, at the moment I can say in the next
33 couple of years there will be a significant risk if we
34 didn't resolve this problem. As I say, we're always
35 looking for opportunities to become more efficient,
36 particularly when it comes to corporate services, and we've
37 embarked, as you noted in our submission, on a number of
38 reform processes to further streamline the corporate
39 service, back office and back of house.
40
41 MR MUSTON: Can I ask you very quickly about those reform
42 processes. That's what you tell us about at paragraph 116
43 and following. Can I ask first at a high level, in
44 relation to those processes and proposals, is it your view
45 that the efficiencies that might be gained there are
46 sufficient to meet this pipeline of expense which will come
47 through with the introduction of these new infrastructure

1 projects, with the completion of these new infrastructure
2 projects?
3
4 MR D'AMATO: No, I think this is what we are currently
5 committed to mitigate some of the risks on our current
6 projections over the forwards. But those that we just
7 discussed in regards to the new capital, or the opening of
8 the new builds, are currently, in my opinion, unmitigated.
9
10 MR MUSTON: Can I take you quickly to paragraph 120. You
11 have identified there for us a list of government-wide
12 savings initiatives. I just want to ask you about a few of
13 them. The first is - can I ask you - "labour
14 hire/contractors". We've heard quite a bit about the use
15 of locums, agency nurses and the VMO workforce as part of
16 the wider health system. Are government-wide savings
17 initiatives addressing labour hire and contractors
18 impacting that in any way?
19
20 MR D'AMATO: These are initiatives we have documented in
21 the PBO costing as well, as I mentioned before, and in that
22 particular instance, they made an assumption that
23 50 per cent of our costs in respect to labour hire and
24 contractors was for frontline staff, therefore there was
25 a discount applied.
26
27 Similarly, there was a discount applied to travel as
28 a result of some of the travel --
29
30 MR MUSTON: Can I ask quickly about the labour hire, the
31 discount that was applied, do we take it that that means a
32 government-wide initiative for savings in the area of
33 labour hire and contracting, at least from health's
34 perspective, excludes its current spend on frontline
35 workforce.
36
37 MR D'AMATO: Frontline, that's right.
38
39 MR MUSTON: So nurses and doctors?
40
41 MR D'AMATO: That's right. That's really targeting more
42 the corporate side.
43
44 MR MUSTON: I think you were about to tell us something
45 about travel. There is a statewide initiative, I gather,
46 to try to reduce the amount of travel expense incurred by a
47 state government.

1
2 MR D'AMATO: Yes.
3
4 MR MUSTON: How is that impacting on health?
5
6 MR D'AMATO: Yes, so this is another item that we
7 negotiated to adjust the baseline that they used to
8 apply a discount. Just to give you an example, all other
9 initiatives have had a target of around 30 per cent
10 reduction, that was the savings target - so in advertising,
11 consultants, external legal, whereas for travel that target
12 was 9 per cent as a result of it. Because we assessed that
13 some of the travel was related to the clinicians travelling
14 as part of their work conditions.
15
16 MR MUSTON: So, for example, staff specialist in a metro
17 hospital might be travelling out to a rural and regional
18 hospital once a week or once a fortnight to deliver
19 services in that area, and you've managed to have cordoned
20 out or quarantined from the travel savings the cost of
21 flying a staff specialist out there to deliver that
22 service?
23
24 MR D'AMATO: In the first instance we negotiated an
25 adjustment as a result of the awards conditions for our
26 staff specialists. Their awards conditions include
27 a component for travel as a result of their regular
28 education and travel and special leave. So that was
29 acknowledged by treasury. However, we are currently
30 estimating the impact on the clinical travel that you
31 described, where clinicians have to travel from a metro
32 area to another area or vice versa to run clinics as
33 a result of our arrangements within the networks, if you
34 want. So that's another area we're targeting. We
35 certainly would not expect to reduce the travel in that
36 particular cohort and that's why we are gathering the
37 evidence to make sure that we can quarantine that.
38
39 MR MUSTON: Can I ask you about the first on the list,
40 "advertising". What areas does health advertise in?
41 I assume you don't put ads in the paper saying, "If you're
42 feeling sick, come to my hospital".
43
44 MR D'AMATO: It's fair to say that the majority of our
45 advertisement spend is related to campaigns for health
46 promotion or screening or preventative care.
47

