Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Thursday, 21 November 2024 at 10.00am

(Day 064)

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 MUSTON: Commissioner, this morning, we've got another largish panel. Sitting in front of you, from your left to right, Alfa D'Amato is back, Steven Carr, Neville Onley, Matthew Daly, Joe Portelli and Sharon Smith.

THE COMMISSIONER: Can we treat Mr D'Amato as on his former oath?

MR MUSTON: We can, but we are told that all of them wish to give an oath.

THE COMMISSIONER: I'll leave it up to him.

<ALFAISTER DAVIS D'AMATO, on former oath: [10.00am]

<STEVEN CARR, sworn:

<NEVILLE ONLEY, sworn:

<MATTHEW DALY, sworn:

<JOE PORTELLI, sworn:

<SHARON SMITH, sworn:

MR MUSTON: I might ask each of you, perhaps excepting you, Mr D'Amato, because you've already told us, but everyone else, if you could just go down the table and give your full name for the record and identify the role that you hold within the ministry.

MR CARR: Thank you, Steven Carr. I'm the executive director, system financial performance and deputy CFO at the Ministry of Health.

MR ONLEY: Neville Onley, the executive director of activity based management.

MR DALY: Matthew Daly, deputy secretary for system sustainability and performance.

MR PORTELLI: Joe Portelli, executive director of the system purchasing branch.

MS SMITH: Sharon Smith executive director of system information and analytics branch.

MR MUSTON: Thank you.

Mr D'Amato, Mr Carr and Mr Onley, you have each contributed to a joint statement dated 14 November 2024.

MR D'AMATO: That's correct.

MR MUSTON: Have you each had an opportunity to review that before giving your evidence today?

MR CARR: Yes.

MR ONLEY: Yes.

MR MUSTON: Mr D'Amato has already told us --

MR D'AMATO: Yes.

MR MUSTON: -- but the rest of you remain satisfied, I take it, that its contents are true and correct?

MR ONLEY: That's right.

MR CARR: Yes.

MR MUSTON: Likewise, Mr Daly, Mr Portelli and Ms Smith, you have prepared for us a statement also dated 14 November 2024. You've had an opportunity to review it before coming to give your evidence today and are satisfied that its contents are true and correct?

MS SMITH: Yes

MR DALY: Yes.

MR PORTELLI: Yes.

MR MUSTON: And are satisfied that its contents are true and correct?

MS SMITH: Yes.

MR MUSTON: That's exhibit M4, Commissioner.

Can I just start with a broad question about the way in which the annual - let's start with LHDs, the annual LHD budget is arrived at. Any of you who feels best equipped

to answer it, perhaps just talk us through, in a narrative way, that process that is gone through by the ministry and the LHDs when arriving at the ultimate point where the service level agreements specify the budget.

MR DALY: I'm happy to start in terms of the process. It is very much an overlapping one between the system purchasing performance and --

MR MUSTON: Can I say in that respect, for the benefit of all of you, you should treat this process as largely conversational. For the benefit of these two people who are taking down what is said, it's great if we could try and speak as slowly as possible and leaning towards the microphones. But, equally, don't feel that if a question has been directed at one of you or one of you has given an answer, that that precludes others from either contributing further thoughts on the same topic or expanding on the same topic or even asking one another questions along the way, if there are things that you think would be usefully fleshed out by asking one another questions about your respective areas of endeavour. That is definitely permissible.

With that interruption, Mr Daly, if you want to kick us off?

MR DALY: Sure. Well, as I said, it's a process that starts in about October of the financial year before, that's largely led through Joe Portelli and Sharon Smith, for their respective responsibilities, and firstly, in October, it's about firstly reviewing the current year's service agreements in terms of learnings to bring back to inform any changes to the service agreements.

MR MUSTON: So when you talk about "learnings", what sort of learnings are you seeking to obtain through that process?

MR DALY: I'll let Joe give you some specific examples.

MR PORTELLI: Yes, basically any kind of learnings to do with the process, the model, maybe inclusions that we wanted to have for the current financial year but, with timing, we couldn't, so we might want to hold them over to the next financial year - so anything, any kind of either process or model related --

MR MUSTON: Could you give us some examples of the sorts of things - when you talk about process or model-related things, what sorts of things are we talking about?

MR PORTELLI: So the timing of the meetings are really important. If we don't have information at a certain point in time there's no point having a meeting, so we will try to shift that timeline and, you know, make sure that the next year we've got more information to have more fulsome discussions with the districts and networks. That's a process example.

A model example might be that we want to include a different purchasing adjuster into the model, and that is predicated or that is calculated using historical data. So if we implement it at a certain point in time, there is no time frame in which the districts can actually act and respond to that adjuster, which means they may get a financial penalty or a financial reward, however minor, but without any ability to change.

So we might decide to go, "Well, we've agreed and discussed it with districts and networks. We think it's a good idea, but we will implement that next year because then they've got time to actually respond to the incentive rather than just be hit with the consequence of it without ability to respond."

MR MUSTON: So in terms of process, we're talking about the process by which discussions lead ultimately to or the process by which the service level agreements and budgets are ultimately set. So the meeting that you refer to might be if particular data about a service is not available to the LHDs at a particular point in time, and that's been revealed through the process, you might, for future service level agreement discussions, adjust the timing of that meeting?

MR PORTELLI: That's correct.

MR MUSTON: And in terms of the adjusters that you were talking about, that's more substantive in terms of the budget that LHDs might ultimately be receiving. What information is informing you about, in that example, the adjusters that may or may not be included.

MR PORTELLI: So in terms of the development of the adjusters generally we go through that consultation process. Depending on the type of feedback that we get and the ability for us to reach all the different stakeholders in the right time in the process, that might determine when we can make a decision about whether to include that adjuster. If that's the case, if it's too late in the year, for example, we might decide to double the value of a particular incentive for a particular model of care.

