

**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**

1 THE COMMISSIONER: Good afternoon.

2

3 MR MUSTON: Good afternoon.

4

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

9

10 <LOUIS KASTOUN, sworn: [2.01pm]

11

12 <JULIAN CORNELIUS, affirmed:

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14 <ALFA D'AMATO, sworn:

15

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

17

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

19

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

22

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

25

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

28

29 MR JAP: Thank you.

30

31 <EXAMINATION BY MR MUSTON:

32

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

34

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

37

38 MR KASTOUN: Louis Kastoun.

39

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

41

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

45

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

1 I think, on 11 November, responding to issues paper 3 of
2 2024.
3
4 MR KASTOUN: Indeed I have.
5
6 MR MUSTON: That, Commissioner, is exhibit M1, which is
7 [TRY.0001.0001.0001].
8
9 THE COMMISSIONER: Thank you, I have that.
10
11 MR MUSTON: Insofar as you are aware, the contents of that
12 submission are, to the best of your knowledge, true and
13 correct?
14
15 MR KASTOUN: It is.
16
17 MR MUSTON: Mr Cornelius, could you state your full name
18 for the record, please?
19
20 MR CORNELIUS: Julian Cornelius.
21
22 MR MUSTON: And could you tell us what your role within
23 NSW Treasury is?
24
25 MR CORNELIUS: I'm the director of the health team in the
26 policy and budget group.
27
28 MR MUSTON: You, as mentioned earlier, were one of the
29 co-authors of the treasury submission received on
30 11 November?
31
32 MR CORNELIUS: That's correct.
33
34 MR MUSTON: And to the best of your knowledge, its
35 contents are true and correct?
36
37 MR CORNELIUS: That's correct.
38
39 MR MUSTON: In due course, that will be tendered as part
40 of the bulk tender, Commissioner.
41
42 Mr D'Amato, could you remind us of your full name?
43
44 MR D'AMATO: Sure. Alfaister Davis D'Amato, or Alfa
45 D'Amato, and I'm the deputy secretary, CFO, NSW Health.
46
47 MR MUSTON: You have prepared or previously participated

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

3
4 MR D'AMATO: That's correct.

5
6 MR MUSTON: Which, Commissioner, I think you'll find at
7 [MOH.9999.0005.0001].

8
9 You have also, I think, prepared a statement dated
10 4 April 2024?

11
12 MR D'AMATO: That's correct.

13
14 MR MUSTON: Which, Commissioner, is [MOH.9999.0763.0001].

15
16 You have now participated in the preparation of
17 a joint statement with Mr Carr and Mr Onley?

18
19 MR D'AMATO: That's correct.

20
21 MR MUSTON: I will ask you this question about that
22 statement.

23
24 MR D'AMATO: Sure.

25
26 MR MUSTON: To the best of your knowledge, are the
27 contents of that most recent statement true and correct?

28
29 MR D'AMATO: Yes.

30
31 MR MUSTON: That statement, Commissioner, is exhibit M6,
32 which you will find at [MOH.0011.0091.0001].

33
34 Now, in the evidence that Mr D'Amato gave us
35 in November of last year, he walked us through the health
36 budget setting process from the ministry's perspective.

37
38 I might ask from a treasury perspective if either of
39 you representatives of NSW Treasury could walk us through
40 in a narrative way the way in which the health budget is
41 set from treasury's perspective, perhaps starting the day
42 after a budget's been delivered and working up on the point
43 where the next budget is delivered.

44
45 MR CORNELIUS: I'm happy to take that one. So after
46 a budget is set for the year ahead, we'll have - that
47 budget year will be established and then the forward

1 estimates will also have an estimate of health's budget for
2 the next - for the next 10 years. That will be set in our
3 forward estimates.
4

5 During the course of the year, we have a - the budget
6 process tends to take the same shape and form most years.
7 It can move around a little bit, depending on whether it's
8 an election year, and other variables might change it a
9 little bit, but normally we have a regular cycle. It
10 involves a budget submission being received around February
11 and March of the year before the budget.
12

13 During the course of that --
14

15 MR MUSTON: Just pausing there, the budget submission
16 that's received in February or March, what's the general
17 nature of the information that's contained in that
18 document?
19

20 MR CORNELIUS: So that will typically include some
21 analysis from health around system performance, around
22 risks and pressures, and around new policy measures. And
23 so when we receive that submission, we prepare advice for
24 government, and we'll typically consider what we think is
25 the base funding requirement for the year ahead, looking at
26 emerging cost pressures and other risks that might have
27 come up and be included in that submission.
28

29 MR MUSTON: So let me just take it back a few steps.
30 System performance information that is contained in the
31 budget submission, what sort of metrics are you looking at
32 there?
33

34 MR CORNELIUS: It might depend a little bit around what
35 parts of the system may be under pressure or may be
36 relevant to the budget submissions that have been received.
37

38 For example, in the submission that we've lodged, we
39 provide an example around planned surgeries, and certainly
40 for that measure, the evidence that was presented
41 referenced how the planned surgery performance had been
42 going and the impact of the pandemic on that.
43

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

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

3
4 MR CORNELIUS: Yes, that's correct, so depending on the
5 nature of the proposal we'll have different data points.
6 I think most relevant are the dataset that the Bureau of
7 Health Information publishes on a quarterly basis that
8 would provide insights into emergency department
9 performance, planned surgeries and other parts of the
10 services.

11
12 MR MUSTON: Just pausing there, that information where you
13 referred to emergency department performance, that's
14 waiting times in emergency?

15
16 MR CORNELIUS: Correct.

17
18 MR MUSTON: And insofar as elective surgery is concerned,
19 again, waiting times for elective surgery?

20
21 MR CORNELIUS: Yes.

22
23 MR MUSTON: The sorts of things that are easily measurable
24 and are routinely published by the Bureau of Health
25 Information.

26
27 MR CORNELIUS: Correct.

28
29 MR MUSTON: Coming back to where that fits in to the
30 budget process, you mentioned the example you give of the
31 increased funding to - I think it has been described as
32 getting over the hump of post-COVID elective surgery. You
33 have also referred to the base funding. Was it
34 contemplated that there would be some increase to the
35 standard base as a result of the process you have gone
36 through there or was that rather a policy proposal for some
37 short-term funding to enable this hump of unmet elective
38 surgery to be dealt with?

39
40 MR CORNELIUS: Yes, that's the latter. For that
41 particular proposal, it was time-limited funding.

42
43 MR MUSTON: But can I come back to the base, starting with
44 the base. Perhaps just tell us, in words that the
45 non-economists amongst us will understand, what the base
46 comprises.
47

1 MR CORNELIUS: Effectively the base is the full recurrent
2 budget for health, which is, I think, around 33 billion or
3 so, and then the escalation factor that is applied forms
4 the base in forward years.
5
6 MR MUSTON: So the base comprises an operational budget on
7 the one hand; is that correct?
8
9 MR CORNELIUS: That's correct.
10
11 MR MUSTON: And then a separate capital budget on the
12 other?
13
14 MR CORNELIUS: That's correct.
15
16 MR MUSTON: How do those two sit together and how do they
17 work?
18
19 MR CORNELIUS: The capital budget again is budgeted on the
20 sum of individual projects that are approved, and there is
21 also a provision in health's forward estimates as well for
22 future works.
23
24 MR MUSTON: So let's stick with the operational component
25 of the budget for present purposes. How is the operational
26 base calculated? How has the figure been arrived at?
27
28 MR CORNELIUS: Well, I think that just reflects the
29 history of incremental budgeting over time.
30
31 MR MUSTON: You might not know, it might be such a piece
32 of ancient history, but do any of you have any
33 understanding of where, in history or how historically the
34 figure was originally arrived at?
35
36 MR CORNELIUS: I don't.
37
38 MR KASTOUN: Before my time as well.
39
40 MR MUSTON: Would it be an assumption that, at some point
41 in history, a decision was made by persons unknown that an
42 amount of money was the amount that it cost to deliver the
43 public health system at that point in time, and that's then
44 grown incrementally or organically since?
45
46 MR CORNELIUS: Yes, I think that's a fair statement.
47

1 MR MUSTON: And I don't say this critically of anyone, but
2 would it be right that the assumption one makes is that
3 that base is an adequate amount to deliver the public
4 health system, save any adjustments or the like that are
5 required, or remains an adequate amount to deliver the
6 public health system?
7

8 MR CORNELIUS: I think the amount of growth in any budget
9 year is dynamic and can change based on the circumstances.
10 So while you're correct to point out that the base is there
11 as it has been and it has evolved over time, the amount of
12 incremental funding that's provided in any budget can
13 change depending on the circumstances of the day.
14

15 MR MUSTON: Perhaps I didn't put my question as clearly as
16 I could have. As part of the assessment of the base year
17 to year, or as part of the growth, assessment of growth, is
18 any calculation or quantification made of the cost of
19 delivering the public health system, the actual cost?
20

21 MR CORNELIUS: I'm not sure I'm not following the
22 question.
23

24 MR D'AMATO: In terms of cost, we determine actually, on
25 a yearly basis, actually every six months, the unit cost of
26 delivering services in the activity based funding model,
27 and that actually is used to inform the state price. So we
28 are confident that then we know the cost. Obviously it's
29 all driven by the demand as well and what we can, within
30 the budget, afford to deliver. So in terms of costs, I'm
31 confident that we certainly know where the costs are and
32 how we calculate that.
33

34 MR MUSTON: I'll come back to my question. So we start
35 with the base figure, which has, since it was arrived at at
36 some point in the past, been allowed to grow through the
37 application of a growth factor year on year. How is that
38 arrived at?
39

40 MR KASTOUN: Just for clarification, as well as that
41 growth factor, incremental decisions by government to also
42 increase for other purposes.
43

44 MR MUSTON: So in terms of the decisions to increase for
45 other purposes, how do they fit into the equation? Are
46 they the NPPs that we've heard some evidence about?
47

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

12
13 MR MUSTON: Just so we can put it into some context, do
14 you have examples? Could you give us some examples of the
15 sorts of new initiatives historically that have been the
16 subject of NPPs or this incremental growth?

