Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Monday, 18 November 2024 at 2.00pm

(Day 061)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Hilbert Chiu SC with Ms Joanna Davidson for NSW Health
Mr Tim Jap for NSW Treasury

THE COMMISSIONER: Good afternoon.

MR MUSTON: Good afternoon.

This afternoon, Commissioner we have a panel comprising Louis Kastoun and Julian Cornelius of NSW Treasury, and Alfa D'Amato from the ministry. They are sitting in front of you in that order, your left to right.

<LOUIS KASTOUN, sworn: [2.01pm]

<JULIAN CORNELIUS, affirmed:

<ALFA D'AMATO, sworn:

THE COMMISSIONER: Mr Chiu, you are here for health?

MR CHIU: I am, with Ms Davidson, thank you.

MR MUSTON: I should probably allow the representative from NSW Treasury to announce their appearance.

MR JAP: My name is Tim Jap, Commissioner, for NSW Treasury.

THE COMMISSIONER: Thank you. Leave is granted for you to appear.

MR JAP: Thank you.

<EXAMINATION BY MR MUSTON:

MR MUSTON: We'll go through each of you respectively

Mr Kastoun, could you state your full name for the record, please.

MR KASTOUN: Louis Kastoun.

MR MUSTON: And what's your role within the NSW Treasury?

MR KASTOUN: Executive director of the health and stronger communities division. It's part of the policy group - budget policy and budget group within NSW Treasury.

MR MUSTON: You have co-authored with Mr Cornelius a submission which is undated, but it was received,

I think, on 11 November, responding to issues paper 3 of 2024.

MR KASTOUN: Indeed I have.

MR MUSTON: That, Commissioner, is exhibit M1, which is [TRY.0001.0001.0001].

THE COMMISSIONER: Thank you, I have that.

MR MUSTON: Insofar as you are aware, the contents of that submission are, to the best of your knowledge, true and correct?

MR KASTOUN: It is.

MR MUSTON: Mr Cornelius, could you state your full name for the record, please?

MR CORNELIUS: Julian Cornelius.

MR MUSTON: And could you tell us what your role within NSW Treasury is?

MR CORNELIUS: I'm the director of the health team in the policy and budget group.

MR MUSTON: You, as mentioned earlier, were one of the co-authors of the treasury submission received on 11 November?

MR CORNELIUS: That's correct.

MR MUSTON: And to the best of your knowledge, its contents are true and correct?

MR CORNELIUS: That's correct.

MR MUSTON: In due course, that will be tendered as part of the bulk tender, Commissioner.

Mr D'Amato, could you remind us of your full name?

MR D'AMATO: Sure. Alfaister Davis D'Amato, or Alfa D'Amato, and I'm the deputy secretary, CFO, NSW Health.

MR MUSTON: You have prepared or previously participated

in a joint statement dated 27 November 2023 with Ms Willcox?

MR D'AMATO: That's correct.

MR MUSTON: Which, Commissioner, I think you'll find at [MOH.9999.0005.0001].

You have also, I think, prepared a statement dated 4 April 2024?

MR D'AMATO: That's correct.

MR MUSTON: Which, Commissioner, is [MOH.9999.0763.0001].

You have now participated in the preparation of a joint statement with Mr Carr and Mr Onley?

MR D'AMATO: That's correct.

MR MUSTON: I will ask you this question about that statement.

MR D'AMATO: Sure.

MR MUSTON: To the best of your knowledge, are the contents of that most recent statement true and correct?

MR D'AMATO: Yes.

MR MUSTON: That statement, Commissioner, is exhibit M6, which you will find at [MOH.0011.0091.0001].

Now, in the evidence that Mr D'Amato gave us in November of last year, he walked us through the health budget setting process from the ministry's perspective.

I might ask from a treasury perspective if either of you representatives of NSW Treasury could walk us through in a narrative way the way in which the health budget is set from treasury's perspective, perhaps starting the day after a budget's been delivered and working up on the point where the next budget is delivered.

MR CORNELIUS: I'm happy to take that one. So after a budget is set for the year ahead, we'll have - that budget year will be established and then the forward

estimates will also have an estimate of health's budget for the next - for the next 10 years. That will be set in our forward estimates.

During the course of the year, we have a - the budget process tends to take the same shape and form most years. It can move around a little bit, depending on whether it's an election year, and other variables might change it a little bit, but normally we have a regular cycle. It involves a budget submission being received around February and March of the year before the budget.

During the course of that --

MR MUSTON: Just pausing there, the budget submission that's received in February or March, what's the general nature of the information that's contained in that document?

MR CORNELIUS: So that will typically include some analysis from health around system performance, around risks and pressures, and around new policy measures. And so when we receive that submission, we prepare advice for government, and we'll typically consider what we think is the base funding requirement for the year ahead, looking at emerging cost pressures and other risks that might have come up and be included in that submission.

MR MUSTON: So let me just take it back a few steps. System performance information that is contained in the budget submission, what sort of metrics are you looking at there?

MR CORNELIUS: It might depend a little bit around what parts of the system may be under pressure or may be relevant to the budget submissions that have been received.

For example, in the submission that we've lodged, we provide an example around planned surgeries, and certainly for that measure, the evidence that was presented referenced how the planned surgery performance had been going and the impact of the pandemic on that.

MR MUSTON: Dealing with that one, the performance metric that you had regard to or were provided with for the purpose of considering whether or not to increase funding for the purpose of ploughing through some further elective

surgery post COVID was, in essence, the wait list as it existed at the time that the submission was made.

MR CORNELIUS: Yes, that's correct, so depending on the nature of the proposal we'll have different data points. I think most relevant are the dataset that the Bureau of Health Information publishes on a quarterly basis that would provide insights into emergency department performance, planned surgeries and other parts of the services.

MR MUSTON: Just pausing there, that information where you referred to emergency department performance, that's waiting times in emergency?

MR CORNELIUS: Correct.

MR MUSTON: And insofar as elective surgery is concerned, again, waiting times for elective surgery?

MR CORNELIUS: Yes.

MR MUSTON: The sorts of things that are easily measurable and are routinely published by the Bureau of Health Information.

MR CORNELIUS: Correct.

MR MUSTON: Coming back to where that fits in to the budget process, you mentioned the example you give of the increased funding to - I think it has been described as getting over the hump of post-COVID elective surgery. You have also referred to the base funding. Was it contemplated that there would be some increase to the standard base as a result of the process you have gone through there or was that rather a policy proposal for some short-term funding to enable this hump of unmet elective surgery to be dealt with?

MR CORNELIUS: Yes, that's the latter. For that particular proposal, it was time-limited funding.

MR MUSTON: But can I come back to the base, starting with the base. Perhaps just tell us, in words that the non-economists amongst us will understand, what the base comprises.

MR CORNELIUS: Effectively the base is the full recurrent budget for health, which is, I think, around 33 billion or so, and then the escalation factor that is applied forms the base in forward years.

MR MUSTON: So the base comprises an operational budget on the one hand; is that correct?

MR CORNELIUS: That's correct.

MR MUSTON: And then a separate capital budget on the other?

MR CORNELIUS: That's correct.

MR MUSTON: How do those two sit together and how do they work?

MR CORNELIUS: The capital budget again is budgeted on the sum of individual projects that are approved, and there is also a provision in health's forward estimates as well for future works.

MR MUSTON: So let's stick with the operational component of the budget for present purposes. How is the operational base calculated? How has the figure been arrived at?

MR CORNELIUS: Well, I think that just reflects the history of incremental budgeting over time.

MR MUSTON: You might not know, it might be such a piece of ancient history, but do any of you have any understanding of where, in history or how historically the figure was originally arrived at?

MR CORNELIUS: I don't.

MR KASTOUN: Before my time as well.

MR MUSTON: Would it be an assumption that, at some point in history, a decision was made by persons unknown that an amount of money was the amount that it cost to deliver the public health system at that point in time, and that's then grown incrementally or organically since?

MR CORNELIUS: Yes, I think that's a fair statement.

MR MUSTON: And I don't say this critically of anyone, but would it be right that the assumption one makes is that that base is an adequate amount to deliver the public health system, save any adjustments or the like that are required, or remains an adequate amount to deliver the public health system?

MR CORNELIUS: I think the amount of growth in any budget year is dynamic and can change based on the circumstances. So while you're correct to point out that the base is there as it has been and it has evolved over time, the amount of incremental funding that's provided in any budget can change depending on the circumstances of the day.

MR MUSTON: Perhaps I didn't put my question as clearly as I could have. As part of the assessment of the base year to year, or as part of the growth, assessment of growth, is any calculation or quantification made of the cost of delivering the public health system, the actual cost?

MR CORNELIUS: I'm not sure I'm not following the question.

MR D'AMATO: In terms of cost, we determine actually, on a yearly basis, actually every six months, the unit cost of delivering services in the activity based funding model, and that actually is used to inform the state price. So we are confident that then we know the cost. Obviously it's all driven by the demand as well and what we can, within the budget, afford to deliver. So in terms of costs, I'm confident that we certainly know where the costs are and how we calculate that.

MR MUSTON: I'll come back to my question. So we start with the base figure, which has, since it was arrived at at some point in the past, been allowed to grow through the application of a growth factor year on year. How is that arrived at?

MR KASTOUN: Just for clarification, as well as that growth factor, incremental decisions by government to also increase for other purposes.

MR MUSTON: So in terms of the decisions to increase for other purposes, how do they fit into the equation? Are they the NPPs that we've heard some evidence about?

MR KASTOUN: Correct, yes. So new policy proposals, as well, as I guess, the initial starting point with an assumed sort of baseline growth, as part of each budget cycle, there is an assessment of the adequacy of that funding and that takes into consideration the capacity of the baseline funding to address growth requirements, cost escalation issues and, in addition to that, the ministry, the minister, would also provide proposals that relate to new initiatives, basically, proposals to either expand existing service delivery or, indeed, completely new initial initiatives.