So one example is this year we decided that we thought it would be a good idea to double the incentive for virtual care, given the benefits. However, by the time we got to the decision, because of various factors, there was no time for the districts to change any models of care to respond to that incentive, so instead we decided to delay it and communicate it, and then that way, that kind of decision will be factored in to this process in October where we go, "Okay, well, what did we learn from the last process? What are we going to do differently this year?"

MR MUSTON: Just teasing out that example, there's a particular way in which virtual care is remunerated under the agreement as a form of activity; is that right?

MS SMITH: Yes. So I'm happy to take that one. Virtual care, if it's in scope of the activity that we deliver across districts and networks and in scope of national weighted activity units, it's already remunerated but we do incentivise certain things in a relatively minor way, but to provide, I guess, an additional payment to districts to do those kinds of activities that we think have value and that are going to derive longer-term value for the New South Wales health system.

We use data that we have available already that identifies where a service might be delivered by virtual care but because it's historical, as Joe said, we need to make sure that the district has time, so that when we do look at the data just before the purchasing process begins again, that if they wanted to increase the amount of virtual care that they deliver, that that's evident in the data, otherwise we're using data from before they knew that we wanted to incentivise it.

MR MUSTON: I'm just trying to understand that, and we will get into the details a little bit more, but why would

it not be equally advantageous to say, "From this point forward we're going to incentivise the use of virtual care for the delivery of activity", and then give districts the benefit of that incentive and that uptick in income, to the extent that they can achieve it during the immediate 12-month period, during which time they can then increase their capacity, perhaps with the benefit of the additional funding that they've got, to deliver more virtual care? Why delay it?

MR PORTELLI: It's timing. So when we release the budget we want to give certainty to the districts as much as possible. We don't want shifting budgets within the year, as much as possible, and then steps taken to try and reduce supplementations throughout the year so districts have as much certainty as possible, which means, with these adjusters, we set them at the point of budget day and that's based on the data that we have available. So for the next 12 months, they will have adjusters based on their performance in the last 12 months.

So having that time lag to say, "Right" - if we said on budget day, "We're going to increase the virtual care adjuster", the districts will be living with the consequences of actions from 12 months prior, before they knew that was going to happen.

So the positive adjuster is probably, you know, fine, people get a windfall; but if it was a negative adjustor, that's a material thing because they haven't had any opportunity to change models of care or maybe change behaviours in a way that would help them avoid that penalty.

MS SMITH: I think it's important to note, though, that the adjusters are fairly small in the general scheme of things. So, for example, the virtual care adjuster might have been a million dollars across the whole of the 17 districts and networks, and there are other ways in which funding to support some of those initiatives does flow to districts, but it's part of the purchasing model to signal what is important to us as a system and the things that we value and want districts to continue to do.

MR MUSTON: Accepting the distinction between positive and negative adjusters, I'm still struggling - and it might be me - to understand why withholding the benefit of

a positive adjuster in the immediate budget period is something which is of benefit to the system.

MR PORTELLI: There's several considerations. One is sometimes those adjusters are implemented at the same time, so they are budget neutral overall. A decision around including a positive adjuster, you know, when there's a total bucket available, means that we will be taking that from the top and not distributing that down.

Again, it comes to a decision on timing and I think when we change adjusters, we don't want to change them one on one; we try to change them in a bulk setting, so again when they are - sometimes, again they're pretty small, so when you try to increase one positive adjuster, you try to have another one to modify behaviour as well, on the other side, so it's budget neutral.

MR MUSTON: So the ultimate upshot of these adjusters, year on year, would it be right to assume from that, might not actually result in the LHD getting any more or significantly more money?

MR PORTELLI: Sometimes they offset sometimes they don't on a district-by-district level.

MR MUSTON: But across the system, they will offset?

MR PORTELLI: But across the system, it's budget neutral, yes.

MR MUSTON: That being right, would it be right that the risk of introducing the positive adjuster to enable LHDs to get the benefit of it, but giving them a 12-month period to acclimatise to the potential negative, would not be budget neutral?

MR PORTELLI: Correct. And also I guess there's an equity argument around the pool of money, how that is carved up. If some districts could have taken more action earlier and would have, they may have got more share of that particular adjuster. So, again, it's probably fairer just to give everyone the same amount of time to react, and people's baselines can change within a 12-month period.

MR MUSTON: I think I distracted you, asking about the learnings. So you told us that we go through the process

of reviewing learnings that can be obtained from past budgetary negotiations. Where do we go from there, once we have learned what we can learn?

MR DALY: I might get Joe to continue through, including the overlap of finance and then the actual allocation of budgets. I think that might be a bit more productive, if that's okay.

MR PORTELLI: So after that point we hold a purchasing workshop in December. In November we also talk with finance as well around what some of the NPP proposals might be. We share some modelling around population, ageing and equity --

MR MUSTON: Pausing there, first thing, the workshop, is that a workshop that's attended by all of the LHDs or are we talking about separate workshops with each of them?

MR PORTELLI: No, we have a system-wide workshop, so all the LHDs, pillars and all the statewide services are included. We include relevant policy branches from the Ministry of Health. Finance is obviously there and presenting with us. It's sort of setting the scene for the next budget process.

MR MUSTON: Then the next thing you told us about was liaising with finance about NPPs that might be on the horizon. Do we take it from that that the purpose of that discussion is to work out what the existing envelope of funding delivered by treasury is, probably get an understanding of the extent to which it might be adjusted by growth, but, equally, if there are new policy proposals which have been put forward to treasury, getting some sense of the likelihood of them being met with favour at treasury and, if so, the consequences in terms of the overall budgetary envelope that you have to distribute to the LHDs?

MR PORTELLI: Yes. I mean, I can talk you through --

MR D'AMATO: It's perhaps best if we step back a bit, because that process is about one component of a budget, it is not the whole budget.