17
18 MR KASTOUN: Yes, I think this year's budget, '24/25
19 included a package to enhance the operation of emergency
20 departments, for example.

21
22 MR CORNELIUS: That's correct.

23
24 MR MUSTON: Just in very broad terms, what did that
25 involve?

26
27 MR KASTOUN: In terms of?

28
29 MR MUSTON: What was the package to enhance emergency
30 departments? Enhance in what respect?

31
32 MR KASTOUN: So basically, to increase the capacity of the
33 emergency department from the perspective of urgent care,
34 the capacity to enhance discharge capability within the
35 hospital system.

36
37 MR D'AMATO: If you want I can provide some more
38 information. The package was worth around 421 million over
39 the forwards and the current and around 6 million in capex.
40 That includes a number of initiatives that will be rolled
41 out throughout the next four years, including single front
42 door, urgent care services, alternate care pathways,
43 health/ambulance metrics and managing the ED demand. There
44 were also some elements in regards to Hospital in the Home,
45 short stay units, discharge concierge, so it was
46 comprehensive, all dedicated to emergency departments.

47

1 MR MUSTON: With the ultimate objective being to divert
2 people away from the emergency department where the view
3 was they probably didn't need to be there, they could be
4 treated elsewhere?
5
6 MR D'AMATO: Yes, that's correct.
7
8 MR MUSTON: For example, in an urgent care setting?
9
10 MR D'AMATO: Yes.
11
12 MR MUSTON: And to the extent that people did arrive in
13 the emergency department and needed to be transitioned
14 through into either an acute setting or discharged quickly,
15 some of these proposals that you've just run through were
16 aimed at creating efficiencies in that process?
17
18 MR D'AMATO: That's correct. In regards to efficiencies,
19 access - improving access as well. Obviously the aim of
20 some of these initiatives is to, if you want, avoid, where
21 possible, patients to attend the emergency departments, so
22 looking at low acuity and diverting to other areas of the
23 system and all - like, for instance, urgent care services.
24 But that also means that, effectively, what we have left,
25 we have capacity, with more complex patients which leads us
26 to more cost pressure.
27
28 MR MUSTON: In relation to that particular proposal, was
29 any consideration given to the impact or the extent to
30 which a thin or failing primary care market might have been
31 contributing to the increase in presentations in emergency?
32
33 MR D'AMATO: It is basically one of the key areas that
34 we've been trying to address, in particular to urgent care
35 services, where at the moment, these are funded by the
36 state and we are not able to claim Commonwealth
37 contribution for some of these centres, and there was
38 a decision made a couple of years ago, so this funding, in
39 effect, is to extend the funding for this initiative for an
40 extra two years.
41
42 MR MUSTON: Was consideration given at that time to the
43 possibility of addressing the problem more at its root
44 cause and filling the void created by thin or failing
45 primary care markets?
46
47 MR D'AMATO: From my point of view, perhaps, that's

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

10
11 MR MUSTON: Can I come back to - I think we were stepping
12 through and I interrupted you, but the base figure,
13 a growth figure and then there's the incremental increases
14 through NPPs. Perhaps talk us through how that growth
15 figure and the NPPs are dealt with throughout the budget
16 process coming back to our narrative walk-through the --

17
18 THE COMMISSIONER: Just before you do, this isn't
19 a criticism either, but you started with an exploration or
20 raised the issue of whether the base amount is adequate to
21 deliver the public health system. That begs the question
22 what the public health system is.

23
24 MR MUSTON: I was going to come back to that, but I can
25 deal with it now.

26
27 THE COMMISSIONER: You are? I will leave it with you.

28
29 MR MUSTON: I'm quite happy to deal with it now.

30
31 The Commissioner has just raised, as to the adequacy
32 of the base, either now or at any point in the past, to
33 deliver the public health system, it raises a real question
34 about what the public health system comprises; do you agree
35 with that?

36
37 MR KASTOUN: Yes.

38
39 MR MUSTON: The evidence that we've heard over the past
40 12 months or so has suggested that health is, in effect,
41 a bottomless bucket, in the sense that you could continue
42 to pour money into it and that, assuming some level of
43 inefficiency which is unavoidable, by and large, that money
44 would be well spent on meeting health needs of people
45 within the community. But a decision has to be made at
46 some point about exactly what the cap on that spending is
47 and at what point do you turn off the tap.

1
2 Are those three propositions broadly acceptable to the
3 three of you?
4

5 MR KASTOUN: In terms of the cap, I think it's important
6 to recognise a number of dynamics at play. Firstly, the
7 fiscal environment we're in at the moment, and I guess
8 drawing attention to our budget papers. I mean, the
9 budget's been in deficit since 2019 - since 2019/20, and
10 for this year, it's a budgeted deficit of 3.6 billion and,
11 at the moment, forecast to continue with the deficit to
12 '27/28, albeit reducing.
13

14 Secondly, the tension around gross debt and, you know,
15 at the moment gross debt is forecast to increase to around
16 200 million by '27/28. That has consequent implications
17 for interest costs for government, and so one of the sort
18 of fiscal priorities for government is to try and, I guess,
19 bring a responsible approach to spending and to try and
20 stabilise the state's fiscal position, from an operating
21 perspective and also from a debt perspective.
22

23 You also have the tension of other competing
24 priorities in other portfolios. So I guess, reflecting on
25 my portfolio responsibilities, for example, you know,
26 government has priorities with regard to out-of-home care,
27 it has priorities with regard to disability, domestic and
28 family violence, social housing and so on, and investment
29 in those areas also has a bearing in terms of the impacts
30 on the health system.
31

32 So there is a tension there between, I guess, the
33 competing priorities that exist within health, within other
34 portfolios, but also trying to balance it against the
35 fiscal bottom line.
36

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

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

3

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

9

10 MR KASTOUN: Indeed.

11

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

17

18 MR KASTOUN: Correct.

19

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

26

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

32

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

39

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

42

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

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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

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

7
8 MR D'AMATO: Look, I think that certainly, you know, the
9 data that we provide treasury is not at the kind of level
10 the same way we manage the system, but I do think that in
11 regards to the base we also need to acknowledge that we're
12 still stepping out of COVID and perhaps it's a bit
13 difficult to identify what is the right base in this
14 environment where there is relatively still a bit of
15 volatility.

16
17 But during COVID, it's fair to say that the budget,
18 you know, we had to flex in regards to the envelope, the
19 growth, because we had to respond to anything. Now, we
20 are - as we're stepping out, we are trying to identify what
21 is the base, the proper base. I also reflect before COVID,
22 we experienced a relatively stable environment
23 economically, fiscally, and we were able to optimise
24 efficiencies, and the way we funded the hospitals through
25 ABF was working well, back then, in a stable environment.
26 Now, I don't think we have a stable environment yet, and
27 that's probably the difficulty, in my opinion, to set the
28 base.

29
30 MR MUSTON: It's probably more a matter for tomorrow and
31 Thursday, but at a ministry level, what level of visibility
32 does ministry have of the particular array of services that
33 are being offered as part of the public health system in
34 each of the LHDs?

35
36 MR D'AMATO: Look, we obviously collect all the data, so
37 we have visibility across the sector in respect to whether
38 there are in-scope services or out of scope services, so
39 I would say that we have visibility across all system.

40
41 MR MUSTON: When you say "in scope or out of scope", are
42 you referring to within the ABF?

43
44 MR D'AMATO: I was referring more in terms of what the
45 Commonwealth would contribute towards, or not. Apologies,
46 there. It's just some of my terminology.

47

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

5
6 MR D'AMATO: Yes.

7
8 MR MUSTON: "Out of scope" are services, when you refer to
9 them, which are being funded wholly by the state?