MR MUSTON: Just so we can put it into some context, do you have examples? Could you give us some examples of the sorts of new initiatives historically that have been the subject of NPPs or this incremental growth?

MR KASTOUN: Yes, I think this year's budget, '24/25 included a package to enhance the operation of emergency departments, for example.

MR CORNELIUS: That's correct.

MR MUSTON: Just in very broad terms, what did that involve?

MR KASTOUN: In terms of?

MR MUSTON: What was the package to enhance emergency departments? Enhance in what respect?

MR KASTOUN: So basically, to increase the capacity of the emergency department from the perspective of urgent care, the capacity to enhance discharge capability within the hospital system.

MR D'AMATO: If you want I can provide some more information. The package was worth around 421 million over the forwards and the current and around 6 million in capex. That includes a number of initiatives that will be rolled out throughout the next four years, including single front door, urgent care services, alternate care pathways, health/ambulance metrics and managing the ED demand. There were also some elements in regards to Hospital in the Home, short stay units, discharge concierge, so it was comprehensive, all dedicated to emergency departments.

MR MUSTON: With the ultimate objective being to divert people away from the emergency department where the view was they probably didn't need to be there, they could be treated elsewhere?

MR D'AMATO: Yes, that's correct.

MR MUSTON: For example, in an urgent care setting?

MR D'AMATO: Yes.

MR MUSTON: And to the extent that people did arrive in the emergency department and needed to be transitioned through into either an acute setting or discharged quickly, some of these proposals that you've just run through were aimed at creating efficiencies in that process?

MR D'AMATO: That's correct. In regards to efficiencies, access - improving access as well. Obviously the aim of some of these initiatives is to, if you want, avoid, where possible, patients to attend the emergency departments, so looking at low acuity and diverting to other areas of the system and all - like, for instance, urgent care services. But that also means that, effectively, what we have left, we have capacity, with more complex patients which leads us to more cost pressure.

MR MUSTON: In relation to that particular proposal, was any consideration given to the impact or the extent to which a thin or failing primary care market might have been contributing to the increase in presentations in emergency?

MR D'AMATO: It is basically one of the key areas that we've been trying to address, in particular to urgent care services, where at the moment, these are funded by the state and we are not able to claim Commonwealth contribution for some of these centres, and there was a decision made a couple of years ago, so this funding, in effect, is to extend the funding for this initiative for an extra two years.

MR MUSTON: Was consideration given at that time to the possibility of addressing the problem more at its root cause and filling the void created by thin or failing primary care markets?

MR D'AMATO: From my point of view, perhaps, that's

a consideration for the policy area. We certainly find ourselves in making judgment calls in regards to the funding, the costing of the - in particular, what is required to support the policy area, but I can only assume that it was the number one priority. But given that, either because of the lack of the primary health care sector or the lack of availability of GPs, this was the best solution for us in order to also, as I say, achieve other policy objectives, such as access.

MR MUSTON: Can I come back to - I think we were stepping through and I interrupted you, but the base figure, a growth figure and then there's the incremental increases through NPPs. Perhaps talk us through how that growth figure and the NPPs are dealt with throughout the budget process coming back to our narrative walk-through the --

THE COMMISSIONER: Just before you do, this isn't a criticism either, but you started with an exploration or raised the issue of whether the base amount is adequate to deliver the public health system. That begs the question what the public health system is.

MR MUSTON: I was going to come back to that, but I can deal with it now.

THE COMMISSIONER: You are? I will leave it with you.

MR MUSTON: I'm quite happy to deal with it now.

The Commissioner has just raised, as to the adequacy of the base, either now or at any point in the past, to deliver the public health system, it raises a real question about what the public health system comprises; do you agree with that?

MR KASTOUN: Yes.

MR MUSTON: The evidence that we've heard over the past 12 months or so has suggested that health is, in effect, a bottomless bucket, in the sense that you could continue to pour money into it and that, assuming some level of inefficiency which is unavoidable, by and large, that money would be well spent on meeting health needs of people within the community. But a decision has to be made at some point about exactly what the cap on that spending is and at what point do you turn off the tap.

Are those three propositions broadly acceptable to the three of you?

MR KASTOUN: In terms of the cap, I think it's important to recognise a number of dynamics at play. Firstly, the fiscal environment we're in at the moment, and I guess drawing attention to our budget papers. I mean, the budget's been in deficit since 2019 - since 2019/20, and for this year, it's a budgeted deficit of 3.6 billion and, at the moment, forecast to continue with the deficit to '27/28, albeit reducing.

Secondly, the tension around gross debt and, you know, at the moment gross debt is forecast to increase to around 200 million by '27/28. That has consequent implications for interest costs for government, and so one of the sort of fiscal priorities for government is to try and, I guess, bring a responsible approach to spending and to try and stabilise the state's fiscal position, from an operating perspective and also from a debt perspective.

You also have the tension of other competing priorities in other portfolios. So I guess, reflecting on my portfolio responsibilities, for example, you know, government has priorities with regard to out-of-home care, it has priorities with regard to disability, domestic and family violence, social housing and so on, and investment in those areas also has a bearing in terms of the impacts on the health system.

So there is a tension there between, I guess, the competing priorities that exist within health, within other portfolios, but also trying to balance it against the fiscal bottom line.

So ultimately, from a treasury perspective, with the advice that we have, the evidence that we receive, we put forward the best advice that we can. You know, I will draw to the point that it is ultimately the decision for government in terms of the level of funding that's provided across portfolios. So our role is to provide advice around the fiscal parameters and to provide advice on the merits of funding proposals that are submitted, not only from health but across multiple portfolios and, ultimately, it is a trade-off conversation for government through the expenditure review committee to determine appropriate

allocations across various portfolios, having regard to its fiscal priorities as well.

MR MUSTON: So the consequence of that is a responsible government that deals with - well, a fiscally responsible government has a confined amount of money that it can use in any given year to deliver on its competing - the competing demands that are placed upon it --

MR KASTOUN: Indeed.

MR MUSTON: -- health, education, housing, no doubt a wide array of others. Decisions have to be made, ultimately, at a political level, informed by treasury and each of the various ministries about how that finite bucket of money is to be divided up between those competing resources.

MR KASTOUN: Correct.

MR MUSTON: Insofar as health is concerned, the practical reality is there's probably not enough money, bearing in mind any reasonable carving up of that money between the various priorities, there's not going to be enough money to deliver everything that everyone wants at any given time. That's a reality. Would that be right?

MR KASTOUN: Ultimately, it is a trade-off - it is a trade-off conversation for government. Yes. There's a finite amount of funding available in any given budget cycle and, you know, it is about prioritising across competing priorities.

MR MUSTON: Maybe I should put it a bit better. As part of that prioritising process, there will inevitably be things that, say, the health ministry or members of the community might want that, as part of the balancing of priorities, are not going to be funded through the health budget in a given year.

MR KASTOUN: I think there's a practical reality to, you know, what government can reasonably fund, yes.

THE COMMISSIONER: There will be margins, though, won't there? The funding will always be there, I assume, for acute services to make sure that, for example, planned surgery takes place within a clinically appropriate time, so that would be a clear goal of health?

MR KASTOUN: Yes.

THE COMMISSIONER: So the money will be there for that; it will be in other things like community health, prevention, et cetera, where there's possibly a bigger debate about how much money is made available for what than in the provision of acute care services in our public hospitals; would that be right?

MR KASTOUN: So look, from a treasury perspective, I guess our key focus each budget cycle when we receive new policy proposals is to, I guess, consider those proposals that are basically the category of urgent unavoidable or address immediate risks, and that is to ensure that core service delivery can continue. And then that's not to say that we don't actively consider and provide advice on the merits of other proposals, you know, relating to, I guess, new models of care, for example, you know, new initiatives and so on and so forth.

MR MUSTON: Coming back to the base, though, and this question of what is to be delivered as part of the public health system, we've got the urgent care that someone might need, if they have had an accident or they have some part of their body fail, if they turn up at hospital and need to have, say, their appendix removed - we'd gather that that's probably largely non-negotiable in the health space. If you walk into a hospital and you need to have something done urgently, you will either have it done there or be transferred to a hospital where it can be done and receive that lifesaving treatment.

MR KASTOUN: You'd certainly hope so, yes.

MR MUSTON: That's those core urgent or acute aspects of it, but then as to what sits around that in terms of those non-urgent acute forms of care, as part of treasury's function, does it have visibility of what's on the table and what's off the table at any given year as part of the public health system, and in determining whether or not the base is adequate?

MR KASTOUN: Yes, would you like to answer that, Mr Cornelius?

MR CORNELIUS: I think it's fair to say we don't have the

same level of visibility around community care as we do for what's in scope for activity based funding. So, you know, I think the system could benefit from a bit more structure and clarity around the scope of services that are provided in the community, because we don't have as much visibility on that as we do for other parts of the system.

MR D'AMATO: Look, I think that certainly, you know, the data that we provide treasury is not at the kind of level the same way we manage the system, but I do think that in regards to the base we also need to acknowledge that we're still stepping out of COVID and perhaps it's a bit difficult to identify what is the right base in this environment where there is relatively still a bit of volatility.

But during COVID, it's fair to say that the budget, you know, we had to flex in regards to the envelope, the growth, because we had to respond to anything. Now, we are - as we're stepping out, we are trying to identify what is the base, the proper base. I also reflect before COVID, we experienced a relatively stable environment economically, fiscally, and we were able to optimise efficiencies, and the way we funded the hospitals through ABF was working well, back then, in a stable environment. Now, I don't think we have a stable environment yet, and that's probably the difficulty, in my opinion, to set the base.

MR MUSTON: It's probably more a matter for tomorrow and Thursday, but at a ministry level, what level of visibility does ministry have of the particular array of services that are being offered as part of the public health system in each of the LHDs?