1 MR MUSTON: What are examples?
2
3 MR D'AMATO: Tobacco --
4
5 MS WILLCOX: The Cancer Institute would do some protection
6 for skin cancer, as an example, tobacco, drug and alcohol.
7
8 MR MUSTON: BreastScreen?
9
10 MS WILLCOX: BreastScreen, yes, it's big.
11
12 MR D'AMATO: In fact the biggest spend in advertising
13 terms it is the Cancer Institute.
14
15 MR MUSTON: So the biggest cost centre for advertising
16 spending within health is the Cancer Institute?
17
18 MR D'AMATO: That's correct, yes. Then the other part we
19 spend advertising money on is advertising for jobs, nurses,
20 doctors and the like. So again, we will try to quarantine
21 that amount too. At the moment, the advertising budget has
22 been cut by 30 per cent based on the assumptions from the
23 PBO during the whole of government savings approach.
24
25 MR MUSTON: So where does that cut happen within health -
26 you mean 30 per cent has come out of the advertising
27 budget?
28
29 MR D'AMATO: We've made a commitment, and obviously we
30 work with our internal stakeholders and we try our best to
31 make sure that we prioritise accordingly, and we've set
32 aside an amount for Cancer Institute, so there is a good
33 baseline, and we are also incorporating in any new policy
34 proposal the cost of advertisement that might need to be
35 added to what we set aside.
36
37 MR MUSTON: For example, the Cancer Institute's
38 advertising budget as a result of the implementation of the
39 government-wide initiative to reduce spend on advertising,
40 has it been reduced?
41
42 MR D'AMATO: It has been reduced, yes. Not as much as
43 30 per cent but it has been reduced.
44
45 MR MUSTON: That spend, I gather, based on what you told
46 us a moment ago, was being wholly directed towards
47 preventative health care?

1
2 MR D'AMATO: Yes, that's correct. And we did raise that
3 as a risk that was noted by treasury when they settled on
4 these targets.
5
6 MR MUSTON: Has there been any reduction in the
7 expenditure on advertising for --
8
9 THE COMMISSIONER: Sorry, it was noted by treasury when
10 they settled on the targets. Is that what you said?
11
12 MR D'AMATO: Yes, that's correct. So when we --
13
14 THE COMMISSIONER: What does "noted" mean?
15
16 MR D'AMATO: Yes, noted. Noted that we had raised and we
17 disagreed with the target, because of the specific nature
18 of the advertisement spending in that portfolio, which is
19 all related to, as I say, the majority to preventative
20 care.
21
22 THE COMMISSIONER: It doesn't seem entirely consistent
23 with the intergenerational report that says health is the
24 biggest cost we have and it increases the most, so we've
25 got to get involved in prevention, and most of this
26 advertising is directed to prevention and then it is cut.
27
28 MR D'AMATO: Yes.
29
30 THE COMMISSIONER: I'm just talking out loud here. You
31 don't have to agree with that.
32
33 MR MUSTON: Did you want to say something, Ms Willcox?
34
35 MS WILLCOX: Look, I think --
36
37 THE COMMISSIONER: It just seems strange. Maybe there is
38 a really good explanation for it. Perhaps someone from
39 treasury will be able to give it to us.
40
41 MS WILLCOX: We'll leave it there in that case.
42
43 MR MUSTON: In terms of the advertising spend on
44 recruitment, did that need to be or was that cut as well?
45
46 MR D'AMATO: We had to obviously review every single spend
47 on the advertisements we prioritise, and the two prioritise