10
11 MR D'AMATO: That's correct.

12
13 MR MUSTON: So you have oversight or some visibility of in
14 scope and out of scope services. Even amongst those
15 services, though, do you have a sense of what the patchwork
16 of services that are being delivered to a community
17 actually looks like?

18
19 MR D'AMATO: Yes, yes.

20
21 MR MUSTON: In what way?

22
23 MR D'AMATO: Either through the activity that we deliver
24 or some of the, if you want, even NGO grants that we pay to
25 community organisations to deliver services on our behalf.
26 And also I think it's important to note that when we choose
27 to engage with some of these third parties, we do it
28 because there's a benefit overall to the system in that
29 ultimately, in many cases, they provide services that
30 either would be too costly for us to be investing in and
31 deliver, or they provide the community type of services
32 that actually allow us to discharge patients earlier than
33 otherwise.

34
35 MR MUSTON: In terms of the activity, what does the data
36 that you have available to you about activity within the
37 LHDs actually tell you about what's happening on the ground
38 in the LHDs?

39
40 MR D'AMATO: Okay, well, the activity section is not under
41 my division, however, it's fair to say that, through a
42 costing exercise that we conduct every six months, we
43 actually trace every single patient in that we actual
44 calculate the cost of every single encounter from the
45 moment that they arrive to our emergency department,
46 throughout the emergency department, when they move into
47 acute settings, when they actually discharge, and wherever

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

5
6 MR MUSTON: Just one last question about the base funding.
7 In terms of discussions and treasury's consideration of the
8 adequacy of the base funding and the extent to which it
9 requires adjustment, is there a discussion that happens
10 between the treasury and the ministry along the lines of,
11 "Here are the services that we think we can provide within
12 the budgetary envelope we've got and provide well; here are
13 services which we think the community needs, but we're not
14 currently able to provide them and they are lower
15 priorities to those that we are providing within the
16 budgetary envelope. If you want us to provide those
17 additional services you have to - you'll have to increase
18 our funding?" Is that a discussion that happens as part of
19 the budget process?

20
21 MR CORNELIUS: Yes.

22
23 MR MUSTON: How does that discussion work into the
24 assessment of the adequacy of the base?

25
26 MR CORNELIUS: So the budget submission is prepared by the
27 minister and so there is a prioritisation process before
28 that submission comes to treasury. So there may be
29 discussions internally around some of those service issues
30 you've mentioned. There'll be a prioritisation process
31 internally and then the submission will come to us and
32 we'll provide advice to government around our assessment of
33 those proposals.

34
35 MR MUSTON: And so again, these are the NPPs that we're
36 talking about or is this part of an assessment of the
37 adequacy of the base itself?

38
39 MR CORNELIUS: The two things happen in parallel,
40 effectively, yes.

41
42 MR MUSTON: Maybe just explain how that happens in
43 parallel and how it works.

44
45 MR CORNELIUS: Typically when we have the budget
46 submission, we will need to provide some advice around what
47 is essentially critical to maintain current service

1 outcomes, in the first instance. So there might be some
2 technical adjustments, accounting adjustments, other cost
3 variations, and things like that that we feel will need to
4 be funded in order to maintain current service outcomes.
5

6 So typically our advice will prioritise those things
7 first; and then we'll turn our mind to the new policy
8 measures or service enhancements, and we'll provide advice
9 around what we think the policy merit of those initiatives
10 are based on the evidence that has been provided and our
11 conversations with the ministry; and then there will be
12 some consideration around, you know, how those proposals
13 link in with government's sort of broader priorities and
14 fiscal capacity as well.
15

16 MR MUSTON: I'm just trying to understand at what level
17 this assessment of the adequacy of the base to meet what
18 has been provided is undertaken once it reaches treasury,
19 accepting that, by the time it gets to you, it's no doubt
20 had its origins in an LHD where decisions have been made
21 about what is needed and what can be afforded, that then
22 passes its way up through you ministry and then ultimately
23 to you.
24

25 MR CORNELIUS: In terms of the consideration of the
26 adequacy of the base, the performance metrics that we spoke
27 about earlier are pretty integral to that conversation.
28 For instance, we spoke a little bit about the planned
29 surgery performance, and that is a really good leading
30 indicator in terms of how the system is tracking in terms
31 of funding adequacy, from our perspective, because that's
32 one of the few areas where the system does have some levers
33 in terms of managing cost.
34

35 So if we're starting to see - you know, outside of the
36 pandemic, which was a bit unusual because they were just
37 paused, but in a normal operating environment, if we start
38 to see some pressure there, that can indicate that the
39 system is under pressure, and, likewise, we'll also look at
40 sort of ambulance and emergency department performance as
41 well, so the indicators of overall system performance.
42

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

1 need, ideally you would like to get them through as quickly
2 as possible because that will undoubtedly increase the
3 score they give in terms of their patient satisfaction, but
4 in terms of the health outcome, whether they wait one hour,
5 two hours or 12 hours, depending on the level of acuity,
6 might not actually make a difference. Would that be right?
7

8 MR CORNELIUS: I think you're right. I think that it's
9 important for us to be looking at the future health
10 strategy, for example, as an indicator of policy that's
11 coming through from the ministry. I think that is a lot
12 about trying to provide the right care at the right place
13 at the right time, the concept of supporting people to stay
14 healthy and the like. So, you know, that alignment with
15 the strategic intent is something that we consider as well
16 when we're assessing the policy proposals that come
17 through.
18

19 MR MUSTON: Likewise, the elective surgery waiting list,
20 whilst some indication, there is an assumption built into
21 it that each of the patients require the operation that
22 they have been scheduled to have, if you like?
23

24 You have to answer out loud, sorry, so the transcript
25 can catch it.
26

27 MR CORNELIUS: Yes, that sounds correct, yes.
28

29 MR MUSTON: And a second assumption that they need it
30 within the time frames contemplated or within the time
31 frame contemplated by the guidelines that you work to?
32 That's right?
33

34 MR CORNELIUS: Yes, that's correct.
35

36 MR MUSTON: And a third assumption, that the outcome of
37 that - of surgery leaves them better off in some material
38 way?
39

40 MR CORNELIUS: Yes, agreed.
41

42 MR MUSTON: None of those three - the correctness or
43 otherwise of those three assumptions is not something that
44 any of us other than those people's clinicians are really
45 able to make an assessment of. Would that be right?
46

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

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

9
10 THE COMMISSIONER: Can I ask a probably naive and possibly
11 stupid question about what you just raised there, but
12 you're here, so I will ask it anyway. It picks up a bit of
13 the topic where you said you have an interest in talking to
14 the ACI about expenditure in terms of low-value care, as an
15 example.

16
17 There's constant papers I have read, or there's
18 constant data about the level of, say, chronic disease in
19 Australia and you can read many papers that suggest that in
20 terms of the growth in the health care spend, if we have an
21 expansion of morbidity, it's more money that we've got to
22 find for health, and if we have a compression of morbidity,
23 hopefully, the growth rate gets contained more sustainably.

24
25 Does the ministry and treasury have discussions about
26 investments in, for example, interventions in early
27 paediatric services that might have really long-term
28 benefits if they are successful or other policy proposals
29 that are aimed at compressing that period of morbidity we
30 have for chronic disease? And whilst this is a very long
31 question, do those discussions go as far as modelling or
32 considering not just what that might mean for the growth in
33 the health spend in terms of, hopefully, containing the
34 growth of the cost of the spend, but also what the
35 secondary impacts might be - that is, the secondary
36 benefits - of more economically active people, greater
37 productivity, those sorts of things? Are those discussions
38 had? Any of you can feel free to answer that question, by
39 the way, or all of you can answer it.

40
41 MR CORNELIUS: Look, they certainly can be. Through the
42 new policy process, those measures are supported by
43 business cases, and those business cases would cover all of
44 the things you've just spoken about.

45
46 THE COMMISSIONER: Right.
47

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

4
5 THE COMMISSIONER: That's the priority, yes.

6
7 MR CORNELIUS: -- a lot of the funding measures have been
8 focused around that. But I think in our submission we
9 reference the growth of health spending as a share of the
10 total through our intergenerational report and what you've
11 just described is exactly the type of conversations we need
12 to be having about how we prioritise investment so that we
13 can take some pressure off that cost curve and also improve
14 health outcomes for people.

15
16 THE COMMISSIONER: And to some extent - tell me if I'm
17 wrong - those discussions have got to involve the
18 Commonwealth as well, don't they? Because part of it will
19 be things that they're in control of, ie, what they say
20 they're in control of, like primary care, for example? Is
21 that fair as well?

22
23 MR CORNELIUS: Yes.

24
25 THE COMMISSIONER: And cooperating in relation to
26 prevention proposals?

27
28 MR CORNELIUS: Yes, I agree.

29
30 MR KASTOUN: Yes.