MR D'AMATO: Look, we obviously collect all the data, so we have visibility across the sector in respect to whether there are in-scope services or out of scope services, so I would say that we have visibility across all system.

MR MUSTON: When you say "in scope or out of scope", are you referring to within the ABF?

MR D'AMATO: I was referring more in terms of what the Commonwealth would contribute towards, or not. Apologies, there. It's just some of my terminology.

MR MUSTON: That's okay. So "in scope" are services for which the Commonwealth is making a contribution of some sort either through ABF or via another grant or funding stream?

MR D'AMATO: Yes.

MR MUSTON: "Out of scope" are services, when you refer to them, which are being funded wholly by the state?

MR D'AMATO: That's correct.

MR MUSTON: So you have oversight or some visibility of in scope and out of scope services. Even amongst those services, though, do you have a sense of what the patchwork of services that are being delivered to a community actually looks like?

MR D'AMATO: Yes, yes.

MR MUSTON: In what way?

MR D'AMATO: Either through the activity that we deliver or some of the, if you want, even NGO grants that we pay to community organisations to deliver services on our behalf. And also I think it's important to note that when we choose to engage with some of these third parties, we do it because there's a benefit overall to the system in that ultimately, in many cases, they provide services that either would be too costly for us to be investing in and deliver, or they provide the community type of services that actually allow us to discharge patients earlier than otherwise.

MR MUSTON: In terms of the activity, what does the data that you have available to you about activity within the LHDs actually tell you about what's happening on the ground in the LHDs?

MR D'AMATO: Okay, well, the activity section is not under my division, however, it's fair to say that, through a costing exercise that we conduct every six months, we actually trace every single patient in that we actual calculate the cost of every single encounter from the moment that they arrive to our emergency department, throughout the emergency department, when they move into acute settings, when they actually discharge, and wherever

there is special level data that we can link, we can trace the cost and we can actually trace the patients for the purpose of planning and the purpose of clinical, if you like, information.

MR MUSTON: Just one last question about the base funding. In terms of discussions and treasury's consideration of the adequacy of the base funding and the extent to which it requires adjustment, is there a discussion that happens between the treasury and the ministry along the lines of, "Here are the services that we think we can provide within the budgetary envelope we've got and provide well; here are services which we think the community needs, but we're not currently able to provide them and they are lower priorities to those that we are providing within the budgetary envelope. If you want us to provide those additional services you have to - you'll have to increase our funding?" Is that a discussion that happens as part of the budget process?

MR CORNELIUS: Yes.

MR MUSTON: How does that discussion work into the assessment of the adequacy of the base?

MR CORNELIUS: So the budget submission is prepared by the minister and so there is a prioritisation process before that submission comes to treasury. So there may be discussions internally around some of those service issues you've mentioned. There'll be a prioritisation process internally and then the submission will come to us and we'll provide advice to government around our assessment of those proposals.

MR MUSTON: And so again, these are the NPPs that we're talking about or is this part of an assessment of the adequacy of the base itself?

MR CORNELIUS: The two things happen in parallel, effectively, yes.

MR MUSTON: Maybe just explain how that happens in parallel and how it works.

MR CORNELIUS: Typically when we have the budget submission, we will need to provide some advice around what is essentially critical to maintain current service

outcomes, in the first instance. So there might be some technical adjustments, accounting adjustments, other cost variations, and things like that that we feel will need to be funded in order to maintain current service outcomes.

So typically our advice will prioritise those things first; and then we'll turn our mind to the new policy measures or service enhancements, and we'll provide advice around what we think the policy merit of those initiatives are based on the evidence that has been provided and our conversations with the ministry; and then there will be some consideration around, you know, how those proposals link in with government's sort of broader priorities and fiscal capacity as well.

MR MUSTON: I'm just trying to understand at what level this assessment of the adequacy of the base to meet what has been provided is undertaken once it reaches treasury, accepting that, by the time it gets to you, it's no doubt had its origins in an LHD where decisions have been made about what is needed and what can be afforded, that then passes its way up through you ministry and then ultimately to you.

MR CORNELIUS: In terms of the consideration of the adequacy of the base, the performance metrics that we spoke about earlier are pretty integral to that conversation. For instance, we spoke a little bit about the planned surgery performance, and that is a really good leading indicator in terms of how the system is tracking in terms of funding adequacy, from our perspective, because that's one of the few areas where the system does have some levers in terms of managing cost.

So if we're starting to see - you know, outside of the pandemic, which was a bit unusual because they were just paused, but in a normal operating environment, if we start to see some pressure there, that can indicate that the system is under pressure, and, likewise, we'll also look at sort of ambulance and emergency department performance as well, so the indicators of overall system performance.

MR MUSTON: Whilst indicators of system performance, in at least a technical performance sense, they don't necessarily equate with system performance in terms of producing the best health outcomes, do they - that is to say, a patient that turns up in emergency, for example, with a low acuity

need, ideally you would like to get them through as quickly as possible because that will undoubtedly increase the score they give in terms of their patient satisfaction, but in terms of the health outcome, whether they wait one hour, two hours or 12 hours, depending on the level of acuity, might not actually make a difference. Would that be right?

MR CORNELIUS: I think you're right. I think that it's important for us to be looking at the future health strategy, for example, as an indicator of policy that's coming through from the ministry. I think that is a lot about trying to provide the right care at the right place at the right time, the concept of supporting people to stay healthy and the like. So, you know, that alignment with the strategic intent is something that we consider as well when we're assessing the policy proposals that come through.

MR MUSTON: Likewise, the elective surgery waiting list, whilst some indication, there is an assumption built into it that each of the patients require the operation that they have been scheduled to have, if you like?

You have to answer out loud, sorry, so the transcript can catch it.

MR CORNELIUS: Yes, that sounds correct, yes.

MR MUSTON: And a second assumption that they need it within the time frames contemplated or within the time frame contemplated by the guidelines that you work to? That's right?

MR CORNELIUS: Yes, that's correct.

MR MUSTON: And a third assumption, that the outcome of that - of surgery leaves them better off in some material way?

MR CORNELIUS: Yes, agreed.

MR MUSTON: None of those three - the correctness or otherwise of those three assumptions is not something that any of us other than those people's clinicians are really able to make an assessment of. Would that be right?

MR CORNELIUS: Yes, I think that's right. I don't think

it's really for treasury to have a view about, you know, what type of clinical treatment is appropriate. We are certainly interested in the work that the Agency for Clinical Innovation does within health around concepts of low-value care and disinvestment in that, but, you know, that's not something we would form a view on independently to the views of the clinicians who are best placed to provide guidance on that.

THE COMMISSIONER: Can I ask a probably naive and possibly stupid question about what you just raised there, but you're here, so I will ask it anyway. It picks up a bit of the topic where you said you have an interest in talking to the ACI about expenditure in terms of low-value care, as an example.

There's constant papers I have read, or there's constant data about the level of, say, chronic disease in Australia and you can read many papers that suggest that in terms of the growth in the health care spend, if we have an expansion of morbidity, it's more money that we've got to find for health, and if we have a compression of morbidity, hopefully, the growth rate gets contained more sustainably.

Does the ministry and treasury have discussions about investments in, for example, interventions in early paediatric services that might have really long-term benefits if they are successful or other policy proposals that are aimed at compressing that period of morbidity we have for chronic disease? And whilst this is a very long question, do those discussions go as far as modelling or considering not just what that might mean for the growth in the health spend in terms of, hopefully, containing the growth of the cost of the spend, but also what the secondary impacts might be - that is, the secondary benefits - of more economically active people, greater productivity, those sorts of things? Are those discussions had? Any of you can feel free to answer that question, by the way, or all of you can answer it.

MR CORNELIUS: Look, they certainly can be. Through the new policy process, those measures are supported by business cases, and those business cases would cover all of the things you've just spoken about.

THE COMMISSIONER: Right.

MR CORNELIUS: I think, you know, for the last few years we've been managing the pandemic response, so it's been an environment where --

THE COMMISSIONER: That's the priority, yes.

MR CORNELIUS: -- a lot of the funding measures have been focused around that. But I think in our submission we reference the growth of health spending as a share of the total through our intergenerational report and what you've just described is exactly the type of conversations we need to be having about how we prioritise investment so that we can take some pressure off that cost curve and also improve health outcomes for people.

THE COMMISSIONER: And to some extent - tell me if I'm wrong - those discussions have got to involve the Commonwealth as well, don't they? Because part of it will be things that they're in control of, ie, what they say they're in control of, like primary care, for example? Is that fair as well?

MR CORNELIUS: Yes.

THE COMMISSIONER: And cooperating in relation to prevention proposals?

MR CORNELIUS: Yes, I agree.

MR KASTOUN: Yes.

MR CORNELIUS: I agree. And I think part of the engagement with the Commonwealth is also around some of the innovative service models that health has started to roll out, things like remote patient monitoring, virtual care, I think, aren't always easily fitting into the activity based funding model, but they're supporting to help people be cared for outside of hospitals at home, getting better health outcomes more efficiently, so, you know, there does need to be a dialogue with the Commonwealth to start making sure that they're in scope for funding.

MR MUSTON: Just while you raise that, in paragraph 2.40 of your submission, you tell us that treasury does not utilise an activity based funding model for health. Could you just explain what you mean when you say that? I gather you mean you're not essentially dealing with it activity by

activity or NWAU by NWAU; rather, you have a funding envelope and you see ABF as being, in effect, an own source revenue that health brings to the table, but correct me if my understanding is wrong.

MR CORNELIUS: Yes, that's correct. So with the base funding model, as we have described it, it's 4 per cent that's set into the forward estimates, sort of notionally allocated between cost and service growth, 2.5 per cent for cost, 1.5 per cent for service growth, and that service growth has some flexibility around where that's invested. So depending on the amount that might go into prevention, some might go into hospital services that might be in scope for ABF, so that may deliver some activity within that pool. But there's not a predetermined mechanism of how that is allocated.