So, for instance, as I described in my statement at 56, the overall budget is set on four key components. One is the base, and I think it's fair to say that the

districts have an opportunity to adjust what the base looks like, not to increase the base, but if there are service configuration changes - and to think about one that has occurred this year, for instance, where a hospital, in Nepean Blue Mountains, used to be a third-party service, so paid through our goods and services, it's now part of our system, it means that they had to move the budget from a goods and servicing to an employee related. So when we then apply the next step, which is the escalation, related to the budget allocated to salaries and wages, we have the ability to increase the budget appropriately to reflect that the wages may increase at a different rate for nurses or other employees, for instance, just to give you an example.

The third part of this, which is the part that is associated with the work at the purchasing workshops and the allocation, that component of the budget, is related to the activity growth, which treasury describe to be this 1.5 per cent on the overall 4 per cent, that at the treasury level is allocated to health.

Then the final part is the specific initiatives, and this includes a number of things, but - and just reflecting back to your comment about the NPPs. So there might be NPPs being worked up at this time of year, around December, where they may have activity included or may attract an extra activity, as in extra NWAUs, and at that point, the conversation with the purchasing team is to reflect, okay, we might ask treasury for additional funding for this particular initiative. If it is then reflected into activity, that is included into the purchasing envelope.

Normally the policy area, so the branches in the ministry, may have a say in respect to where and which area of the system may receive this funding, and that's how it is basically - and the sum of all of these is the budget.

MR CARR: The NPP process does provide, in the early stages, a context for when we go around - and I attend with Joe and Sharon to the different districts - a bit of a context when we're talking to districts about what they're saying they need, but also that helps us guide some of those discussions. The NPP process early on might change towards the end, but it does provide some context for those discussions.

MR MUSTON: So when you say that the NPP process might change towards the end, that's because a proposal put forward to treasury might be accepted, might not be accepted, might be accepted in part; is that right?

MR CARR: That's right.

MR MUSTON: Which, ultimately, the process that Mr D'Amato has just talked us through, coupled with the outcome of any NPPs, will form the budgetary envelope that's available from treasury?

MR CARR: Yes.

MR D'AMATO: That's correct.

MR MUSTON: Mr D'Amato, when you were telling us a moment ago about the base and the adjustment to the base on account of, say, a hospital or a facility that has been brought in-house, to use a simple term, is that a discussion that's happening with treasury or are we talking about a discussion that's happening at the district level about their base?

MR D'AMATO: It's at the district level. And there is an opportunity for the district to reflect changes around February, so then we finalise the base by March/April, and then we can start the calculation in regards to what there is then to be allocated as what we call "cost escalation".

MR MUSTON: The base that is made available to each of the LHDs, is that informed at all, and, if so, to what extent, by the base which is made available to the ministry in general by treasury?

MR D'AMATO: Historically there is a relationship, absolutely. Obviously, the bases inside the districts move according, then, to decisions in regards to the purchasing and some of the movements are more pronounced when there is a new hospital, for instance.

MR MUSTON: We heard evidence on Monday from treasury and Mr D'Amato about the somewhat mysterious history of the base as identified by treasury. Can I ask in respect of the base which is applied to each of the LHDs - it's a figure which, subject to the sorts of adjustments that

Mr D'Amato has just told us about, is a historical figure; would that be right?

MR PORTELLI: Yes.

MR D'AMATO: I think the challenge - sorry - to go back to the base --

MR MUSTON: I think there was some nodding. If you want to say "Yes", you have to say it out loud, so it gets onto the transcript.

MR PORTELLI: I mean, from an activity point of view, yes, but, like Alfa said, there is more to it.

MR D'AMATO: If I go back to when the bases were set, it was when the area health services were split, basically. They formed the base and at that point then we introduced activity based funding through the NHRA. So from there on we just started, where there was activity, new policy proposals and the like.

MR MUSTON: Even at that point, was the historical sequence that there were area health services which had their own base of sorts?

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

MR MUSTON: Albeit based on a different approach - approach through a different funding lens?

MR D'AMATO: Yes.

MR MUSTON: LHDs were created by the carving up of those area health services - that's correct?

MR D'AMATO: That's correct.

MR MUSTON: The funds that were traditionally made available to those area health services, or the base that existed within those area health services, needed to be carved up and divided amongst the LHDs?

MR D'AMATO: That's correct.

MR PORTELLI: That's correct, yet.

MR MUSTON: So the base figures that the LHDs had, at least at that point in time, bore some relationship to the historical base which had been applied to the area health services at some distant point in the past?

MR D'AMATO: That's correct.

MR ONLEY: So it formed the funding model, basically.

MR MUSTON: In terms of the extent to which the base which has historically been applied to each of the LHDs reflects the cost of meeting the particular health needs of the community within those catchments, does anyone know when, in the past, an assessment was made of that and whether or not that was an adequate amount of money, at some point in the past, to meet all of the health needs of the community within either those area health services or more recently the local health districts?

MR DALY: I could comment as a chief executive of two previous area health services, when they were the big beasts that they were, that there was far less local influence and alteration; most of the activity was routinely in place through traditional arrangements of VMO appointments, both in terms of numbers and specialties and sub-specialties, which is what drives your activity, and then there would be, and was, programmatic influence from the ministry or Department of Health, as it was at the time, just as there is today, around particular areas - could be mental health, could be drug and alcohol or health prevention and promotion. But the influence or the conscious decisions around changes to profile was less active than certainly the devolved model that I've observed since being back in the ministry for the last two and a half years particularly.

MR MUSTON: Because we've heard evidence this week, and again I'll invite any of you to disagree with this proposition, but health is one of those areas where, "if you build it, they will come", and with perfect efficiency you could continue to spend money on standing up services and there would be demand for those services within communities.

MR DALY: Largely, yes.

MR MUSTON: And not only is it services that they would

like to have, it's services which, if you were able to fund all of them, with good efficiency, would potentially be providing good health outcomes for sections of those communities?

MR DALY: Yes.

MR ONLEY: Yes.

MR MUSTON: But within the real world where we've got a limited budgetary envelope which needs to be distributed amongst the various priorities of government - health, education, community services, transport, et cetera - there is always going to be a confined portion of money which is available to the health sector?