31
32 MR CORNELIUS: I agree. And I think part of the
33 engagement with the Commonwealth is also around some of the
34 innovative service models that health has started to roll
35 out, things like remote patient monitoring, virtual care,
36 I think, aren't always easily fitting into the activity
37 based funding model, but they're supporting to help people
38 be cared for outside of hospitals at home, getting better
39 health outcomes more efficiently, so, you know, there does
40 need to be a dialogue with the Commonwealth to start making
41 sure that they're in scope for funding.

42
43 MR MUSTON: Just while you raise that, in paragraph 2.40
44 of your submission, you tell us that treasury does not
45 utilise an activity based funding model for health. Could
46 you just explain what you mean when you say that? I gather
47 you mean you're not essentially dealing with it activity by

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

5
6 MR CORNELIUS: Yes, that's correct. So with the base
7 funding model, as we have described it, it's 4 per cent
8 that's set into the forward estimates, sort of notionally
9 allocated between cost and service growth, 2.5 per cent for
10 cost, 1.5 per cent for service growth, and that service
11 growth has some flexibility around where that's invested.
12 So depending on the amount that might go into prevention,
13 some might go into hospital services that might be in scope
14 for ABF, so that may deliver some activity within that
15 pool. But there's not a predetermined mechanism of how
16 that is allocated.

17
18 MR D'AMATO: The only comment I would like to add is that,
19 at the moment, we have reached a Commonwealth cap,
20 6.5 per cent, so we effectively won't be able to access any
21 additional revenue as yet. This is subject to the new
22 NHRA, which is currently being negotiated.

23
24 MR MUSTON: Just coming back, one final question in
25 relation to the base. Treasury's ability to, as it were,
26 pull levers that might have an impact on the health of the
27 population, the shape of the health system, would it be
28 right to say that they really exist at the point at which
29 you come to assess new policy proposals - that is to say,
30 the base is the base; the way in which health chooses to
31 spend that base within the system, subject to efficiencies
32 and short waiting times in emergency and those sorts of
33 things - treasury's ability to say, "I think this money
34 would be better spent on, say, the Commissioner's
35 paediatric care than doing twice as many knee operations as
36 we're currently doing", is something that really lays a bit
37 outside the control, your control?

38
39 MR CORNELIUS: Yes, I think that's right. I think from
40 time to time, treasury may do a broader agency review, and
41 in that scenario, there may be part of that work to be
42 a deeper dive around the base expenditure, but we wouldn't
43 do that as part of every budget cycle because, you know,
44 like this process, it's a very comprehensive piece of work.

45
46 MR MUSTON: So if it were the position that health had
47 identified what it felt it could reasonably achieve with

1 the base funding in terms of that patchwork of services
2 that were being provided across the system using its own
3 prioritisation to work out what's above the line, as it
4 were, and what falls below the line, if it wanted to
5 include as part of a service offering things that were
6 currently below the line, for treasury to have a little bit
7 more control over whether or not that did or didn't happen,
8 it would need to be put forward as a new policy proposal?
9

10 MR CORNELIUS: That's correct.
11

12 MR MUSTON: So if the ministry were, as part of that new
13 policy proposal, instead of saying, "Here is a wonderful
14 idea, if we had" - taking some examples from things we've
15 heard in our travels - "an extra two or three helicopters
16 there would be no black spots across the state in terms of
17 retrieval, so we should, as a policy proposal, get some
18 more helicopters, please" - if it was more, "Here is the
19 patchwork of services we're offering, here is an area of
20 need that we can't currently afford to meet, if you
21 increase our funding, we will be able to", that's the point
22 at which treasury might have a slightly greater visibility
23 but also control over the extent of the size and shape of
24 the public health system?
25

26 MR CORNELIUS: We'd definitely have greater visibility and
27 we'd provide advice on it but we wouldn't control it.
28

29 MR MUSTON: No, you would be controlling it only to the
30 extent that you would assume that if money was sought for
31 a particular service and that policy proposal was met with
32 a favourable response, that the money would, in fact, be
33 spent on that service?
34

35 MR CORNELIUS: Correct, yes.
36

37 THE COMMISSIONER: Mr Morgan would be pretty unhappy if he
38 didn't get his three helicopters.
39

40 MR MUSTON: I didn't say it was a bad idea, but we have
41 seen a lot of paediatricians who talk about community
42 paediatricians and their value to community, who also have
43 said lots of things to us about their very great value.
44

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

1 that escalation process involves?

2

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

14

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

18

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

30

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

43

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

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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

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

5 So there is certainly the opportunity to review the
6 appropriateness of that rate each year. And you've
7 mentioned the operating costs of new builds, certainly
8 through the budget process, that's something that health
9 will highlight and will continue to highlight.
10

11 I think there's merit in considering an approach where
12 there's - that rate moves a little bit each year, depending
13 on the scale of new facilities that are coming on in any
14 given year. There may be an argument for it not to be
15 a flat 1.5 per cent every year, that it moves around a
16 little bit depending on what is happening in the health
17 system, what's happening with population growth, what's
18 happening with the capital program as well.
19

20 MR MUSTON: Can I come back to just those broad concepts
21 of change - population changes and the like. To what
22 extent or in what way is the growth factor that is applied
23 to the base arrived at by reference to, say, increased
24 burden - an identified increased burden of disease within
25 the community, if at all? It might not be, but --
26

27 MR CORNELIUS: As I mentioned, that 1.5 per cent was set
28 back in 2019, and it wasn't overly scientific. It was with
29 reference broadly - it had the concept of the population
30 growth and a bit of a concept around demand; certainly we
31 had a conversation with health at the time around what some
32 of those impacts would be, but ultimately, it was
33 considered in the context of what was fiscally affordable
34 at the time. But then there has been opportunity to
35 continue to sort of re-prosecute the appropriateness of
36 that through each budget cycle as well.
37

38 MR KASTOUN: Just in terms of the 1.5 per cent, I wanted
39 to clarify that that is recognition that there is a demand
40 component to health expenses going forward. That
41 arrangement is established for health only. So other
42 agencies, to the best of my knowledge, don't have that
43 additional escalation parameter. Generally speaking, other
44 portfolios, other agencies, have, essentially, the cost
45 escalation component only.
46

47 MR MUSTON: What about the extent to which the evolving

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

7
8 MR CORNELIUS: I think that's why we have seen sort of
9 6 per cent growth over the last few years and before that
10 5 per cent or thereabouts, growth for a number of years
11 before that. So the growth that has gone into the system
12 has been significant.

13
14 MR MUSTON: How does it take into account, though, things
15 like the increased cost of delivering medicine?

16
17 MR CORNELIUS: I think it needs to consider all of the
18 cost impacts. So there's a number of things that are less
19 costly now than they were historically. We've got a number
20 of procedures that are now being done in the same day that
21 used to be done in five days. You know, there's
22 opportunities, if we can get better interfaces with
23 Commonwealth parts of the system, residential aged care and
24 other similar areas, primary care as well, that would
25 potentially take pressure off the system.

26
27 So I think one of the challenges in thinking about
28 what an appropriate growth rate is is you've got a lot of
29 moving parts, and that's why we keep coming back to the
30 analysis of the performance metrics, because they are
31 giving us a guide as to how adequately that base is
32 delivering services to the community.

33
34 MR MUSTON: Do the performance metrics capture what might
35 be characterised as unmet need within the community, do you
36 think? So that is to say, if there are health needs within
37 the community that are not currently being met by the
38 health system, do you have any metrics that you rely on
39 which assist you to identify what they are and what it
40 might cost to meet them?

41
42 MR D'AMATO: It's a bit difficult, but I would argue that
43 our process, where Mr Cornelius described the 4 per cent,
44 is - it is not enhanced, but we have the NPP process,
45 that's where we then submit it and that's what we've done
46 for this financial year; we've submitted, for instance,
47 policy proposals to address the gap, if you want, of

1 1.5 per cent that has been historically set aside for
2 population and ageing, to meet what is forecast, and that
3 is where we take into account things like unmet needs, the
4 projection on the waiting time, you know, to maintain the
5 current performance.
6

7 Similarly, we put a submission in this year for the
8 cost escalation to address the fact, again, we are
9 relatively - in my opinion, the environment is still
10 relatively volatile when it comes to cost escalation and
11 the impact of CPI that we are experiencing.
12

13 Similarly again, you know, Mr Cornelius mentioned that
14 we also submitted a proposal for the new builds, to take
15 into account that this year, for instance, we had a major
16 development opening, which was Tweed, which opened late
17 last financial year and now we are seeing the full impact.
18

19 We also know when other key capital programs will come
20 on line, so we're monitoring with our colleagues regularly
21 and we update regularly, because we meet every fortnight,
22 and, you know, that's how we address these uncertainties,
23 if you want. But I would tend to think that the 4 per cent
24 is a starting point and then all these complex initiatives
25 or the unmet needs are covered through our submissions in
26 the budget process.
27