MR D'AMATO: The only comment I would like to add is that, at the moment, we have reached a Commonwealth cap, 6.5 per cent, so we effectively won't be able to access any additional revenue as yet. This is subject to the new NHRA, which is currently being negotiated.

MR MUSTON: Just coming back, one final question in relation to the base. Treasury's ability to, as it were, pull levers that might have an impact on the health of the population, the shape of the health system, would it be right to say that they really exist at the point at which you come to assess new policy proposals - that is to say, the base is the base; the way in which health chooses to spend that base within the system, subject to efficiencies and short waiting times in emergency and those sorts of things - treasury's ability to say, "I think this money would be better spent on, say, the Commissioner's paediatric care than doing twice as many knee operations as we're currently doing", is something that really lays a bit outside the control, your control?

MR CORNELIUS: Yes, I think that's right. I think from time to time, treasury may do a broader agency review, and in that scenario, there may be part of that work to be a deeper dive around the base expenditure, but we wouldn't do that as part of every budget cycle because, you know, like this process, it's a very comprehensive piece of work.

MR MUSTON: So if it were the position that health had identified what it felt it could reasonably achieve with

the base funding in terms of that patchwork of services that were being provided across the system using its own prioritisation to work out what's above the line, as it were, and what falls below the line, if it wanted to include as part of a service offering things that were currently below the line, for treasury to have a little bit more control over whether or not that did or didn't happen, it would need to be put forward as a new policy proposal?

MR CORNELIUS: That's correct.

MR MUSTON: So if the ministry were, as part of that new policy proposal, instead of saying, "Here is a wonderful idea, if we had" - taking some examples from things we've heard in our travels - "an extra two or three helicopters there would be no black spots across the state in terms of retrieval, so we should, as a policy proposal, get some more helicopters, please" - if it was more, "Here is the patchwork of services we're offering, here is an area of need that we can't currently afford to meet, if you increase our funding, we will be able to", that's the point at which treasury might have a slightly greater visibility but also control over the extent of the size and shape of the public health system?

MR CORNELIUS: We'd definitely have greater visibility and we'd provide advice on it but we wouldn't control it.

MR MUSTON: No, you would be controlling it only to the extent that you would assume that if money was sought for a particular service and that policy proposal was met with a favourable response, that the money would, in fact, be spent on that service?

MR CORNELIUS: Correct, yes.

THE COMMISSIONER: Mr Morgan would be pretty unhappy if he didn't get his three helicopters.

MR MUSTON: I didn't say it was a bad idea, but we have seen a lot of paediatricians who talk about community paediatricians and their value to community, who also have said lots of things to us about their very great value.

I think I have very much diverted. So we've got the base. Then you tell us in your statement about the escalation process. Could you just tell us briefly what

that escalation process involves?

MR CORNELIUS: So over the forward estimates, we have visibility of health's budget for 10 years. When we introduce a new year, we roll it in and that's, effectively, by escalating the tenth year that's there by a set amount. At the moment, that tenth year is escalated at 4 per cent to create a new year in forward estimates, and then, as that year gets closer to becoming the budget year, there may have been policy decisions or changes that have been made over the course of time, but effectively, when we build a new year into the database, it's escalated at that 4 per cent figure.

MR MUSTON: Is that the same thing as the growth figure that we've talked about or is the escalation a different concept to the growth?

MR CORNELIUS: I think the escalation is what is applied, as I say, when this year is rolled in, but the actual growth in a given year may be different. So, for example, I mentioned that we have an assumption in that 4 per cent of 2.57 per cent cost, which is a long-term average, but if we have wages, the government 's wages position is higher, we may adjust that escalation during the course of the budget process as well. Likewise, we might change some of the service components. So the actual growth that goes in in a given year reflects, you know, the range of changes that may have been made over the period of time.

MR MUSTON: So would it be right to say that you've got your base figure, which is historical and has reached the point that it has reached as at today; that base figure then might be adjusted to take into account some non-negotiables, like perhaps an adjustment to a health sector award or something like that, which will, in a way which is going to roll across the system, increase the notional cost of the base, and then on top of that, you have a growth figure, which is the 4 per cent-ish, that gets added to take into account a range of factors like inflation, et cetera? Is that right or have I oversimplified it and got it completely wrong?

MR CORNELIUS: No, I think that's broadly correct. So when we publish the budget papers, we'll reference a headline growth rate and an underlying growth rate. Do you want me to talk a little bit about those?

MR MUSTON; Yes.

MR CORNELIUS: So in the budget papers you'll see a headline growth, which is just literally the movement between the current year projection and the new budget year. Then we have an underlying growth rate, which reflects the movement in ongoing services. So there's a number of things we extract from the headline growth rate. There are some volatile items, for example, or some technical items like depreciation that move up and down a bit, and there may be some other temporary measures. In the case of this budget there were some temporary COVID measures, things like the junior medical officers' settlement that affected one year, a one-off expense, but we remove those items so we get a clearer understanding of what the ongoing movement is in underlying or core expenditure year to year.

MR MUSTON: So that adjusts the base. But then is there an additional growth factor which is applied to that which is this figure that includes things like the, as you have told us about in the submission, cost of operating refurbished or new hospitals and the like?

MR CORNELIUS: Yes. So we start with a growth, as we build a new year into the forward estimates, and then over time, that will - that may move up and down depending on policy measures, and then when we publish the budget, whatever the actual movement is is reflected as the growth rate year on year.

MR MUSTON: You tell us in the submission that health gets the benefit of an additional 1.5 per cent service growth assumption. Could you just explain what that is and how it's been arrived at?

MR CORNELIUS: Yes. So that was a decision of government back in 2019 where the growth rate over the full 10-year planning horizon was set at 4 per cent. The 1.5 per cent was - it's a fairly notional concept. It's slightly higher than population growth. Health would argue that it's not enough to cover the impact of population ageing as well as population growth. It was determined with reference to fiscal capacity at the time. You know, as we've seen through the course of the pandemic, through the budget process, there's an opportunity to assess whether that, you

know, overall growth rate is sufficient, and so while that decision at the time was 4 per cent over that period, since then it's been 6 per cent in practice.

So there is certainly the opportunity to review the appropriateness of that rate each year. And you've mentioned the operating costs of new builds, certainly through the budget process, that's something that health will highlight and will continue to highlight.

I think there's merit in considering an approach where there's - that rate moves a little bit each year, depending on the scale of new facilities that are coming on in any given year. There may be an argument for it not to be a flat 1.5 per cent every year, that it moves around a little bit depending on what is happening in the health system, what's happening with population growth, what's happening with the capital program as well.

MR MUSTON: Can I come back to just those broad concepts of change - population changes and the like. To what extent or in what way is the growth factor that is applied to the base arrived at by reference to, say, increased burden - an identified increased burden of disease within the community, if at all? It might not be, but --

MR CORNELIUS: As I mentioned, that 1.5 per cent was set back in 2019, and it wasn't overly scientific. It was with reference broadly - it had the concept of the population growth and a bit of a concept around demand; certainly we had a conversation with health at the time around what some of those impacts would be, but ultimately, it was considered in the context of what was fiscally affordable at the time. But then there has been opportunity to continue to sort of re-prosecute the appropriateness of that through each budget cycle as well.

MR KASTOUN: Just in terms of the 1.5 per cent, I wanted to clarify that that is recognition that there is a demand component to health expenses going forward. That arrangement is established for health only. So other agencies, to the best of my knowledge, don't have that additional escalation parameter. Generally speaking, other portfolios, other agencies, have, essentially, the cost escalation component only.

MR MUSTON: What about the extent to which the evolving

nature of health care has meant that the costs of delivering health care in 2024 has increased radically, we're told, from the cost of delivering health care in earlier times, perhaps when the base was set, through things like, very large increase in technology, large increases in sub-specialisation, people living longer?

MR CORNELIUS: I think that's why we have seen sort of 6 per cent growth over the last few years and before that 5 per cent or thereabouts, growth for a number of years before that. So the growth that has gone into the system has been significant.

MR MUSTON: How does it take into account, though, things like the increased cost of delivering medicine?

MR CORNELIUS: I think it needs to consider all of the cost impacts. So there's a number of things that are less costly now than they were historically. We've got a number of procedures that are now being done in the same day that used to be done in five days. You know, there's opportunities, if we can get better interfaces with Commonwealth parts of the system, residential aged care and other similar areas, primary care as well, that would potentially take pressure off the system.

So I think one of the challenges in thinking about what an appropriate growth rate is is you've got a lot of moving parts, and that's why we keep coming back to the analysis of the performance metrics, because they are giving us a guide as to how adequately that base is delivering services to the community.

MR MUSTON: Do the performance metrics capture what might be characterised as unmet need within the community, do you think? So that is to say, if there are health needs within the community that are not currently being met by the health system, do you have any metrics that you rely on which assist you to identify what they are and what it might cost to meet them?

MR D'AMATO: It's a bit difficult, but I would argue that our process, where Mr Cornelius described the 4 per cent, is - it is not enhanced, but we have the NPP process, that's where we then submit it and that's what we've done for this financial year; we've submitted, for instance, policy proposals to address the gap, if you want, of

1.5 per cent that has been historically set aside for population and ageing, to meet what is forecast, and that is where we take into account things like unmet needs, the projection on the waiting time, you know, to maintain the current performance.

Similarly, we put a submission in this year for the cost escalation to address the fact, again, we are relatively - in my opinion, the environment is still relatively volatile when it comes to cost escalation and the impact of CPI that we are experiencing.

Similarly again, you know, Mr Cornelius mentioned that we also submitted a proposal for the new builds, to take into account that this year, for instance, we had a major development opening, which was Tweed, which opened late last financial year and now we are seeing the full impact.