1 were, first of all, the preventative advertisements, so we
2 set an amount aside for that, and the other one was the
3 recruitment,, everything else had to be looked very hard in
4 determining where we could identify additional - or
5 alternative solutions.
6
7 MR MUSTON: But back to the recruitment component of the
8 advertising spend, was it also cut as a result of the
9 implementation of this policy by treasury?
10
11 MR D'AMATO: What we did, we basically forecast an amount
12 that we needed in this current environment for recruitment
13 and we set that aside. So we did a bit of a bottom-up, you
14 know, both of them, we determined what Cancer Institute
15 needed as the minimal amount, determined what would have
16 been the minimal amount for advertisement and then we said
17 "Okay, everything else needs to be reconsidered."
18
19 And obviously I think that my approach is that I'm
20 looking at these items at the aggregate. So where I can
21 actually achieve the further savings, say, perhaps in
22 other - I don't want to call anyone in particular, but say
23 the consultants, for instance, then I can offset, you know,
24 the overspend in other items. That's how I interpreted it
25 because I believe that the advertisement for us is an
26 important strategy and we shouldn't necessarily just stop
27 everything.
28
29 MR MUSTON: So in terms of the way in which you've sought
30 to implement this, whilst there has been a cut in
31 advertising, you've sought to minimise the extent of that
32 cut by taking the view that achieving savings in (b), (c),
33 (d), (e) and (f) --
34
35 MR D'AMATO: That's right.
36
37 MR MUSTON: -- on that list, so long as globally, you get
38 savings, then you are faithfully complying with the policy
39 as you understand it?
40
41 MR D'AMATO: That's my approach, yes.
42
43 MR MUSTON: To what extent is your view or your approach
44 on that able to overbear the views of treasury?
45
46 MR D'AMATO: Look, I don't think that I'm the only one in
47 this situation across the sector. We talk, you know, with

1 other CFOs and they have similar challenges, but we
2 certainly try our best to make sure that the aggregate, we
3 can achieve the savings targets from whole of government
4 savings. I don't think that we - I can't speak for
5 treasury, but I think it is a fair position to identify
6 where are our priorities, and I can tell you that there
7 is a - that's why I wanted to mention the treasury noted
8 risks, because at that point we flagged there was going to
9 be a risk. Similar with the legal costs, we flagged it's
10 going to be a risk in regards to the expected target.
11
12 MS WILLCOX: If I could just say, I think just a pragmatic
13 result to this would not - I could not imagine the
14 government would be looking for us to cut campaigns around
15 skin cancer and BreastScreen and the like, so the approach
16 that Mr D'Amato was taking to look at an in globo budget
17 sort of response to this, we have to make our contribution
18 to the request from government and we will do that in a
19 risk approach, and try and identify those things we think
20 will have the least impact on our services and the
21 community. That's why I think Mr D'Amato has explained
22 bundling it all up and then targeting those areas where we
23 can make our contribution.
24
25 THE COMMISSIONER: But advertising for prevention should
26 be increased, shouldn't it, arguably?
27
28 MS WILLCOX: Arguably, it could.
29
30 MR MUSTON: That was all I had to ask these witnesses,
31 Commissioner, if you had any other questions?
32
33 Thank you very much.
34
35 THE COMMISSIONER: I will just check with Mr Cheney. Do
36 you have anything?
37
38 MR CHENEY: No, thank you.
39
40 MS WILLCOX: I don't wish to extend the time, but if
41 I might just very briefly, just go back to the discussion
42 around the capital planning and the forward pressure on the
43 budget, in no way do I disagree with Mr D'Amato about the
44 risks and the pressure that it is imposing on us, but there
45 are two things I would say. The process of once a capital
46 build has been identified and funding allocated is
47 a clinical service planning process that a local health