28 MR MUSTON: How does the ministry or what does the
29 ministry do to seek to quantify unmet need and put it
30 forward as part of a budget proposal?
31

32 Let me give an example, just so we can - we're
33 thinking tangibly about it. Unmet need might be -
34 obviously we've already had an example of someone who has
35 their ruptured appendix and they rush into hospital, they
36 need to have that dealt with. Obviously enough, if it's
37 not being dealt with, that's unmet need, but we read about
38 that on the front page of the paper, if that need is not
39 met.
40

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

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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

1 growth figure that is applied to the health budget, that
2 the increasing cost of delivering the identified need means
3 that, in effect, the gap between the cost of meeting all of
4 that need out there and the funding envelope continues to
5 grow wider?
6

7 MR CORNELIUS: I think the new policy process does provide
8 scope for proposals that are addressing unmet need, and
9 that will involve the ministry doing some work around gaps
10 analysis. We've had proposals around mental health
11 proposals, for example, that have been based around what
12 you've just described, you know, a fairly detailed and
13 comprehensive gaps analysis. So I think in a scenario
14 where - and you talked about paediatric waiting lists,
15 I think once there was sufficient groundswell of support
16 within the ministry, it would go to the policy area and
17 that would be considered through the budget process. So
18 I think there are mechanisms to consider unmet need through
19 the budget process.
20

21 MR MUSTON: So that process would be ministry, no doubt
22 informed by the LHDs and the policy unit would decide, "We
23 need additional funding to try and retain more
24 paediatricians and run more community-based paediatric
25 clinics. We've costed what that would look like in terms
26 of an annual cost of delivering the service. We've come up
27 with some economic analysis as to the immense benefits,
28 social benefits, not only to the individuals but to the
29 wider economy of intervening in learning difficulties and
30 the like at that very early stage, and we think it's
31 a proposal that should commend itself to you", treasury
32 would then consider that as part of the NPP process, make
33 recommendations to government so that government can make a
34 choice.
35

36 MR CORNELIUS: Yes, if it was included in the budget
37 submission of the agency, we would consider it then.
38

39 MR MUSTON: Just in relation to the growth figure, you
40 have identified the standard 4 per cent plus the 1.5 and
41 then told us that the growth that's actually applied from
42 one year to the next does vary from that. How is that
43 variation arrived at? What are the - is it just NPPs or is
44 it something else that goes into the process that leads to
45 it being adjusted?
46

47 MR CORNELIUS: Yes, it is normally considered through the

1 budget process. So as I mentioned, going backwards, since
2 that rate was applied we've actually been averaging
3 6 per cent and that's largely due to decisions to support
4 the pandemic response, would be the main drivers, but
5 there's been a few other policy decisions in there that
6 have added to the growth as well.

7
8 MR MUSTON: Can I come to capital projects. The actual
9 cost of delivering those capital projects you tell us about
10 in the submission, effectively, as having been informed by
11 an assessment made by Health Infrastructure NSW. So just
12 so I can understand the process, a decision is made to
13 possibly refurb a facility or build a new facility
14 somewhere, costing is then derived from Health
15 Infrastructure NSW; is that right, as part of a proposal
16 for the infrastructure project?

17
18 MR CORNELIUS: Alfa, do you want to talk to that? I think
19 it can be a bit of an iterative process between the - the
20 scope may be determined before the - in parallel with the
21 budget. So which one comes first, I think is a question
22 probably for the ministry.

23
24 MR MUSTON: Well, you tell us how that works.

25
26 MR D'AMATO: Okay. I also need to acknowledge that the
27 division that covers the capital planning is not my
28 division, but I'm informed and work with the team in
29 respect to the financials.

30
31 So the process normally starts with discussions with
32 the districts to identify their local needs. This is
33 again, similar to the NPP process and similar to unmet
34 needs, if you want, they are prioritised at the ministry
35 level, these are then submitted to the minister and then
36 from there goes to the ERC.

37
38 The part that I think we have confidence in now is
39 that there is an assessment at that point when the decision
40 is made around the technical adjustments, being the
41 depreciation of a new asset coming on our books, because
42 we're experiencing significant increases in the
43 depreciation expenses over the last few years. There is an
44 impact on some of our spend metrics.

45
46 Then, once that is done, the part that we monitor
47 together is the opening time, the footprint in determining

1 how many more beds or more services we have, and then we'll
2 use that information to determine whether we need to submit
3 an NPP that requires, if you want, an uplift above the
4 4 per cent or above the 1.5 per cent set aside to address
5 the new - the operating cost of the new build.
6

7 In the past before COVID, we were able to live within
8 our 1.5 per cent because we, effectively, were looking at
9 the one hospital a year and relatively small footprint,
10 whereas now we're seeing - in particular over the forwards,
11 we expect to see significant developments coming online,
12 and that's probably also the result of a few years ago when
13 we accelerated the capital program altogether. So these
14 are some of the concepts.
15

16 MR MUSTON: I'll come to the operating expenses in a
17 moment. In terms of the capital expense, we have heard
18 some evidence in our travels of decisions having been made
19 and announced to build a new facility or to fund the
20 upgrade or refurbishing of a particular facility, there's
21 a particular figure identified for that work which takes
22 into account an assessment made at some point in the
23 hopefully not too distant past as to what it would cost to
24 deliver on the range of services that it is hoped will be
25 delivered through that facility, but then increasing costs,
26 the build costs, between that date and the date when the
27 official ribbon cutting happens are such that by the time
28 it's actually built and opened, the facility, still built
29 within the budgetary envelope allocated to it, actually
30 delivers a lot less than was originally foreshadowed. Is
31 there some growth factor or some process which is embarked
32 upon to try and keep the original capital figure keeping
33 track with things like inflation, increased cost of
34 construction work, et cetera?
35

36 MR CORNELIUS: Yes, it's certainly an issue right across
37 the sector. The increased cost of infrastructure across
38 New South Wales has escalated significantly over recent
39 years.
40

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

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

3
4 MR MUSTON: How does that actually happen, though, the
5 putting it to government bit? So let it be assumed that an
6 amount of money has been earmarked for a particular
7 facility based on an assessment made at or shortly before
8 the time of that announcement of what services are required
9 to be delivered through that facility. As we come closer
10 to the actual completion date, or even perhaps the
11 commencement of the build date, we have a process we've
12 been told about, a value management process, where, as the
13 money that you've got buys less and less, you repeatedly
14 trim things out of the project. At what point does that
15 trimming exercise hit government decision-making?

16
17 MR CORNELIUS: Yes, so there would be an internal process
18 for the ministry to consider as to whether it wants to
19 escalate something for a government decision. Once that
20 decision is arrived at, then it would typically go through
21 the budget process along with any other budget proposal.

22
23 MR MUSTON: Effectively, a capital version of an NPP;
24 would that be right?

25
26 MR CORNELIUS: That's correct, yes.

27
28 MR MUSTON: So perhaps Mr D'Amato, for you, a question:
29 do you know - and it may not be your area - what the
30 trigger point is for the ministry in terms of raising an
31 NPP once it's realised that the refurbishment of
32 a particular facility or a particular envelope of money
33 marked to build a new hospital is no longer sufficient to
34 meet the perceived needs of the community to be served by
35 it?

36
37 MR D'AMATO: I think there are two key drivers, before we
38 go into the particular point. One is the delays. Any
39 delays will take an impact on the cost of delivering and,
40 in particular, because originally they'd planned for
41 a delivery time frame which takes into account cost
42 escalation. Unfortunately, the cost escalation in these
43 last few years probably has gone above and beyond what we
44 forecast it to be, so at times we struggle.

45
46 The second part is scope of services. Obviously when
47 we plan at the very beginning of the journey it takes a few

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

9
10 In terms of the trigger point, obviously there are
11 policies in place that require us to go to treasury when
12 the ETC, or the estimated total cost, is above 10 per cent
13 on the original cost, so that is one.

14
15 The second, obviously, is within the overall envelope,
16 because we need to acknowledge that at times there are
17 opportunities to - not prioritise, re-cash-flow, if you
18 want. At times there might be opportunities to take into
19 account the facility is probably able to be completed a
20 little bit earlier versus one that is delayed and so we try
21 to work within what is allocated to us.

22
23 If what is allocated to us is not sufficient to cover
24 the new cost estimate, then we go to the ERC, and we did so
25 for this financial year specifically for a number of
26 projects which were at risk, and we acknowledge that, you
27 know, there were a number of factors outside our control.

28
29 MR MUSTON: In terms of the cost increase exceeding by
30 10 per cent as a trigger, that assumes, does it not, that
31 their value management process has been undertaken and,
32 nevertheless, despite that project, there is still
33 a 10 per cent increase - there's no correlation between all
34 of the services that were intended originally to be
35 delivered through the new hospital and the point at which
36 you have to tell treasury that there's been a cost blowout,
37 unless and until, even after a process of value management,
38 you're still more than 10 per cent above the price. Would
39 that be right?