We also know when other key capital programs will come on line, so we're monitoring with our colleagues regularly and we update regularly, because we meet every fortnight, and, you know, that's how we address these uncertainties, if you want. But I would tend to think that the 4 per cent is a starting point and then all these complex initiatives or the unmet needs are covered through our submissions in the budget process.

MR MUSTON: How does the ministry or what does the ministry do to seek to quantify unmet need and put it forward as part of a budget proposal?

Let me give an example, just so we can - we're thinking tangibly about it. Unmet need might be - obviously we've already had an example of someone who has their ruptured appendix and they rush into hospital, they need to have that dealt with. Obviously enough, if it's not being dealt with, that's unmet need, but we read about that on the front page of the paper, if that need is not met.

Paediatric service of the type that the Commissioner raised within a slightly more community setting, but delivered through the public health system, there might be an enormous need for early intervention, we're told there is a significant need for early intervention, but as to whether that need is being met or not, it's, on one view of it --

THE COMMISSIONER: We've heard an example of it not being met, we've just heard in terms of the service is there but the wait times are so long that they're clinically significant. That's an example of an unmet need.

MR MUSTON: Yes, and these are not elective surgery wait times, these are wait times to see a publicly funded paediatrician, for example, or receive speech pathology care through a public paediatric multidisciplinary clinic.

But to what extent is unmet need of that type assessed - perhaps start with you, Mr D'Amato - by the ministry?

MR D'AMATO: We would rely on the policy units, if you want, within the ministry, and then through the process that we've built internally, assess and process these NPPs through the, if you want, approval process, and that's how we then prioritise through the minister, we submit it to the ERC. Treasury provide the assessment on these policy proposals and then government makes a decision. But normally there is the policy unit that will bring these items to us.

THE COMMISSIONER: Would that be a new policy, though? It might just be a service that's being delivered but it's funded in a manner that means that the wait times are so long, as I said, to be based on what the clinicians tell us, clinically significant - that is, disadvantageous because the wait times are so long. Do you get that level of detail in relation to what is discussed with you or not?

MR D'AMATO: We do get a fair bit of details and again, the policy proposals that we receive will start from, say, anything that could be even just 2 million or, you know, 50 million or 500 million, like the emergency department package. So we assess accordingly and at times, some of these initiatives then are prioritised internally, even though they might not make the cut to go to treasury and to ERC, and we decide to fund internally, and some of these are relative to safety and quality, which is an important area of our sector.

MR MUSTON: Just on the topic of this unmet need, though, is there not a risk that if an assessment of that unmet need is not being made and factoring in some way into the

growth figure that is applied to the health budget, that the increasing cost of delivering the identified need means that, in effect, the gap between the cost of meeting all of that need out there and the funding envelope continues to grow wider?

MR CORNELIUS: I think the new policy process does provide scope for proposals that are addressing unmet need, and that will involve the ministry doing some work around gaps analysis. We've had proposals around mental health proposals, for example, that have been based around what you've just described, you know, a fairly detailed and comprehensive gaps analysis. So I think in a scenario where - and you talked about paediatric waiting lists, I think once there was sufficient groundswell of support within the ministry, it would go to the policy area and that would be considered through the budget process. So I think there are mechanisms to consider unmet need through the budget process.

MR MUSTON: So that process would be ministry, no doubt informed by the LHDs and the policy unit would decide, "We need additional funding to try and retain more paediatricians and run more community-based paediatric clinics. We've costed what that would look like in terms of an annual cost of delivering the service. We've come up with some economic analysis as to the immense benefits, social benefits, not only to the individuals but to the wider economy of intervening in learning difficulties and the like at that very early stage, and we think it's a proposal that should commend itself to you", treasury would then consider that as part of the NPP process, make recommendations to government so that government can make a choice.

MR CORNELIUS: Yes, if it was included in the budget submission of the agency, we would consider it then.

MR MUSTON: Just in relation to the growth figure, you have identified the standard 4 per cent plus the 1.5 and then told us that the growth that's actually applied from one year to the next does vary from that. How is that variation arrived at? What are the - is it just NPPs or is it something else that goes into the process that leads to it being adjusted?

MR CORNELIUS: Yes, it is normally considered through the

budget process. So as I mentioned, going backwards, since that rate was applied we've actually been averaging 6 per cent and that's largely due to decisions to support the pandemic response, would be the main drivers, but there's been a few other policy decisions in there that have added to the growth as well.

MR MUSTON: Can I come to capital projects. The actual cost of delivering those capital projects you tell us about in the submission, effectively, as having been informed by an assessment made by Health Infrastructure NSW. So just so I can understand the process, a decision is made to possibly refurb a facility or build a new facility somewhere, costing is then derived from Health Infrastructure NSW; is that right, as part of a proposal for the infrastructure project?

MR CORNELIUS: Alfa, do you want to talk to that? I think it can be a bit of an iterative process between the - the scope may be determined before the - in parallel with the budget. So which one comes first, I think is a question probably for the ministry.

MR MUSTON: Well, you tell us how that works.

MR D'AMATO: Okay. I also need to acknowledge that the division that covers the capital planning is not my division, but I'm informed and work with the team in respect to the financials.

So the process normally starts with discussions with the districts to identify their local needs. This is again, similar to the NPP process and similar to unmet needs, if you want, they are prioritised at the ministry level, these are then submitted to the minister and then from there goes to the ERC.

The part that I think we have confidence in now is that there is an assessment at that point when the decision is made around the technical adjustments, being the depreciation of a new asset coming on our books, because we're experiencing significant increases in the depreciation expenses over the last few years. There is an impact on some of our spend metrics.

Then, once that is done, the part that we monitor together is the opening time, the footprint in determining

how many more beds or more services we have, and then we'll use that information to determine whether we need to submit an NPP that requires, if you want, an uplift above the 4 per cent or above the 1.5 per cent set aside to address the new - the operating cost of the new build.

In the past before COVID, we were able to live within our 1.5 per cent because we, effectively, were looking at the one hospital a year and relatively small footprint, whereas now we're seeing - in particular over the forwards, we expect to see significant developments coming online, and that's probably also the result of a few years ago when we accelerated the capital program altogether. So these are some of the concepts.

MR MUSTON: I'll come to the operating expenses in a moment. In terms of the capital expense, we have heard some evidence in our travels of decisions having been made and announced to build a new facility or to fund the upgrade or refurbing of a particular facility, there's a particular figure identified for that work which takes into account an assessment made at some point in the hopefully not too distant past as to what it would cost to deliver on the range of services that it is hoped will be delivered through that facility, but then increasing costs, the build costs, between that date and the date when the official ribbon cutting happens are such that by the time it's actually built and opened, the facility, still built within the budgetary envelope allocated to it, actually delivers a lot less than was originally foreshadowed. Is there some growth factor or some process which is embarked upon to try and keep the original capital figure keeping track with things like inflation, increased cost of construction work, et cetera?

MR CORNELIUS: Yes, it's certainly an issue right across the sector. The increased cost of infrastructure across New South Wales has escalated significantly over recent years.

Ultimately, what we rely on through the budget process is advice around any variations to the existing capital projects. So that could include government making decisions to consider the additional cost to maintain the original scope and how much extra that would cost; and also, you know, what alternatives - what changes to the scope would be required in order to deliver it within the

existing budget, and that'll be put to government to make a decision about.

MR MUSTON: How does that actually happen, though, the putting it to government bit? So let it be assumed that an amount of money has been earmarked for a particular facility based on an assessment made at or shortly before the time of that announcement of what services are required to be delivered through that facility. As we come closer to the actual completion date, or even perhaps the commencement of the build date, we have a process we've been told about, a value management process, where, as the money that you've got buys less and less, you repeatedly trim things out of the project. At what point does that trimming exercise hit government decision-making?

MR CORNELIUS: Yes, so there would be an internal process for the ministry to consider as to whether it wants to escalate something for a government decision. Once that decision is arrived at, then it would typically go through the budget process along with any other budget proposal.

MR MUSTON: Effectively, a capital version of an NPP; would that be right?

MR CORNELIUS: That's correct, yes.

MR MUSTON: So perhaps Mr D'Amato, for you, a question: do you know - and it may not be your area - what the trigger point is for the ministry in terms of raising an NPP once it's realised that the refurbishment of a particular facility or a particular envelope of money marked to build a new hospital is no longer sufficient to meet the perceived needs of the community to be served by it?

MR D'AMATO: I think there are two key drivers, before we go into the particular point. One is the delays. Any delays will take an impact on the cost of delivering and, in particular, because originally they'd planned for a delivery time frame which takes into account cost escalation. Unfortunately, the cost escalation in these last few years probably has gone above and beyond what we forecast it to be, so at times we struggle.

The second part is scope of services. Obviously when we plan at the very beginning of the journey it takes a few

years before getting to the point where we start the consultation, so there might be challenges in regards to the original scope of the facility or the refurbishment, and we also identify opportunities may be presented to the moment when we are refurbishing, say, three-quarters of a building, and we have builders on site, it's probably an opportunity to also finish the full build. So these are some of the considerations.

In terms of the trigger point, obviously there are policies in place that require us to go to treasury when the ETC, or the estimated total cost, is above 10 per cent on the original cost, so that is one.

The second, obviously, is within the overall envelope, because we need to acknowledge that at times there are opportunities to - not prioritise, re-cash-flow, if you want. At times there might be opportunities to take into account the facility is probably able to be completed a little bit earlier versus one that is delayed and so we try to work within what is allocated to us.

If what is allocated to us is not sufficient to cover the new cost estimate, then we go to the ERC, and we did so for this financial year specifically for a number of projects which were at risk, and we acknowledge that, you know, there were a number of factors outside our control.