1 district would go through to identify what services they
2 would want in that new build, and that would inform the
3 construction of the building. As part of that, we would
4 take into account things like virtual care, increasing
5 community-based care. There may be differences in
6 procedure rooms for day surgery versus 10 large operating
7 theatres that all look the same.
8
9 So as we iterate in this process, we try to look for
10 what are, you know, good and contemporaneous models of
11 care that are efficient, that we believe meet the needs of
12 the community, so it's not always a like for like, just
13 bigger.
14
15 But one of the things we are working on at the moment,
16 because this is a forward risk for us, is how we can work
17 more closely with our local health districts and community
18 to get these choices and options around what sort of health
19 care they want, before we start laying bricks and mortar on
20 the ground to see if we can fashion a new way of providing
21 health care.
22
23 I just wanted to make the point it's on our radar. We
24 are doing some forward work and there are some iterative
25 steps before we land in a position with a building to turn
26 the lights on and have to go to government for more money,
27 and there are always staging options as well.
28
29 MR MUSTON: That's an important point. A commitment is
30 made by government to build a new hospital or to replace an
31 existing hospital. Am I right in understanding that once
32 that commitment is made, decision-making around exactly
33 what that hospital might look like and how it will be
34 configured is something which is sent off to Health
35 Infrastructure?
36
37 MS WILLCOX: And the local health district in the main
38 with the support of Health Infrastructure. In the main,
39 local health districts will already have a plan for their
40 district in terms of their service configuration,
41 networking, et cetera, but once you have a commitment to
42 build something, then the very detailed planning goes on in
43 terms of what you actually are going to need in that
44 hospital. Where does it interact with, where does it
45 network with? What's your population needs? What sorts of
46 things - as I say, you may not necessarily build exactly
47 the same. You might be looking at something hopefully a

1 little bit more future facing. Again, that is quite
2 a lengthy process inviting community, staff, working with
3 Health Infrastructure and the local health district and
4 hospital teams to develop that clinical plan completely.
5
6 MR MUSTON: That planning process would take into account,
7 for example, these three key objectives that we discussed
8 at the very outset?
9
10 MS WILLCOX: Definitely. The priorities around hospital
11 avoidance, people getting their care in the right place -
12 as we pointed out in the submission, it's increasing in the
13 community. So these are all the dimensions that would be
14 taken into account as we plan for what needs to go within
15 the four walls of the hospital. That's not to say pressure
16 doesn't come to bear, because, you know, community and
17 clinicians, earlier we talked about expectation. But
18 that's part of the process.
19
20 MR MUSTON: In terms of bringing the community and
21 clinicians along with you, in terms of building what might
22 be the best facility to further those three key objectives,
23 amongst others, how does that process work? You mentioned
24 the involvement in the LHD.
25
26 MS WILLCOX: Yes. There's quite a well-worn governance
27 arrangement for when you are working with your staff and
28 the community around what you're going to build. There
29 will be craft groups that come together to talk about the
30 particular things in their discipline - for instance,
31 emergency department or critical care, and start with the
32 basis of from first principles, what is it you would want,
33 and then from that, drill down into the detail as to what
34 that would actually look like when the builders come in to
35 do it.
36
37 We usually - we always have, I should say, not
38 "usually", community groups. We would have, if it's an
39 area where there is a large particular culturally diverse
40 group, we would make sure they were involved in how they
41 want their care delivered, our Aboriginal communities. So
42 it's about identifying local need, thinking about
43 contemporary models of care, drawing on the resources from
44 Agency for Clinical Innovation and other parts of the
45 ministry to help formulate options and choices for
46 community that then will inform the construction. And yes,
47 some of the new builds are very large, but it doesn't

1 necessarily mean, whilst there's always a recurrent cost,
2 that they may not be more efficient models of care that
3 have been designed into the build that in the longer term
4 hopefully give you a more sustainable way to deliver those
5 services.
6
7 MR MUSTON: But the fact is, whilst there may be savings
8 generated through the longer term, there is still --
9
10 MS WILLCOX: An upfront cost, yes.
11
12 MR MUSTON: An upfront cost of operating a hospital, which
13 if I have understood Mr D'Amato's evidence correctly, is
14 not currently built in - it doesn't automatically get added
15 to a health budget because a new infrastructure build has
16 been added to the infrastructure side of the ledger.
17
18 MS WILLCOX: Yes, that's correct. That's the negotiation
19 and the technical discussion that needs to occur.
20
21 MR MUSTON: Thank you. Thank you very much.
22
23 MS WILLCOX: Thank you for allowing me to add that.
24 Thank you.
25
26 THE COMMISSIONER: Thank you both very much for your time
27 in relation to the report and the evidence you have given.
28 It is greatly appreciated.
29
30 We will adjourn until 19 February 2024.
31
32 **AT 3.38PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
33 **TO 19 FEBRUARY 2024**
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