MR PORTELLI: Yes.

MR MUSTON: And that confined portion of money needs to be used in a way which ideally delivers those services which those running the health service think are, of the universe of services that could be provided, those which are best provided within the budgetary envelope - that is to say --

MR PORTELLI: Yes.

(Mr Onley and Mr Daly also nodded)

MR MUSTON: -- "We'll be given a bucket of money and we will do with it what we think is the best we can do with it", accepting it's not everything.

MR CARR: Trying to achieve the best value for money is, I think, one of our objectives.

MR MUSTON: "Best value for money" in what sense?

MR CARR: Value in terms of patient outcomes; in terms of looking at our - we have a range of KPIs in our service agreement, which we try and achieve those, because they are tied to our "Future Health" strategy, so we try and tie it to those.

MR MUSTON: We might come back to them a little bit later.

Mr D'Amato?

MR D'AMATO: May I make a comment in regards to what you were describing about having to work with a finite resource and the way we allocate this?

I think it's important that we reflect on the approach we have established in New South Wales in that decisions around the budget allocation for new services or extra activity is not a matter for finance. I think we established this process where we're two divisions, two clear distinct divisions, working collaboratively to then determine how to distribute the new money, being the activity.

I think it is important to reflect on that, because activity based funding, ultimately, is a mechanism. It doesn't drive the strategy. We just use the best possible way to optimise efficiencies, to create the transparent environment where there's benchmarking, when there is an opportunity also to engage, probably also be more accountable from both sides, be it the districts or the ministry, but ultimately the decisions are separate to the finance decision to the degree that there is an envelope and that is always going to be the case, but how the envelope is allocated, distributed, the mechanism and the priorities are set by a different division. I think it's important we reflect on that, because we are unique in Australia in the way we implement activity based funding.

MR MUSTON: We might come back to that as well.

In terms of this discussion around the base, at some point in the past when the area health services had their base identified, it was presumably an amount of money which reflected an assessment made at that point in time of the best way, across the whole state, of distributing the limited budgetary envelope that was available to deliver the public health system, that confined suite of the universe of services that we could be delivering, which we decided was the public health system at that time.

MR DALY: Well, that was how the eight area health services were formulated, which ironically was from the 28 previous area health services being amalgamated into the large eight area health services, and it was literally a matter of pulling the budget bases of those existing area health services - sometimes two, sometimes three, sometimes more, of those smaller area health services - in to create

the large one, with all the efficiencies that come from moving from 28 delivery units to eight, and government had a very clear agenda for what those savings should be invested into.

MR MUSTON: So just taking it all the way back to that point in time, accepting that the number or the figure that reflected the total base spread across those 28 units might have been an - I was going to say, "an arbitrary figure", but a figure which was not necessarily informed by careful assessment of precisely what amount of money was needed to meet all of the health needs of the state.

MR DALY: Other than in programmatic areas, yes, it was largely just an historical feature for those 28 --

MR D'AMATO: I think perhaps we also need to reflect back then, at the area health service level, there was a different funding model, which was the RDF, so that would have influenced the way ultimately that the eight area health services received their portion of the budget.

MR MUSTON: But the budget itself was, effectively, a political figure, a figure that was determined as the amount which would be applied to the delivery of health, as compared with education, transport, the various other competing demands on the budget, and in that day, the RDF figure was the means by which the ministry used to, in effect, divide it up amongst its geographic constituent parts.

MR D'AMATO: Yes. Fundamentally, that's what it was.

MR MUSTON: And that historical approach to the funding has come to inform, in a way, the way in which the money is divided up amongst the LHDs, albeit instead of using that formula as a currency, we're now using activity as a currency?

MR D'AMATO: That's correct. The activity we've used then from when we, call it, jumped off from the area health services, the ABF has effectively allowed us to do the same work but to distribute the new money across the system.

MR MUSTON: It might be useful, I'm reminded, if whichever of you is best qualified could just give us the 100 words or less description of what the RDF approach to funding

was?

THE COMMISSIONER: Can anyone remember?

MR DALY: From a practical perspective, the RDF, yes, "resource distribution formula", which it stood for, was an amalgam of a whole host of adjusters, if you like, in our current parlance, reflecting all manner of socioeconomic influences that will be within the community of that area health service.

It's influence was fairly minor, but nonetheless, as a true chief executive, I fought it because it was disadvantageous to my area health service, which is what chief executives do.

MR MUSTON: We were told that a few days ago.

MR DALY: But it actually made a marginal difference. But health doesn't respond - and I think I used this term when I last spoke to you - by revolution, it only responds through evolution; and the RDF did, just as the purchasing adjusters do, incremental changes around directing and focusing financial resources to those areas of statistical need that we can identify. So that's kind of the history that I lived through for a number of years.

THE COMMISSIONER: I think in someone's submission they have attached a press release from Mr Iemma, who was the premier at the time, explaining the RDF with great pride, only for it to disappear shortly thereafter, not through his decision.

MR ONLEY: As I recall, it was reviewed every five years, I think, so whatever the distribution pattern that it derived was in for five years before another review occurred. That's my recollection.

MR MUSTON: If we could go back to that historical time when the 28 different constituent parts of the health system were amalgamated into the area health services, we were told - and you mentioned a moment ago - that the efficiencies that could be generated through those larger regulatory bodies had the capacity to, in effect, make better use of the budgetary envelope that was available. Have I understood you, at least in terms of its objective?

MR DALY: I was involved in terms of setting up the South East Sydney Illawarra Area Health Service, which is now two LHDs, and the identified savings were such that I was directed, appropriately, to invest those administrative savings into a reduction, ironically, in planned surgery that, for that area health service, was between 6,000 and 7,000 breached patients, and that funding actually addressed that and brought them all back within their category of planned treatment, and there would have been different investment decisions peculiar to that new area health service's need that government, through the Department of Health or ministry, would have directed those savings towards.

MR MUSTON: So at that point in time, the efficiencies that were derived, ideally, meant that the limited budgetary envelope that was available was able to deliver more in terms of precisely what the public health system was at that point in time?