MR MUSTON: In terms of the cost increase exceeding by 10 per cent as a trigger, that assumes, does it not, that their value management process has been undertaken and, nevertheless, despite that project, there is still a 10 per cent increase - there's no correlation between all of the services that were intended originally to be delivered through the new hospital and the point at which you have to tell treasury that there's been a cost blowout, unless and until, even after a process of value management, you're still more than 10 per cent above the price. Would that be right?

MR D'AMATO: That's right.

MR MUSTON: Can I come, then, to the next aspect of it, which is the operational costs. Mr D'Amato, in your evidence last November, you did express concerns about the extent to which the growth factor applied to health's budget was adequate to meet the increased costs of

delivering care through what I think you told us was 800 additional beds across the system over the short-term future. Is that still an issue or is it an issue that's been raised with treasury?

MR D'AMATO: It is an issue that has been raised. In fact, we submitted a business case in this financial year to make sure there is visibility of the challenge.

I think that the next few years will be particularly challenging in regards to what is due to come on line. Now, whether, as we have seen in the submissions from our colleagues from treasury, at times these timeframes might change, but eventually they have to open and, as I said, within the forwards. So we have two kids hospitals, Randwick and Westmead; John Hunter, and these are all major redevelopments. So I think this is going to be challenging for us to certainly accommodate within our 1.5 per cent.

MR MUSTON: Without needing to get into the minutiae of decisions around that particular issue, just conceptually or mechanically is that again effectively dealt with through the NPP process?

MR CORNELIUS: That's correct, yes, it will come through the budget process, yes.

MR MUSTON: So health would identify an increased cost of doing its day-to-day business attributable to these infrastructure projects which have happened; it would then put forward a policy proposal calling for an increase in its base, referable to the increased cost of delivering health care through the additional beds being brought on line?

MR CORNELIUS: Yes, that's right. It will form part of a broader proposal around sort of population growth requirements, so there will be a component that's related to the new builds and then a component that's related to the general activity growth across the state.

MR MUSTON: You, I think in your submission, have expressed the view that the operating expenses for large hospital projects are generally not added to the expenditure budget when capital projects are improved, but you I think are of the view that the existing growth figure that is applied year on year is adequate to meet those

costs - is that a fair assessment of your view or have I --

MR CORNELIUS: No, I think what we were saying is that those costs are a little unpredictable when the approval for the capital project is first granted. So it's difficult to specify exactly what year those operating costs are going to hit and then how much headroom there may be within the growth rate in that year at the time, and so what we've - how we respond to that is through the annual budget process to go through the arrangement that we just talked about, to have a look at how much growth there is in that year and what new facilities are coming on board and then provide some advice around that.

I think it is fair to acknowledge that the capital program at the moment is at historically very high levels so we've been averaging over 3 billion per annum in capital works for the last few years, which is probably double what the long-term average has been. I think when we first conceptualised the growth rate, I think we had a lower capital program in mind.

So there's definitely some tension in that, as those works start coming on line, that will challenge the 1.5 per cent that's in the growth rate at the moment, but we will consider that through each budget process.

MR MUSTON: We've heard some evidence in our travels about the way in which contemporary hospitals are being built also adding significantly to the costs of running them, even if you don't get any increase in activity or necessarily even a substantial increase in bed numbers in those hospitals, because, for example, a single room is much more labour intensive to monitor than a Nightingale ward that had 12 patients, lined up on either side of the room. That's generally been your experience of the submissions that you've been receiving in relation to this issue?

MR CORNELIUS: Yes, that's correct. Certainly for us, it's important for us to understand how much of the funding ask is relating to that additional cost component versus how much of it's relating to additional capacity, because that informs the relationship between the overall ask for activity growth, but it's an important distinction.

MR MUSTON: Can I quickly ask about whole-of-government

savings programs. We heard some evidence in November last year about the particular savings initiatives which were rolled out across the government, one being travel and another being advertising.

Now, in relation to travel, I understand from that evidence that some particular arrangements have been entered into with health to, as it were, quarantine clinical related travel from the savings initiative that would otherwise have required that travel to be cut, is that right - that is to say, there's been a quarantining of clinical based travel from the savings initiative?

MR CORNELIUS: Yes, that's correct. Our understanding is that it hasn't been government's intention to apply a reduction in clinical travel, and so that's how that saving is being monitored.

MR MUSTON: So whilst one can readily see the virtue of introducing some travel savings initiatives, they would be misplaced if they were applied to, say, metropolitan based specialists in the employ of the public system who were flying out to deliver needed health care to regional and rural communities that didn't have resident specialists?

MR CORNELIUS: Agreed. That's our understanding of the policy intent.

MR MUSTON: In relation to advertising, I think the evidence that we received in November last year was to the effect that the 30 per cent cut required on the advertising spend within health was predominantly affecting preventative health advertising and promotional material, principally within the Cancer Institute. Is that something that was brought to your attention as part of a budget proposal or a budget submission?

MR CORNELIUS: Yes, it was certainly brought to our attention, yes.

MR MUSTON: What was the nature of the discussion around that issue? Let me perhaps take it in two steps. There was no equivalent quarantining, at least as at November last year, of advertising spend within, for example, the Cancer Institute on preventative health promotion?

MR CORNELIUS: My recollection is we were advised of the -

how that saving would be applied and that it would largely impact the Cancer Institute, and we passed that advice on to government, and government - you know, it's a government policy, so --

MR MUSTON: I'm not saying this was your decision, but do you know what government's response to that advice was?

MR CORNELIUS: I probably need to check the record to give the correct advice on that, I think.

MR MUSTON: Do you have a recollection, Mr D'Amato, of what the government's response to that was?

MR D'AMATO: I do actually recall that there was - that the advertisement target had been caught into the component we would normally spend on public health campaigns versus advertising for other - even recruitment, and because this, yes, is involving that, it is correct that there has been confusion. But, ultimately, there was no acknowledgment of the fact that we had a challenge in respect of public health, and we put forward a paper providing evidence that investing in public health campaigns actually has a huge return on investment. So that's where we left that. There was no - I don't recall any response back from government and we're still working within that.

MR MUSTON: Anyway, the role that the three of you have is to provide advice to government so government can make a properly informed decision and, properly informed, they've made a decision and that's what it is?

MR D'AMATO: Yes.

MR MUSTON: You tell us in paragraph 2.38 of your submission that the future adequacy of funding for health is likely to be impacted by Commonwealth funding arrangements and the effectiveness of interfaces with primary care, aged care, disability and mental health services. Could I just invite you to expand a little bit on exactly what you were conveying there?

MR KASTOUN: Yes, I'll take that one.

So in our evidence presented to the Commission we've highlighted a number of limitations with regard to Commonwealth funding. If I may, I would start with regard

to the point around the Commonwealth's contribution rate under the National Health Reform Agreement. So there has been a longstanding ambition under successive NHRA agreements for the Commonwealth to increase its funding share to the states and territories under the NHRA.

As per the evidence we provided, there's been a sort of trajectory towards increasing that over the last decade, but in recent times, that has declined quite considerably. So we were trending towards 39 to 40 per cent; we're now sort of projecting a CCR rate of 38 per cent.

MR MUSTON: Just pausing there, what's the cause of that decline structurally?

MR D'AMATO: There are two key factors impacting the Commonwealth contribution rate. The first is that if we have reached the cap, that means that Commonwealth will keep paying for every single activity but at a lower rate. So they'll still pay for everything but at a lower rate, reduced rate.

Then there is a more technical reason, which is related to what we call "back-casting" of the activity. So in the NHRA there's a process whereby, in order to calculate the growth, they have to apply what they call "back-casting". That particular policy is developed and implemented by IHACPA.

We've raised some concerns now over the years in regards to how that was implemented. In fact, just recently I wrote to the administrator of the health funding body as well to seek further clarification, because we are a little bit concerned that the application of that policy has inadvertently impacted on the Commonwealth contribution rate.

MR MUSTON: But in terms of hitting the 6 per cent, to the extent that that has resulted in a reduction of funding, is that because activity has increased or the cost of delivering that activity has increased in recent times to a greater extent than had historically been the case?

MR D'AMATO: Well, 6.5 per cent is calculated on the total funding, so once we reach that point, the component is - sorry, us breaching the cap is normally a combination of the price, being the national efficient price, increasing

above what we originally expect it to be, or volume. Normally the national efficient price takes a bigger component of the growth rate, so that's where we see the impact there, which is then reflected also in the CPI that we are seeing at the moment.

MR MUSTON: I think I interrupted you, but that's an answer to why the --

MR KASTOUN: Yes, so encouragingly, with the current round of negotiations with the Commonwealth around the next addendum to the NHRA, the Commonwealth has, I think, recognised the importance of increasing its contribution rate. With the parameters being discussed at the moment, that would see the CCR essentially being increased to 45 per cent over a 10-year horizon.

It's encouraging, but I think the point to sort of raise there is that's still at least a decade away to get to that point, and this has been a longstanding ambition. So our view is that, I guess, a more rapid glide path towards 45 per cent would be beneficial and would provide significant funding into the health system, not just ours but nationally in hospital systems nationally.

The second point is in any given day in the hospital system, you have a number of patients that are ready to be discharged from hospital, that are there because there aren't any alternative arrangements through the aged care sector or indeed disability, as well as sort of outcomes for those patients.

Inevitably what that means is it has an impact on efficiency for the hospital system, and the state being the majority funder of essentially the cost of hospital services means that we carry a large disproportionate share of the costs associated with those patients being in the hospital system, when indeed they fall under essentially - well, should be theoretically under a Commonwealth sort of managed facility or funding responsibility, and I think --

MR MUSTON: That's because Commonwealth funding of aged care is delivered through a private market based system. The market currently is not sufficient to meet the demand being placed upon it. To the extent there's a shortfall, it ultimately results in a funding saving by the Commonwealth, but if that shortfall is sitting in a public

hospital in New South Wales, the state is picking it up, subject to an arrangement which exists for the partial funding of those placements.