40
41 MR D'AMATO: That's right.

42
43 MR MUSTON: Can I come, then, to the next aspect of it,
44 which is the operational costs. Mr D'Amato, in your
45 evidence last November, you did express concerns about the
46 extent to which the growth factor applied to health's
47 budget was adequate to meet the increased costs of

1 delivering care through what I think you told us was
2 800 additional beds across the system over the short-term
3 future. Is that still an issue or is it an issue that's
4 been raised with treasury?

5
6 MR D'AMATO: It is an issue that has been raised. In
7 fact, we submitted a business case in this financial year
8 to make sure there is visibility of the challenge.

9
10 I think that the next few years will be particularly
11 challenging in regards to what is due to come on line.
12 Now, whether, as we have seen in the submissions from our
13 colleagues from treasury, at times these timeframes might
14 change, but eventually they have to open and, as I said,
15 within the forwards. So we have two kids hospitals,
16 Randwick and Westmead; John Hunter, and these are all major
17 redevelopments. So I think this is going to be challenging
18 for us to certainly accommodate within our 1.5 per cent.

19
20 MR MUSTON: Without needing to get into the minutiae of
21 decisions around that particular issue, just conceptually
22 or mechanically is that again effectively dealt with
23 through the NPP process?

24
25 MR CORNELIUS: That's correct, yes, it will come through
26 the budget process, yes.

27
28 MR MUSTON: So health would identify an increased cost of
29 doing its day-to-day business attributable to these
30 infrastructure projects which have happened; it would then
31 put forward a policy proposal calling for an increase in
32 its base, referable to the increased cost of delivering
33 health care through the additional beds being brought on
34 line?

35
36 MR CORNELIUS: Yes, that's right. It will form part of
37 a broader proposal around sort of population growth
38 requirements, so there will be a component that's related
39 to the new builds and then a component that's related to
40 the general activity growth across the state.

41
42 MR MUSTON: You, I think in your submission, have
43 expressed the view that the operating expenses for large
44 hospital projects are generally not added to the
45 expenditure budget when capital projects are improved, but
46 you I think are of the view that the existing growth figure
47 that is applied year on year is adequate to meet those

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

2
3 MR CORNELIUS: No, I think what we were saying is that
4 those costs are a little unpredictable when the approval
5 for the capital project is first granted. So it's
6 difficult to specify exactly what year those operating
7 costs are going to hit and then how much headroom there may
8 be within the growth rate in that year at the time, and so
9 what we've - how we respond to that is through the annual
10 budget process to go through the arrangement that we just
11 talked about, to have a look at how much growth there is in
12 that year and what new facilities are coming on board and
13 then provide some advice around that.

14
15 I think it is fair to acknowledge that the capital
16 program at the moment is at historically very high levels
17 so we've been averaging over 3 billion per annum in capital
18 works for the last few years, which is probably double what
19 the long-term average has been. I think when we first
20 conceptualised the growth rate, I think we had a lower
21 capital program in mind.

22
23 So there's definitely some tension in that, as those
24 works start coming on line, that will challenge the
25 1.5 per cent that's in the growth rate at the moment, but
26 we will consider that through each budget process.

27
28 MR MUSTON: We've heard some evidence in our travels about
29 the way in which contemporary hospitals are being built
30 also adding significantly to the costs of running them,
31 even if you don't get any increase in activity or
32 necessarily even a substantial increase in bed numbers in
33 those hospitals, because, for example, a single room is
34 much more labour intensive to monitor than a Nightingale
35 ward that had 12 patients, lined up on either side of the
36 room. That's generally been your experience of the
37 submissions that you've been receiving in relation to this
38 issue?

39
40 MR CORNELIUS: Yes, that's correct. Certainly for us,
41 it's important for us to understand how much of the funding
42 ask is relating to that additional cost component versus
43 how much of it's relating to additional capacity, because
44 that informs the relationship between the overall ask for
45 activity growth, but it's an important distinction.

46
47 MR MUSTON: Can I quickly ask about whole-of-government

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

5
6 Now, in relation to travel, I understand from that
7 evidence that some particular arrangements have been
8 entered into with health to, as it were, quarantine
9 clinical related travel from the savings initiative that
10 would otherwise have required that travel to be cut, is
11 that right - that is to say, there's been a quarantining of
12 clinical based travel from the savings initiative?

13
14 MR CORNELIUS: Yes, that's correct. Our understanding is
15 that it hasn't been government's intention to apply
16 a reduction in clinical travel, and so that's how that
17 saving is being monitored.

18
19 MR MUSTON: So whilst one can readily see the virtue of
20 introducing some travel savings initiatives, they would be
21 misplaced if they were applied to, say, metropolitan based
22 specialists in the employ of the public system who were
23 flying out to deliver needed health care to regional and
24 rural communities that didn't have resident specialists?

25
26 MR CORNELIUS: Agreed. That's our understanding of the
27 policy intent.

28
29 MR MUSTON: In relation to advertising, I think the
30 evidence that we received in November last year was to the
31 effect that the 30 per cent cut required on the advertising
32 spend within health was predominantly affecting
33 preventative health advertising and promotional material,
34 principally within the Cancer Institute. Is that something
35 that was brought to your attention as part of a budget
36 proposal or a budget submission?

37
38 MR CORNELIUS: Yes, it was certainly brought to our
39 attention, yes.

40
41 MR MUSTON: What was the nature of the discussion around
42 that issue? Let me perhaps take it in two steps. There
43 was no equivalent quarantining, at least as at November
44 last year, of advertising spend within, for example, the
45 Cancer Institute on preventative health promotion?

46
47 MR CORNELIUS: My recollection is we were advised of the -

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

5
6 MR MUSTON: I'm not saying this was your decision, but do
7 you know what government's response to that advice was?

8
9 MR CORNELIUS: I probably need to check the record to give
10 the correct advice on that, I think.

11
12 MR MUSTON: Do you have a recollection, Mr D'Amato, of
13 what the government's response to that was?

14
15 MR D'AMATO: I do actually recall that there was - that
16 the advertisement target had been caught into the component
17 we would normally spend on public health campaigns versus
18 advertising for other - even recruitment, and because this,
19 yes, is involving that, it is correct that there has been
20 confusion. But, ultimately, there was no acknowledgment of
21 the fact that we had a challenge in respect of public
22 health, and we put forward a paper providing evidence that
23 investing in public health campaigns actually has a huge
24 return on investment. So that's where we left that. There
25 was no - I don't recall any response back from government
26 and we're still working within that.

27
28 MR MUSTON: Anyway, the role that the three of you have is
29 to provide advice to government so government can make
30 a properly informed decision and, properly informed,
31 they've made a decision and that's what it is?

32
33 MR D'AMATO: Yes.

34
35 MR MUSTON: You tell us in paragraph 2.38 of your
36 submission that the future adequacy of funding for health
37 is likely to be impacted by Commonwealth funding
38 arrangements and the effectiveness of interfaces with
39 primary care, aged care, disability and mental health
40 services. Could I just invite you to expand a little bit
41 on exactly what you were conveying there?

42
43 MR KASTOUN: Yes, I'll take that one.

44
45 So in our evidence presented to the Commission we've
46 highlighted a number of limitations with regard to
47 Commonwealth funding. If I may, I would start with regard

1 to the point around the Commonwealth's contribution rate
2 under the National Health Reform Agreement. So there has
3 been a longstanding ambition under successive NHRA
4 agreements for the Commonwealth to increase its funding
5 share to the states and territories under the NHRA.
6

7 As per the evidence we provided, there's been a sort
8 of trajectory towards increasing that over the last decade,
9 but in recent times, that has declined quite considerably.
10 So we were trending towards 39 to 40 per cent; we're now
11 sort of projecting a CCR rate of 38 per cent.
12

13 MR MUSTON: Just pausing there, what's the cause of that
14 decline structurally?
15

16 MR D'AMATO: There are two key factors impacting the
17 Commonwealth contribution rate. The first is that if we
18 have reached the cap, that means that Commonwealth will
19 keep paying for every single activity but at a lower rate.
20 So they'll still pay for everything but at a lower rate,
21 reduced rate.
22

23 Then there is a more technical reason, which is
24 related to what we call "back-casting" of the activity. So
25 in the NHRA there's a process whereby, in order to
26 calculate the growth, they have to apply what they call
27 "back-casting". That particular policy is developed and
28 implemented by IHACPA.
29

30 We've raised some concerns now over the years in
31 regards to how that was implemented. In fact, just
32 recently I wrote to the administrator of the health funding
33 body as well to seek further clarification, because we are
34 a little bit concerned that the application of that policy
35 has inadvertently impacted on the Commonwealth contribution
36 rate.
37

38 MR MUSTON: But in terms of hitting the 6 per cent, to the
39 extent that that has resulted in a reduction of funding, is
40 that because activity has increased or the cost of
41 delivering that activity has increased in recent times to
42 a greater extent than had historically been the case?
43