MR DALY: Yes, and they remained in those communities under that now new area health service.

MR MUSTON: Accepting there have been carve-ups, adjustments and growth applied to the base, we've heard some evidence to the effect that the rate at which the cost of delivering health care to the population over the past five, 10 years, has increased at a rate which exceeds the growth factor which is applied to the base. Would you agree with that?

Maybe let me break it down into its constituent parts. There has been a range of changes in the way health has been delivered over the past decades. There's a lot more we can do in terms of interventions, that's - you have to say "Yes" out loud.

MR D'AMATO: Yes.

MR PORTELLI: Yes.

MS SMITH: Yes.

MR DALY: Yes.

MR MUSTON: Those interventions are keeping people alive for longer?

MR D'AMATO: Yes.

MS SMITH: Yes.

MR MUSTON: It's costing more to deliver those interventions than it once cost to do the less-advanced interventions that were available in times gone past, perhaps when the base was originally identified?

MR DALY: I wouldn't say always, no.

MR PORTELLI: No, not always.

MR DALY: It's like, you know, as a pup in health, we were warned, if not threatened, that if health continued to grow at the rate that it was, it would move from taking over a third of the state's budget to the whole state's budget within 20 years.

Now, I have lived that 20-year cycle and worked in that 20-year cycle and we are still consuming a third of the state's budget. We are treating far more patients, far more efficiently. We are disinvesting - not to the degree that I think we should, because it's pretty tough, when your outputs are human beings, to disinvest, but the efficiencies of technology, changes in models of care - just simple examples like day-only joint replacements now - all of which contribute to much cheaper and often better outcomes to be able to free up existing resources to treat population growth, which still is not being fully met particularly in the last few years, I think it would be fair to say, but, you know, the system has not just continued to move in the kind of direction that your question implied.

THE COMMISSIONER: Population growth and ageing are the consequences of that.

MR DALY: Yes, indeed.

MR MUSTON: But those efficiencies aside, it's not the case, is it, that the rate of growth that has been applied to the standard base has enabled us to continue to deliver - well, the cost of delivering the care that we are delivering to people across the board - that is, the cost of running a health system - has continued to increase at

a rate that exceeds growth, has it not?

MR DALY: Yes, in my experience.

MR D'AMATO: Yes, look, I agree. Perhaps we need to make a distinction from what happened after COVID, because I think COVID kind of created more challenges.

Before COVID, in a very relatively, you know, stable environment, when wages or even, you know, CPI was relatively under control, we were able to deliver and drive efficiencies at the same time. So those efficiencies were reinvested to do more activity, but that was the key, the stability in the economic and the fiscal environment.

Now, we are in a different situation, and I think that's where the challenge is at the moment. I don't know whether we're ready to set the new base at this stage.

MR MUSTON: We might come back to this, but in what way are we in a new situation now?

MR D'AMATO: I think that after COVID, obviously the system went through significant shocks that affected our cost base overall, whether in goods and services, whether in the workforce or the lack of workforce or some of the dependency on agency costs that we didn't see before, that's still in our costs at the moment.

I don't know how long we're going to live in this kind of environment, but certainly it's different to where we were before COVID. And we've certainly always had a degree - or if you want, we always spend money in agency or locums and the like, but not to the extent that we're seeing now.

MR CARR: Yes, medical and nursing supply definitely changed. That market changed in the last couple of years, and the rates that we are paying are much higher and the decisions of that labour supply - nurses, for example, may say they don't want to work five days a week anymore, they only want to work four days; they don't want to work in a particular area which is, you know, quite onerous, they will say, "Well, I only choose to work in this area." So the labour supply has definitely changed.

MR MUSTON: We've heard some evidence about screening

programs that have been introduced which have had the effect of identifying increased need or areas where services could be provided, and should be provided, to provide the ideal health care to people who have passed through that screening process and been identified as needing to go to that next step in the process, to have an intervention of some sort.

MS SMITH: There are certainly new programs - I think you are talking potentially about Brighter Beginnings and The First 2000 Days program, which does a lot of screening of younger children, identifying any sorts of issues that they might have, before they go to school, which is obviously a better outcome both for the child, for the family and for the community if we can address those sorts of issues early.

But I think we've just touched on some of the workforce supply issues. Even if we did have the funding available, the envelope available, to increase those types of services once a child with needs is identified, we have workforce limitations. Being able to identify allied health and nursing staff that might be able to deliver care or deliver those developmental services, for example, is challenging in the current environment since COVID as well.

MR MUSTON: So challenging in the current environment, but just coming back to the starting proposition, say, the Brighter Beginnings has identified a number of children within the community who would benefit from an intervention of some sort, either through allied health or paediatric care?

MS SMITH: I believe that's the case, so that's the purpose of the program, is to screen children early and identify those that could do with intervention.

MR MUSTON: Other screening programs include, for example, the bowel screening which the Commonwealth Government has championed, which has a knock-on effect in terms of the state health system, where someone gets a letter back saying, "You should go and get a test, a further test, or intervention performed"; it's the state that needs to do that.

MS SMITH: That's correct and similarly with BreastScreen and other types of screening programs.

MR MUSTON: Current discussions around chest x-rays and the screening for lung cancer presumably will have the same consequence, where something is detected in an x-ray that needs closer examination, there will be a need for the public health system in New South Wales to actually deliver that intervention or that further test to work out whether this patient has lung cancer or just an abnormal shadow on their x-ray?

MS SMITH: That's right. I guess those patients would have potentially always flowed to our system but they might have come into our hospital system later in the trajectory of their disease. The benefits of the screening programs are that we would be seeing them, hopefully, sooner and so that the complexity of their disease might be lower and they would have a better outcome.

MR MUSTON: In that respect, is there a bit of a distinction that can be drawn between, say, the bowel screening, breast screening and lung screening programs on the one hand, which ideally aim to identify an illness early rather than when it's progressed, as opposed to, say, The First 2000 Days or the Brighter Beginnings, where children who don't get picked up through that screening program might not actually end up in the health system; they might end up in a different system?