MR KASTOUN: Yes, that's right. I recognise there are complexities, they are thin markets and so on and so forth, but as my previous point, it does mean that the states are essentially carrying a disproportionate share.

I guess the third dimension is - and I think the Commissioner has sort of looked at this - is with regard to the interface with essentially the primary care sector. Again, any given day, there's quite a number of presentations to the emergency departments which are probably unavoidable in the scheme of things that are probably better served through the primary care network but because of thin markets or market failures, you know, inevitably the only option they have is to essentially attend an ED department.

Again, there is a similar point with aged care. That does represent a disproportionate cost of being shifted to the states and territories.

So when you think about those three factors combined, you know, there is certainly scope to improve the Commonwealth funding dimension across a number of areas, CCR principally, but also through aged care and the primary care network, and those would undoubtedly have a significant impact in terms of alleviating the cost pressures within the health system in New South Wales, and indeed other states and territories.

MR MUSTON: So increasing the funding from the Commonwealth perspective might have the effect of reviving a thin or failed market, potentially, in which case it would have the consequence that you would hope for, namely, better primary care or smooth transition into aged care for these patients who are currently in medical wards?

MR KASTOUN: Correct.

MR MUSTON: An alternative way of dealing with it might be for the state, which is more able to deliver services rather than funding streams, to create the infrastructure, both human and physical, required to deliver some of these services but then tap into the Commonwealth funding streams

with a view to accessing the Commonwealth funding to enable it to do so?

MR KASTOUN: I mean, that is a potential option for government to consider. I mean, there are complexities attached to that as well and, you know, I would defer to ministry colleagues who have probably been looking at the sort of complexities around that.

It certainly is an option for government to consider and it would essentially hinge on the strength of, you know, the business cases that are put forward for government to consider.

I understand, essentially, the costs and benefits in going down that path. It would require, I guess, a firm commitment in alliance with the Commonwealth as well to be able to support such arrangements. So, you know, yes, that option is potentially there for government to consider but it relies on those parameters.

MR MUSTON: Again, probably a matter better for the health ministry to consider, but there may well be some synergies that could be capitalised upon within the acute care setting and both primary care and aged care, to the extent that there was, in the way that we see in the MPS facilities, for example, a leaning in by the state to the delivery of those sorts of care, but your point is it would need to be backed up with an appropriate funding stream from the Commonwealth?

MR KASTOUN: Correct.

MR D'AMATO: Sorry, which includes capital as well.

MR KASTOUN: Yes, indeed.

MR D'AMATO: Only because the current Commonwealth approach really covers only operating, so I think if we were to go into an aged care environment, we really need to think about also the capital investment required of the state, if there was a decision made --

MR MUSTON: You give that answer with respect to aged care. In relation to primary care, there might be a capital consideration, but to some extent, facilities already available to NSW Health in small hospitals and MPS

facilities in small towns might already provide the capital infrastructure; it's the human infrastructure that you need.

MR D'AMATO: I totally agree on that. I'm more concerned about the aged care which is probably the part that requires a significant capital investment consideration.

MR MUSTON: In paragraph 2.45 and following of your statement, you tell us a little bit about the relative efficiency of the New South Wales public hospitals when compared with other jurisdictions, ultimately, concluding that New South Wales operates at very much the more efficient end of the scale.

Two questions about that. The first is, does that potentially indicate that the room for finding further efficiencies is - let me put it another way: we'll soon reach a point where further efficiencies are very, very hard to find within the existing budgetary envelope?

MR CORNELIUS: Look, I don't think so. I think the health system is going to continue to evolve, and we've spoken about some of the impacts of technology and the like.

I think there's always going to be opportunity to do things differently and more efficiently. Those opportunities are going to continue to change over time. But, yes, I think there will continue to be opportunities for efficiencies in certain areas, and I think the important part of that is, when we're thinking about the base, it is critically important to be looking at how all those dollars are being spent and whether they're being spent on the right things. If there is opportunity to redirect them to support better patient outcomes, then I think that's the - you know, a key thing that we all need to be working towards.

MR MUSTON: The second question I was going to ask about that is: to what extent, if any, does the relative efficiency of New South Wales, when compared with its interstate equivalents, rest on the extent to which there is a disparity between wages in New South Wales, or at least until recently, has been a disparity in the wages of NSW Health workers when compared with, say, particularly their Queensland and Victorian equivalents?

MR CORNELIUS: It's an interesting question. We see Queensland actually having the lowest average weighted cost. So I would have thought that wage relativities would be a part of it. Whenever we've looked at the wage relativities, though, it's quite difficult to get a sense of what actual earnings are, with the complexities of some of the award structures.

MR MUSTON: Could you just unpack that a little bit?

MR CORNELIUS: I think typically when there's benchmarking, the benchmarking looks at the hourly rates and it's more challenging to compare how the different allowances over and above those hourly rates compare in terms of take-home pay.

MR MUSTON: So, for example, you might have one jurisdiction that theoretically has a slightly higher hourly rate and therefore it is assumed has a slightly higher take-home pay in the hands of that particular health worker, but if you then compare it with New South Wales, where the hourly rate might be lower but across the board, the overtime rate is a little bit higher and is part of day-to-day business, everyone does a degree of overtime which means the average take-home pay is actually slightly higher than the comparator, but you really do need to get into the nuts and bolts of it in that way to work out what the true comparison is; would that be right?

MR CORNELIUS: Yes, agreed.

MR MUSTON: And across the very wide range of health awards that we have in New South Wales, and no doubt exist in other states, doing that on an award-by-award basis is extremely complex?

MR CORNELIUS: It is, yes.

MR MUSTON: Mr D'Amato, in your most recent statement, you draw the distinction between parameters and technical adjustments for the continued delivery of existing services in the preparation of the budget. Could you just explain to us the distinction between a parameter and technical adjustment for continued delivery of existing --

MR D'AMATO: This is probably a question better answered by my colleagues, if you don't mind.

MR MUSTON: Whoever is best able to answer it, please do.

MR CORNELIUS: I'm happy to take that one. We do have a treasury policy guidance document that we can share with you that covers the distinction between those and new policy measures as well, if that would be helpful.

MR MUSTON: I think we might have found that, but for the laypeople amongst us, what's the broad distinction and what's the intention behind it?

MR CORNELIUS: So if we go back a little bit, when we were talking a little bit about the approach to providing advice through the budget process, we focused initially around what we think the core funding requirement is, and so that is why it's important for us to distinguish between the different types of budget proposals.

A technical adjustment is typically something like an accounting-driven adjustment. So through the last budget, health had done some asset reevaluations that required a significant increase in depreciation over the forward estimates, and so that's an example of a technical adjustment.

Now, in that circumstance, they have accounting guidance that is directing them to make that adjustment. So if that wasn't approved, they would need to offset it somewhere else in the system which would have a service impact. So typically through a budget process we will consider them in advance of the service enhancements, because if those things are not supported, then there's a likely deterioration of service as a consequence.

Then moving on to parameter adjustments, they focus a little bit more on the concept of cost. So, for example, during the last budget process, we considered impacts around cost escalation, and we treated that as a parameter adjustment. So no changes to the scope of services, but a change to the cost.

Some of the things we were talking about in terms of the cost of capital projects, that variation can be considered as a parameter adjustment, noting that there's always the scope - there's always the opportunity to consider the scope as well, but for the purposes of the

definition, that change of costs for the same policy outcome is a parameter adjustment.

MR MUSTON: Coming back to a matter referred to in your submission, you tell us - and I think you've told us this afternoon - about the role played by the intergenerational report in this process. I just want to unpack that a little bit.

The intergenerational report is replete with references to the value of preventative health care and the consequences from the point of view of the health spend, future health spend, in the event that those things are not - that that preventative health care is not adequately delivered.

To what extent does - or in what way does that feature in this budget-building process? Is it a factor which is called upon in an NPP - that is to say, "Here's a new policy proposal, it is meeting this issue raised in the intergenerational report", or does treasury itself use the intergenerational report in a way to inform decisions around budgets?

MR CORNELIUS: Yes, I think there's a bit of policy connection. So certainly health will reference the "Future Health" strategy, and that is definitely picking up some of the concepts that are raised in the intergenerational report. So the extent that a new policy measure is consistent in giving effect to that strategy, which is aligned with the intergenerational report, and there's a strong evidence base for that policy, that will definitely be considered in the treasury assessment of that proposal.

MR MUSTON: Now, in paragraph 2.30 of your submission, you express the view that having regard to health's financial and operational performance, the current level of funding is adequate. Can I just test my understanding of that. The financial and operational performance that you refer to there, is that, from an operational performance point of view, the emergency wait times, elective surgery wait times and patient satisfaction ratings that you've referred to toward the end of the submission?

MR CORNELIUS: That's correct, yes. They're some of the examples of the operational performance that we're

referencing, and the financial performance we're referencing the extent that health has operated within its budget during the course of the financial year.

MR MUSTON: But at one level, what that tells you, is it not, is that health is doing its best with the parcel of money that has been allocated to it, but is doing so in a way which is targeted at ensuring that those two or three key metrics are kept within acceptable parameters, but it doesn't really tell you much more than that, does it, in terms of the overall effectiveness of the health system in meeting the needs of the community's health in the short and long term?

MR CORNELIUS: Well, I think in terms of considering whether the funding is adequate, that's probably the best point of reference that we've got, and certainly through the budget process, as we've spoken about, some of the other dynamics around areas of unmet need can be considered through the budget process as well. But I think what we're trying to get a sense of in answering that question is how does NSW Health perform relative to other health systems, and I think the answer to that is NSW Health performs very, very well.

MR MUSTON: But even then, it performs well in what sense? By what metric?

MR CORNELIUS: Yes, I guess by the metrics we've just spoken about, taking on board your challenge that there may be some other things that we need to be throwing into the mix around --

MR MUSTON: Health outcomes.