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

1 above what we originally expect it to be, or volume.
2 Normally the national efficient price takes a bigger
3 component of the growth rate, so that's where we see the
4 impact there, which is then reflected also in the CPI that
5 we are seeing at the moment.
6

7 MR MUSTON: I think I interrupted you, but that's an
8 answer to why the --
9

10 MR KASTOUN: Yes, so encouragingly, with the current round
11 of negotiations with the Commonwealth around the next
12 addendum to the NHRA, the Commonwealth has, I think,
13 recognised the importance of increasing its contribution
14 rate. With the parameters being discussed at the moment,
15 that would see the CCR essentially being increased to
16 45 per cent over a 10-year horizon.
17

18 It's encouraging, but I think the point to sort of
19 raise there is that's still at least a decade away to get
20 to that point, and this has been a longstanding ambition.
21 So our view is that, I guess, a more rapid glide path
22 towards 45 per cent would be beneficial and would provide
23 significant funding into the health system, not just ours
24 but nationally in hospital systems nationally.
25

26 The second point is in any given day in the hospital
27 system, you have a number of patients that are ready to be
28 discharged from hospital, that are there because there
29 aren't any alternative arrangements through the aged care
30 sector or indeed disability, as well as sort of outcomes
31 for those patients.
32

33 Inevitably what that means is it has an impact on
34 efficiency for the hospital system, and the state being the
35 majority funder of essentially the cost of hospital
36 services means that we carry a large disproportionate share
37 of the costs associated with those patients being in the
38 hospital system, when indeed they fall under essentially -
39 well, should be theoretically under a Commonwealth sort of
40 managed facility or funding responsibility, and I think --
41

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

1 hospital in New South Wales, the state is picking it up,
2 subject to an arrangement which exists for the partial
3 funding of those placements.
4

5 MR KASTOUN: Yes, that's right. I recognise there are
6 complexities, they are thin markets and so on and so forth,
7 but as my previous point, it does mean that the states are
8 essentially carrying a disproportionate share.
9

10 I guess the third dimension is - and I think the
11 Commissioner has sort of looked at this - is with regard to
12 the interface with essentially the primary care sector.
13 Again, any given day, there's quite a number of
14 presentations to the emergency departments which are
15 probably unavoidable in the scheme of things that are
16 probably better served through the primary care network but
17 because of thin markets or market failures, you know,
18 inevitably the only option they have is to essentially
19 attend an ED department.
20

21 Again, there is a similar point with aged care. That
22 does represent a disproportionate cost of being shifted to
23 the states and territories.
24

25 So when you think about those three factors combined,
26 you know, there is certainly scope to improve the
27 Commonwealth funding dimension across a number of areas,
28 CCR principally, but also through aged care and the primary
29 care network, and those would undoubtedly have
30 a significant impact in terms of alleviating the cost
31 pressures within the health system in New South Wales, and
32 indeed other states and territories.
33

34 MR MUSTON: So increasing the funding from the
35 Commonwealth perspective might have the effect of reviving
36 a thin or failed market, potentially, in which case it
37 would have the consequence that you would hope for, namely,
38 better primary care or smooth transition into aged care for
39 these patients who are currently in medical wards?
40

41 MR KASTOUN: Correct.
42

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

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

3
4 MR KASTOUN: I mean, that is a potential option for
5 government to consider. I mean, there are complexities
6 attached to that as well and, you know, I would defer to
7 ministry colleagues who have probably been looking at the
8 sort of complexities around that.

9
10 It certainly is an option for government to consider
11 and it would essentially hinge on the strength of, you
12 know, the business cases that are put forward for
13 government to consider.

14
15 I understand, essentially, the costs and benefits in
16 going down that path. It would require, I guess, a firm
17 commitment in alliance with the Commonwealth as well to be
18 able to support such arrangements. So, you know, yes, that
19 option is potentially there for government to consider but
20 it relies on those parameters.

21
22 MR MUSTON: Again, probably a matter better for the health
23 ministry to consider, but there may well be some synergies
24 that could be capitalised upon within the acute care
25 setting and both primary care and aged care, to the extent
26 that there was, in the way that we see in the MPS
27 facilities, for example, a leaning in by the state to the
28 delivery of those sorts of care, but your point is it would
29 need to be backed up with an appropriate funding stream
30 from the Commonwealth?

31
32 MR KASTOUN: Correct.

33
34 MR D'AMATO: Sorry, which includes capital as well.

35
36 MR KASTOUN: Yes, indeed.

37
38 MR D'AMATO: Only because the current Commonwealth
39 approach really covers only operating, so I think if we
40 were to go into an aged care environment, we really need to
41 think about also the capital investment required of the
42 state, if there was a decision made --

43
44 MR MUSTON: You give that answer with respect to aged
45 care. In relation to primary care, there might be
46 a capital consideration, but to some extent, facilities
47 already available to NSW Health in small hospitals and MPS

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

4
5 MR D'AMATO: I totally agree on that. I'm more concerned
6 about the aged care which is probably the part that
7 requires a significant capital investment consideration.

8
9 MR MUSTON: In paragraph 2.45 and following of your
10 statement, you tell us a little bit about the relative
11 efficiency of the New South Wales public hospitals when
12 compared with other jurisdictions, ultimately, concluding
13 that New South Wales operates at very much the more
14 efficient end of the scale.

15
16 Two questions about that. The first is, does that
17 potentially indicate that the room for finding further
18 efficiencies is - let me put it another way: we'll soon
19 reach a point where further efficiencies are very, very
20 hard to find within the existing budgetary envelope?

21
22 MR CORNELIUS: Look, I don't think so. I think the health
23 system is going to continue to evolve, and we've spoken
24 about some of the impacts of technology and the like.

25
26 I think there's always going to be opportunity to do
27 things differently and more efficiently. Those
28 opportunities are going to continue to change over time.
29 But, yes, I think there will continue to be opportunities
30 for efficiencies in certain areas, and I think the
31 important part of that is, when we're thinking about the
32 base, it is critically important to be looking at how all
33 those dollars are being spent and whether they're being
34 spent on the right things. If there is opportunity to
35 redirect them to support better patient outcomes, then
36 I think that's the - you know, a key thing that we all need
37 to be working towards.

38
39 MR MUSTON: The second question I was going to ask about
40 that is: to what extent, if any, does the relative
41 efficiency of New South Wales, when compared with its
42 interstate equivalents, rest on the extent to which there
43 is a disparity between wages in New South Wales, or at
44 least until recently, has been a disparity in the wages of
45 NSW Health workers when compared with, say, particularly
46 their Queensland and Victorian equivalents?
47

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

8
9 MR MUSTON: Could you just unpack that a little bit?

10
11 MR CORNELIUS: I think typically when there's
12 benchmarking, the benchmarking looks at the hourly rates
13 and it's more challenging to compare how the different
14 allowances over and above those hourly rates compare in
15 terms of take-home pay.

16
17 MR MUSTON: So, for example, you might have one
18 jurisdiction that theoretically has a slightly higher
19 hourly rate and therefore it is assumed has a slightly
20 higher take-home pay in the hands of that particular health
21 worker, but if you then compare it with New South Wales,
22 where the hourly rate might be lower but across the board,
23 the overtime rate is a little bit higher and is part of
24 day-to-day business, everyone does a degree of overtime
25 which means the average take-home pay is actually slightly
26 higher than the comparator, but you really do need to get
27 into the nuts and bolts of it in that way to work out what
28 the true comparison is; would that be right?

29
30 MR CORNELIUS: Yes, agreed.

31
32 MR MUSTON: And across the very wide range of health
33 awards that we have in New South Wales, and no doubt exist
34 in other states, doing that on an award-by-award basis is
35 extremely complex?

36
37 MR CORNELIUS: It is, yes.

38
39 MR MUSTON: Mr D'Amato, in your most recent statement, you
40 draw the distinction between parameters and technical
41 adjustments for the continued delivery of existing services
42 in the preparation of the budget. Could you just explain
43 to us the distinction between a parameter and technical
44 adjustment for continued delivery of existing --

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

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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

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

3
4 MR MUSTON: Coming back to a matter referred to in your
5 submission, you tell us - and I think you've told us this
6 afternoon - about the role played by the intergenerational
7 report in this process. I just want to unpack that a
8 little bit.

9
10 The intergenerational report is replete with
11 references to the value of preventative health care and the
12 consequences from the point of view of the health spend,
13 future health spend, in the event that those things are
14 not - that that preventative health care is not adequately
15 delivered.

16
17 To what extent does - or in what way does that feature
18 in this budget-building process? Is it a factor which is
19 called upon in an NPP - that is to say, "Here's a new
20 policy proposal, it is meeting this issue raised in the
21 intergenerational report", or does treasury itself use the
22 intergenerational report in a way to inform decisions
23 around budgets?