MS SMITH: That's correct, and the consequences might not have been felt in the health system but perhaps education, justice and other parts of government services.

MR MUSTON: I think I have distracted us significantly from our narrative walk through the budgeting process. Perhaps can I come back to that. So you have your workshop with all of the LHDs?

MR PORTELLI: That's correct.

MR MUSTON: Where do we go from there?

MR PORTELLI: We digest that information. We think about what, if any, changes to the model are appropriate. Then we have a roadshow discussion where we meet with every district chief and their executive --

MR MUSTON: What does that involve?

MR PORTELLI: The agenda usually includes an update on the financial environment, any steer that we have at that point in time.

MR MUSTON: Just pausing there. "Update on the financial environment" is you communicating to the LHDs what?

MR PORTELLI: Normally it's a narrative by finance, so it's probably worth passing to my colleagues for them to go through --

MR CARR: So we will look at the budget, release from the previous budget which shows the forecasts for expenditure and also the position of the state government in that year and then the out years, and it shows whether they're looking to improve their financial performance over the coming years - and that's generally the case.

We will talk about some of the impacts of CPI and a general outcome of where the system is, the health system, financially. So it's sort of a fairly high-level direction of what the pressures are from a financial perspective coming from what we see in treasury. There's the half-yearly review that has come from treasury, usually in December, if there is any sort of information from there, we will provide that update.

MR MUSTON: So, "This is where the state's currently at financially, this is where they're heading, this is what we anticipate will be the overall slice of the state's budget that will be devoted to health, taking into account the information we've got now", and the information around the state's position is contextual to explain why --

MR CARR: Yes, that's right, yes.

MR MUSTON: -- we find ourselves in, to use a term I have seen in a lot of letters, a challenging budgetary environment.

MR D'AMATO: I think the objective there is to provide some context more than anything else and set the scene and perhaps also adjust the expectations of the districts. If there is a fiscal pressure there at the aggregate, at the state level, best we inform and share that with the districts before we set expectations that more money should

come to health, but at that point we only have the information at the aggregate, so only the state position, we don't know what is supposed to come to us at that point.

MR MUSTON: So you've given the context through that part of the roadshow presentation. What's next?

MR PORTELLI: It's probably worth at this point drawing a line between what would happen pre-COVID and what has happened post-COVID, because the information and the experience is different.

Pre-COVID, we would have had a number to give them in terms of what we have allocated for population, ageing and equity, and that would have given at least some certainty to districts and networks about what their growth envelope is going to look like.

That's very important for them because it might change what they request from us. If they have demands for, say, core business, BAU type of services, say, increasing presentations to the emergency department, they might look at that envelope and go, "Right, well, that's what that growth rate is for: we've got a growing population, an ageing population, and there is an allocation for that in that number. So we've got the discretion to allocate some funding to address those demands."

MR MUSTON: I might just unpack that a little bit. So before COVID they were given, or assumed, did they, that they would get the base that they had got in the past?

MR PORTELLI: Correct.

MS SMITH: Yes.

MR MUSTON: And then this number that you're talking about is a number that you were previously able to give them which reflected the increase on that base that you anticipated they would be getting as part of their growth funding?

MR PORTELLI: That's correct. And we work through that number, we work through the equity model, how that works and how that looks at the entire base of activity that is purchased from every district and network and, through the model, looks at whether or not health service utilisation

should be adjusted in different districts, and then again addressing sort of that longer-term move towards an equitable model from what funding we have.

Then we talk about any other strategic initiatives that have come through, any kind of NPP that we know that we're rolling out, maybe an NPP that was approved in a previous year but is coming through in an enhanced second year of funding, that we need to reallocate some more funds. We talk about any changes to the purchasing adjusters, and then we have a section that they can raise any other issues that they would like.

So often what has come up recently has been particularly the new builds, any kind of redevelopment that has come open, just because of the scale and size of them.

Prior to COVID, those were quite small and so that conversation was probably more about, you know, "I've a got a particular demand in the system and I would like to address it with a significant step up." I say "significant", maybe because the service didn't exist and so there is no base from which it can grow, so it is establishing a new service or maybe doubling a service because the need was greater than they anticipated.

MR MUSTON: Just pausing there, what's the currency that these discussions are taking place in relation to? Is it "Here's a budgetary envelope in dollars that we will give you to deliver on what you consider to be the best use of these funds for meeting the health needs of the community", or is it activity?

MR PORTELLI: It is both activity and block. We err towards activity, because actually a lot of services can actually be classified as activity. So I think a lot of services - and my colleague Sharon can correct me if I'm wrong - any kind of interaction between a clinician and a patient that has a therapeutic or clinical benefit can be counted under the financial model.

I think a lot of people think because a patient is not admitted, it has to be block funded, which is not the case. So that part of that discussion is fleshing that out, whether or not the service can be counted and costed and classified and priced using the NWAU model.

MR MUSTON: I might ask a question at that point. Does that assume that IHACPA has recognised that the activity - I won't use the word "activity" because that will confuse it - the service which is being delivered is one which is capable of being recognised through the ABF model or does the state take --

MS SMITH: There's a slight difference between the national model, particularly in the non-admitted space that Joe's just spoken about. There are a number of services that whilst IHACPA might have a clinic classification for those services, it doesn't have an NWAU from the national perspective, so that we don't receive national funding under NHRA for those services - things like primary care or general counselling, would be examples - but we have a state weight that we use and we still purchase that activity from districts and networks. So, in fact, we purchase more from the districts and networks than is in scope for ABF at a national level. So our model is slightly different.

MR MUSTON: We're jumping ahead a little bit, but to the extent that there might be KPIs around activity generation, do those KPIs - can they be satisfied through both types of activity - that is --

MS SMITH: That's right.

MR MUSTON: -- national within scope and outside of scope activity, so long as it's activity recognised by the state?