THE COMMISSIONER: As an example, we've discussed the growing rates of chronic disease. If that was the metric for operational performance, then you'd say, "Well, in relation to that, given that chronic disease is rising, if that's the metric we judge ourselves by, we're not - we might not be adequately funded to address that." If you're looking at other metrics, it's different.

MR CORNELIUS: Yes, look, I think it's a challenge when we start thinking about outcomes, because some of those outcomes around chronic disease may be quite difficult for the health system to influence.

THE COMMISSIONER: Yes, sure.

MR CORNELIUS: It's not to say there shouldn't be programs targeting investment to improve outcomes --

THE COMMISSIONER: It might be difficult for health undoubtedly, because the social determinants of health are involved, so housing, education all of that, yes.

MR CORNELIUS: Yes, exactly. No, I agree.

MR MUSTON: Can I invite you, Mr D'Amato, to express a view on whether you agree with what's set out in paragraph 2.30 of the submission, namely, that health's financial and operational performance suggests that the current level of funding is adequate?

MR D'AMATO: Okay, I feel that it's a bit difficult for me to make a call whether we're adequately funded. We do the best we can with what has been allocated to us and we always try to do our best for our patients and our workforce. Ultimately, that's what we do.

Admittedly, I think we've done relatively well compared to the other states and other territories, and perhaps also internationally, but I do think that we're now stepping into a different environment and it is challenging. It is challenging to maintain the level of performance and it is challenging because, in my opinion, we need to start thinking more about medium and long term outcomes, investment in prevention, which before - we probably tried to get there, just before COVID, as we were working with other policies, treasury policies, with outcome budgeting and then, all of a sudden, we interrupted the whole process.

I think there was an evolution in our ABF moving towards more of an outcome framework. We had investment in value based health care, but during COVID, obviously, all of these had been paused. So for me to answer your question, I feel that it's a bit premature. I think we need to acknowledge that the environment's changed now.

MR MUSTON: Would it be right to say that if the level of funding was increased, coming back to something we touched on a bit earlier, there would be ways that it could be

spent which would potentially produce good health outcomes for the community, which are currently not being achieved within the existing funding envelope?

MR D'AMATO: In my opinion, yes, that is the case, and in my opinion, we have good frameworks, we have robust internal control processes to make sure that we can achieve these outcomes.

I admit that it is not easy, because measuring outcomes will take longer than a budget cycle, and probably even longer than the forwards, in terms of four years. But I think that we have a very well-connected system and a mature system that can probably achieve it.

MR MUSTON: Coming back to --

MR KASTOUN: I would just say I guess adequacy also needs to be considered in the context of what is also fiscally affordable for government, and also the other competing priorities that exist across other portfolios as well. So, you know, we can't just take a single sort of health-centric lens, I don't think. It's a broader concept for government to consider, what's adequate and what's affordable.

MR MUSTON: You have anticipated my next question, which was as to what is or is not adequate. There are two questions, really: what is the amount we could spend to neat all of the health need, and then there is a second question, how much do we actually as part of that balancing priorities wish to spend on meeting the health needs of the community and having made a decision about that, how best to spend it?

MR KASTOUN: Yes.

MR MUSTON: One last question about that, though. In terms of the different priorities of government and the competing priorities amongst different sections of government, to what extent is there, as it were, at the treasury level, collaborative consideration of the extent to which maybe a little bit of money which is being spent on housing or education might actually be achieving something which is also being put forward by a proposed additional spend in health or might result in a reduction in a spend on health or vice versa?

MR KASTOUN: If I can understand your question, it is that - what sort of trade-off conversations are being had across portfolios? Is that right?

MR MUSTON: Yes, let me give an example.

MR KASTOUN: Yes.

MR MUSTON: We've talked a little bit about this hypothetical community paediatric service. Health might say, "We would like additional funding. We need additional funding because we're not able to provide this service which is very much needed." Education might say, "We need a little bit of extra funding to provide a greater level of in-class support for students who have the sorts of needs that this paediatric service might also be picking up".

I don't pretend for one moment that I'm in any position to express a view about which may or may not be the better spend, but to what extent is that sort of consideration happening at a government level when the budgets of all of these agencies are being arrived at?

MR KASTOUN: In terms of treasury and the advice that we prepare, I guess firstly, there is an element of moderation across treasury in terms of ensuring that our assessments of proposals that are urgent, critical and so on and so forth, there is at least a consistency of assessment and use of evidence is consistent across all proposals that are submitted by the sector.

With regard to, you know, I guess the sort of trade-off conversation, I mean, ultimately, we put forward the best advice that we can on the evidence that we have, and we also provide government with an understanding of implications of going down one path versus the other, and that is ultimately the sort of deliberation process within the expenditure review committee which then makes those sorts of calls.

There is nothing also stopping agencies from collaborating and bringing forward proposals of a joint nature, recognising, you know, sort of mutual benefits across certain initiatives. That, though, requires agencies to actually engage and prepare submissions accordingly.

MR MUSTON: I had in mind that the point at which the varying priorities of these agencies meet is you. So --

MR CORNELIUS: It's interesting. Also the business cases themselves should be taking, you know, a broader perspective. There's a couple of examples, where that broader systems thinking is important. I think some of the paediatric initiatives you've talked about, probably in the context of the "First 2000 Days" sort of framework, that is looking at sort of whole of system impacts, also mental health proposals impact right across the board, and so does housing. You know, measures, investments in those areas can have broader impacts than just impacts for those particular agencies that are putting forward the budget proposal. But the business cases provide the framework to be describing the benefits more broadly.

MR MUSTON: I suppose my question, inelegantly put, was: to the extent that these business cases might have been generated in the silos of the different agencies without a degree of collaboration, it's not necessarily a choice between one or the other; it may well be that the two can be combined in a way that actually produces a better outcome long term. But at the treasury level, is there some process whereby you look at these varying proposals and, as it were, put parties together, say, "Well, you're asking for this, housing is asking for that" or "education is asking for that, I think we're not going to fund either of those things as they stand, but you two go away and work out a way of collaborating to produce what would seem to be a slightly overlapping, but nevertheless at least theoretically complementary, if done properly, proposal and bring it back to us"? Is there any process like that where you, as treasury, do those sorts of things?

MR KASTOUN: I wouldn't describe it as a formal process, however, across our P&B cohort, there is strong engagement and we are consistently engaging and, I guess, for want of a better term, comparing notes on proposals that are coming forward. Certainly, you know, there is vigilance in terms of proposals that could be combined. I wouldn't say it's a formal process, though, but, you know, having said that, from time to time government also, as part of its budget prioritisation, seeks specific proposals across certain areas - for example, "Closing the Gap", and so on. You know, those, for example, offer the opportunity to consider

the interconnectedness of proposals and the ability to sort of jointly come forward - agencies jointly coming forward with new policy proposals of that nature.

So there are, I guess, mechanisms and, you know, there are conversations that are had that, you know, continuously sort of evaluate things that are coming forward to look for those sorts of synergies, but I wouldn't call it a formal process.

MR MUSTON: You touched on the "First 2000 Days". Policy priorities of that type, which are identified either as a premier's priority or some other explicitly identified government priority, they are a mechanism through which funding can be obtained by a range of different agencies by pointing to --

MR KASTOUN: Sorts of thematics, basically?

MR MUSTON: Yes.

MR KASTOUN: Yes.

MR MUSTON: If there was a standing priority for the prevention of chronic illness, for example, whether that be through healthy eating campaigns, through delivery of health literacy through education, for example, through the infrastructure to get people out walking and riding their bikes, that would be another way, not just through the lens of health, to facilitate --

MR KASTOUN: Indeed. It's also relying on policy areas across agencies also recognising those synergies and actually engaging and working collaboratively. So - but yes, there is the scope for that.

MR MUSTON: Can I ask you, Mr D'Amato, it may well be that the collaboration has already occurred by the time these proposals reach you, but do you know whether collaboration of this type actually occurs as between --

MR D'AMATO: Absolutely.

MR MUSTON: -- the health ministry and other agencies?

MR D'AMATO: Absolutely. Absolutely. Actually, as Mr Kastoun mentioned, it is informal but it happens all the

time.

I will give you a couple of examples. One is that the Department of Justice, often their bids, as in NPPs, they go through the process and at that point then colleagues from treasury alert us that there might be an impact on our Justice Health system, and that's when we join, then, to that bid, for instance, where then an allocation is provided to the Department of Communities and Justice but then it's related to us.

An other example is future maintenance. There was an initiative from before COVID, where it was a relatively complex initiative and they tried to align education, the justice system, the court system, with a view that investing in the prevention of kids - trying to prevent them getting into the juvenile system had a significant impact across all different agencies, with a view that investing in education up-front would have prevented that journey, potentially. Look, this was before COVID, so now perhaps it's not as advanced as we were trying to be, but these are good examples that cross-agency collaboration exists, in my opinion, all the time, even though it is informal.

MR MUSTON: I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Mr Chiu, do you have any questions?

MR CHIU: I have no questions.

THE COMMISSIONER: To the three of you, before I thank you, is there anything any of you would like to add that you don't think was covered that you think is important in relation to the matters raised in your submission or from the discussion with Mr Muston?

MR KASTOUN: Not from me, Commissioner.

MR CORNELIUS: Nothing from me.

MR D'AMATO: No, nothing from me. I just want to acknowledge that we have been working in a very collaborative manner for many, many years, and we tend to obviously not get everything right, but we aspire to always do our best, certainly in the way I work with my colleagues

in treasury.

THE COMMISSIONER: I'm sure you do.

Thank you very much for your time, to the three of you. We're very grateful for the assistance you have given the Inquiry. So thank you.

With that, we'll adjourn until 10 o'clock tomorrow. We'll adjourn until then, thanks.

AT 3.54PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 19 NOVEMBER 2024 AT 10AM

B

C

D

E

F

G

H

O

P

Q

R

S