24
25 MR CORNELIUS: Yes, I think there's a bit of policy
26 connection. So certainly health will reference the "Future
27 Health" strategy, and that is definitely picking up some of
28 the concepts that are raised in the intergenerational
29 report. So the extent that a new policy measure is
30 consistent in giving effect to that strategy, which is
31 aligned with the intergenerational report, and there's
32 a strong evidence base for that policy, that will
33 definitely be considered in the treasury assessment of that
34 proposal.

35
36 MR MUSTON: Now, in paragraph 2.30 of your submission, you
37 express the view that having regard to health's financial
38 and operational performance, the current level of funding
39 is adequate. Can I just test my understanding of that.
40 The financial and operational performance that you refer to
41 there, is that, from an operational performance point of
42 view, the emergency wait times, elective surgery wait times
43 and patient satisfaction ratings that you've referred to
44 toward the end of the submission?

45
46 MR CORNELIUS: That's correct, yes. They're some of the
47 examples of the operational performance that we're

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

4
5 MR MUSTON: But at one level, what that tells you, is it
6 not, is that health is doing its best with the parcel of
7 money that has been allocated to it, but is doing so in a
8 way which is targeted at ensuring that those two or three
9 key metrics are kept within acceptable parameters, but it
10 doesn't really tell you much more than that, does it, in
11 terms of the overall effectiveness of the health system in
12 meeting the needs of the community's health in the short
13 and long term?

14
15 MR CORNELIUS: Well, I think in terms of considering
16 whether the funding is adequate, that's probably the best
17 point of reference that we've got, and certainly through
18 the budget process, as we've spoken about, some of the
19 other dynamics around areas of unmet need can be considered
20 through the budget process as well. But I think what we're
21 trying to get a sense of in answering that question is how
22 does NSW Health perform relative to other health systems,
23 and I think the answer to that is NSW Health performs very,
24 very well.

25
26 MR MUSTON: But even then, it performs well in what sense?
27 By what metric?

28
29 MR CORNELIUS: Yes, I guess by the metrics we've just
30 spoken about, taking on board your challenge that there may
31 be some other things that we need to be throwing into the
32 mix around --

33
34 MR MUSTON: Health outcomes.

35
36 THE COMMISSIONER: As an example, we've discussed the
37 growing rates of chronic disease. If that was the metric
38 for operational performance, then you'd say, "Well, in
39 relation to that, given that chronic disease is rising, if
40 that's the metric we judge ourselves by, we're not - we
41 might not be adequately funded to address that." If you're
42 looking at other metrics, it's different.

43
44 MR CORNELIUS: Yes, look, I think it's a challenge when we
45 start thinking about outcomes, because some of those
46 outcomes around chronic disease may be quite difficult for
47 the health system to influence.

1
2 THE COMMISSIONER: Yes, sure.

3
4 MR CORNELIUS: It's not to say there shouldn't be programs
5 targeting investment to improve outcomes --

6
7 THE COMMISSIONER: It might be difficult for health
8 undoubtedly, because the social determinants of health are
9 involved, so housing, education all of that, yes.

10
11 MR CORNELIUS: Yes, exactly. No, I agree.

12
13 MR MUSTON: Can I invite you, Mr D'Amato, to express
14 a view on whether you agree with what's set out in
15 paragraph 2.30 of the submission, namely, that health's
16 financial and operational performance suggests that the
17 current level of funding is adequate?

18
19 MR D'AMATO: Okay, I feel that it's a bit difficult for me
20 to make a call whether we're adequately funded. We do the
21 best we can with what has been allocated to us and we
22 always try to do our best for our patients and our
23 workforce. Ultimately, that's what we do.

24
25 Admittedly, I think we've done relatively well
26 compared to the other states and other territories, and
27 perhaps also internationally, but I do think that we're now
28 stepping into a different environment and it is
29 challenging. It is challenging to maintain the level of
30 performance and it is challenging because, in my opinion,
31 we need to start thinking more about medium and long term
32 outcomes, investment in prevention, which before - we
33 probably tried to get there, just before COVID, as we were
34 working with other policies, treasury policies, with
35 outcome budgeting and then, all of a sudden, we interrupted
36 the whole process.

37
38 I think there was an evolution in our ABF moving
39 towards more of an outcome framework. We had investment in
40 value based health care, but during COVID, obviously, all
41 of these had been paused. So for me to answer your
42 question, I feel that it's a bit premature. I think we
43 need to acknowledge that the environment's changed now.

44
45 MR MUSTON: Would it be right to say that if the level of
46 funding was increased, coming back to something we touched
47 on a bit earlier, there would be ways that it could be

1 spent which would potentially produce good health outcomes
2 for the community, which are currently not being achieved
3 within the existing funding envelope?
4

5 MR D'AMATO: In my opinion, yes, that is the case, and in
6 my opinion, we have good frameworks, we have robust
7 internal control processes to make sure that we can achieve
8 these outcomes.
9

10 I admit that it is not easy, because measuring
11 outcomes will take longer than a budget cycle, and probably
12 even longer than the forwards, in terms of four years. But
13 I think that we have a very well-connected system and a
14 mature system that can probably achieve it.
15

16 MR MUSTON: Coming back to --
17

18 MR KASTOUN: I would just say I guess adequacy also needs
19 to be considered in the context of what is also fiscally
20 affordable for government, and also the other competing
21 priorities that exist across other portfolios as well. So,
22 you know, we can't just take a single sort of
23 health-centric lens, I don't think. It's a broader concept
24 for government to consider, what's adequate and what's
25 affordable.
26

27 MR MUSTON: You have anticipated my next question, which
28 was as to what is or is not adequate. There are two
29 questions, really: what is the amount we could spend to
30 meet all of the health need, and then there is a second
31 question, how much do we actually as part of that balancing
32 priorities wish to spend on meeting the health needs of the
33 community and having made a decision about that, how best
34 to spend it?
35

36 MR KASTOUN: Yes.
37

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

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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.

1
2 MR MUSTON: I had in mind that the point at which the
3 varying priorities of these agencies meet is you. So --
4

5 MR CORNELIUS: It's interesting. Also the business cases
6 themselves should be taking, you know, a broader
7 perspective. There's a couple of examples, where that
8 broader systems thinking is important. I think some of the
9 paediatric initiatives you've talked about, probably in the
10 context of the "First 2000 Days" sort of framework, that is
11 looking at sort of whole of system impacts, also mental
12 health proposals impact right across the board, and so does
13 housing. You know, measures, investments in those areas
14 can have broader impacts than just impacts for those
15 particular agencies that are putting forward the budget
16 proposal. But the business cases provide the framework to
17 be describing the benefits more broadly.
18

19 MR MUSTON: I suppose my question, inelegantly put, was:
20 to the extent that these business cases might have been
21 generated in the silos of the different agencies without
22 a degree of collaboration, it's not necessarily a choice
23 between one or the other; it may well be that the two can
24 be combined in a way that actually produces a better
25 outcome long term. But at the treasury level, is there
26 some process whereby you look at these varying proposals
27 and, as it were, put parties together, say, "Well, you're
28 asking for this, housing is asking for that" or "education
29 is asking for that, I think we're not going to fund either
30 of those things as they stand, but you two go away and work
31 out a way of collaborating to produce what would seem to be
32 a slightly overlapping, but nevertheless at least
33 theoretically complementary, if done properly, proposal and
34 bring it back to us"? Is there any process like that where
35 you, as treasury, do those sorts of things?
36

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

1 the interconnectedness of proposals and the ability to sort
2 of jointly come forward - agencies jointly coming forward
3 with new policy proposals of that nature.
4

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

10
11 MR MUSTON: You touched on the "First 2000 Days". Policy
12 priorities of that type, which are identified either as
13 a premier's priority or some other explicitly identified
14 government priority, they are a mechanism through which
15 funding can be obtained by a range of different agencies by
16 pointing to --

17
18 MR KASTOUN: Sorts of thematics, basically?
19

20 MR MUSTON: Yes.
21

22 MR KASTOUN: Yes.
23

24 MR MUSTON: If there was a standing priority for the
25 prevention of chronic illness, for example, whether that be
26 through healthy eating campaigns, through delivery of
27 health literacy through education, for example, through the
28 infrastructure to get people out walking and riding their
29 bikes, that would be another way, not just through the lens
30 of health, to facilitate --
31

32 MR KASTOUN: Indeed. It's also relying on policy areas
33 across agencies also recognising those synergies and
34 actually engaging and working collaboratively. So - but
35 yes, there is the scope for that.
36

37 MR MUSTON: Can I ask you, Mr D'Amato, it may well be that
38 the collaboration has already occurred by the time these
39 proposals reach you, but do you know whether collaboration
40 of this type actually occurs as between --
41

42 MR D'AMATO: Absolutely.
43

44 MR MUSTON: -- the health ministry and other agencies?
45

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

1 time.

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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

1 in treasury.

2

3 THE COMMISSIONER: I'm sure you do.

4

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

8

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

11

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

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