MS SMITH: That's correct.

MR PORTELLI: So, yes, we have two KPIs, one for in scope, one for total - in scope for Commonwealth and one for total. So those discussions then are worked through - those discussions raise those issues, we discuss what we can in the meeting and that usually happens around February and March. We take that information back and we work through that with various policy branches. Particularly if there is, you know, a particular service that has a statewide policy around it, we make sure that those are in line. We assess them for dollar value, particularly if they are requesting money above what an ABF model might give. We don't say "No"; we just say "Why", and we explore that, and then if there is value - sorry, like a viability issue with the ABF model, then we will consider block

funding for that particular purpose. We then --

MR MUSTON: Just pausing there, Mr Onley, did you want to add something?

MR ONLEY: I was just going to comment that while the October workshops in that area are happening, the districts are busy doing all their costing from the previous year, so there's no price discussion, really, that takes place at that particular point in time. It is later, after Christmas, January, when we do get an idea of what the cost structure is like and what the average cost is like, that we start coming up with the price. So the purchasing discussions are going on independent of knowing what next year's pricing is at that point in time.

MR MUSTON: So is it right that the purchasing discussions that are happening are happening - there's a term I think I used earlier, the currency is activity. So it's not necessarily telling them exactly how much they will get for delivering that activity but it's a discussion around the amount of activity that --

MS SMITH: That's right.

MR MUSTON: -- you will be purchasing from them at whatever cost is ultimately arrived at as the --

MR ONLEY: But we do start playing around with price for the second round, the March ones, and that's when we take data and the requests and the activity and start to marry it up to see then if it fits into the envelope, so it then becomes that iterative process.

MR PORTELLI: And concurrently, all of us are also meeting outside these meetings, so the discussions with the districts and networks are attended by both our divisions and relevant policy branches as well, the strategic initiatives on that front.

After those meetings, as we work through it, we are meeting fortnightly about those things, so consolidating the requests, looking at what we will likely support or not for various reasons, what the size of the envelope is, the pricing, what we can and can't sort of fit within the envelope.

MR MUSTON: Just coming back to that - and it may be that I'm ahead of the process - in paragraph 18 of the statement that Mr D'Amato et al have prepared, there's a reference to New South Wales public health services being funded at a price per national weighted average unit and based on activity as negotiated in the service agreements between the secretary of NSW Health and the chief executive. This roadshow process that we're working through at the moment is part of that negotiation?

MR PORTELLI: It is determining that NWAU number that is multiplied against the price.

MR MUSTON: Can I ask you to explain to us the way in which the negotiation about how much activity operates? How does it work year to year? What are the parameters of negotiation?

MR PORTELLI: So again, I will talk about pre-COVID and post-COVID. So pre-COVID, again, we started with a number, that was largely the bulk of it, I think around 80 per cent of our total envelope was allocated using the ageing population and equity calculation. If you want a deep dive into that, maybe I will pass to my colleague Sharon to talk through that.

MS SMITH: Yes. Would you like to hear about the way that those calculations occur?

MR MUSTON: Yep.

MS SMITH: So we take into consideration in the growth model three factors, so changes year on year in the size of the population in a local health district; secondly, we take into consideration the age composition of that district, so some districts remain very stable, population size, but their population is ageing, which impacts the demand on health service that we can expect to occur in the coming year; and the third component takes into consideration sociodemographic factors that are linked to demand for health services and utilisation of health services, over and above the size and age composition of a local health district. So we make an adjustment to the activity purchased so that those sociodemographic characteristics are taken into consideration.

MR MUSTON: And presumably that's a formula of some sort,

or formulae, that you apply to do that?

MS SMITH: Yes.

MR MUSTON: As part of this negotiation process, are those formulas and each of the integers that are fed into them presented to the local health districts?

MS SMITH: Yes. So the model is refreshed regularly, usually at least once a month during the process, and those results are released to each local health district so they can see the components of the model that will be applied to them and they can see the formulae that sit behind it. In fact, we make available to all health districts all health districts' data, so they can see their numbers but they can also see other districts' numbers within the information that we release.

MR MUSTON: So if, as a result of that formula being applied to the population in, say, Murrumbidgee LHD, hypothetically you get a 4.5 per cent growth rate that gets applied, does that translate as for every hundred units of activity that were once being purchased from Murrumbidgee, in the next period, there will be 104.5 units of activity that will be purchased?

MR PORTELLI: Those are the first two steps, yes, and then we add on all the other bits about what we negotiate for new builds, but essentially, yes.

MS SMITH: That's correct.

MR MUSTON: Okay. Let's get to those next few steps.

MR PORTELLI: That's an important quantification that, you know, roughly about 80 per cent of that information is provided to them in the first meeting.

Then in the second meeting, we would go back, and I think in that stage as well there was potentially a third, where we would go back and discuss in more detail some of those proposals, think about the models, talk about the volume of patients they're likely to see, how would they be classified, whether or not we would expect a certain outcome and what the NWAU value of that particular service would be and then we would sum all that up again.

The final kind of step in the process is getting approval through the ministry executive meeting where the deputy secretaries and the secretary would look at the overall envelope, the model, how it's being allocated, cutting it different ways, getting an equity lens over it at the service level, because you may have really equitable decisions on each of the components but overall, you know, if the model has delivered a really bad outcome, you might need to reevaluate some things. Generally not, because generally the model works pretty well. So that would then lead to the final NWAU allocation that would go out to the districts and networks in the final model. That would be usually around the end of May, beginning of June, and then the final budget is then released on budget day.

Now, that's pre-COVID.

So post-COVID, with all the uncertainty and the timing issues, we have not been able to provide that level of information to districts until well into May, often after we've had the second meeting, and the level of activity that we've been able to purchase from them has been substantially lower, and so overall, we've had to take a proportional value of what the population and ageing component of our allocation was, and that's not to say that they haven't been given funding increases, and my colleagues can talk more to that.

MR MUSTON: So when you say "lower", they've got their base, say, in the COVID year, which was - let's say it's at 100 just to use an easy number --

MR PORTELLI: Yes.

MR MUSTON: -- it wasn't a situation that in the following year they got 98?

MR PORTELLI: No.

MR MUSTON: But whereas they might have got 104.5 --

MR PORTELLI: Yes.

MR MUSTON: -- the adjusters might give them 104.5 or the calculations, but instead, they're going to get 102?

MR PORTELLI: They might get 102; that's correct. Some districts may have got the 104.5, but also the expectation now that they need to also open up a whole facility which has growth demands expected of them as well. So there is that element to it in the last four years, concurrently with COVID, there's also been the opening of significant new infrastructure, which has large cost and activity expectations associated with it.

MR MUSTON: Putting aside the new hospital that's built which has an obvious impact on the amount of activity that is able to be generated - more basally, the amount of money that the district needs to deliver care - the adjusters that you are using for your growth figure, are they based on an analysis of the actual identified needs of the community in terms of its health needs from one population to another or are they the high level things like population growth, overall levels of particular disease and the like?

MS SMITH: There are those three components. So population growth is one component, so we do that, push that, put that aside; the ageing component, that's calculated and then put aside; but the equity component looks at, I guess, the prevalence of particular factors within a local community that we know drive increased health needs.

So we look at what the expected health utilisation or health service utilisation is of the community, once it's adjusted for their underlying issues that might drive additional need, and we compare that to their actual consumption of health services, and where there's a gap - so if they're consuming fewer health services than we would expect - then that's where we would look at providing the top-up or the additional activity purchase into that local health district so that we bring them closer to their expected utilisation as compared to their actual utilisation.

THE COMMISSIONER: What does "particular factors within a local community" mean? What are examples of that?

MS SMITH: It includes a lot of sociodemographic matters like SEIFA status. We look at Aboriginality. We look at number of people born overseas and in particular born in countries that are high health service utilisers. We look

at an index of GP attendance within that local health district, standardised mortality rates and a range of others, but they're the key ones that are taken into consideration. And they are to adjust for factors that can't just be explained by the age and other composition of the population, because the ageing's already factored in, some of those things you would expect.

THE COMMISSIONER: Yes.

MR MUSTON: The index of GP attendance, just maybe develop that a little bit. What is it you are looking at there?

MS SMITH: We use information that is either published by AIHW or the bureau of statistics in most of our modelling, so that would have been produced and reported on by AIHW. So it's looking generally at MBS billing rates within local communities, and we would aggregate that up to a district and network to look at whether or not that district has a lower utilisation of GPs, versus other parts of the state.

MR MUSTON: What do you do with that information? Say the district that's got a lower utilisation of GPs, what does that do --

MS SMITH: We would expect that district to utilise ED services at a higher rate than others and we would give them some additional ED growth to compensate for the fact that they have lower utilisation of GPs.

MR MUSTON: So you identify the absence of or a thinning market of GPs within that community as resulting, down the track, in an increased level of --

MS SMITH: Demand.

MR MUSTON: More people going to the emergency department, sicker, and so you increase the amount of emergency department activity that is being purchased?

MS SMITH: That's correct.

MR D'AMATO: And that step is actually a step from the RDF formula. So we've already kind of blended, a little bit, our ABF approach by incorporating this extra step.

MS SMITH: But the way would express that additional activity is in NWAU terms. So that's where the ABF component comes in.

MR MUSTON: So is this process happening as part of a collaborative service planning that you're doing with each LHD or is it being done centrally and based on a pocket of data, population data, which is available to you centrally?

MS SMITH: It is being done centrally but it is certainly something we discuss with local health districts. They will often come to us with ideas about the way in which we can improve the model or factors that we can incorporate into that equity calculation.

MR MUSTON: Is there any process at this stage of the game where you sit down with LHDs and have them identify for you what they think, based on the information they've got, the information you've got, perhaps even the information contributed by, say, the PHN and other bodies, what the health needs, actual health needs of that particular community are, the services that the LHD thinks, prioritising a spend of a limited budgetary envelope, would best meet the needs, health needs of that community and what it's potentially going to cost to deliver those services?

MR PORTELLI: So probably indirectly, would be my answer. We wouldn't specifically talk about the health needs, in these discussions; we would talk about the services that they would like to establish. The idea that we allocate funding to districts is so they have that, I'm going to call this, discretionary budget, the population ageing and equity model gives them the ability to attribute resources to their areas of need.

We have a central planning function that helps them do their clinical services planning and they have to do a joint planning process, and it escapes me at the moment, but with the PHNs around what that looks like for both the parties, and it's through understanding that that the districts then would come to us and say, "Well, according to our plan, we would want these things."

Potentially, some of them don't even come to us because if they had the certainty of the budget in that

February/March meeting, they would be able to go, "Right, well, that's our allocation, and this is what we're going to do with it." And it's only really if it's like a step cost in something or maybe a statewide service where they're providing a service on behalf of the entire population of New South Wales and they don't want to dip into their local population allocation, they would have a discussion with us. So indirectly, those conversations should come through in that process.

Again, post-COVID, when that allocation hasn't been provided to them or that certainty hasn't been provided to them up-front, and, you know, their general and financial environment and the focuses on COVID and the response, those conversations probably haven't been as fulsome as they have been in the past, but that's easily rectifiable with certainty in the February meeting, because that has worked pretty well in the past.

MR MUSTON: Could I just pick up the example that you gave of the GP presentations being low within an area resulting potentially in an increase in emergency presentations and more activity purchased for that.

An LHD might come to you and say, "We've got a thin or failing GP market in our town, or in towns within our catchment. We think the best way of dealing with that problem in terms of meeting the health needs of the community is for us to" - in some but not all of those towns - "either stand up or in some other way support the delivery of primary care in a way which is potentially efficient and can utilise resources that are being utilised in the delivery of acute care. It's going to cost this much money."

First question: is the amount of money that could be delivered or generated through - I'll take it back a step. The delivery of primary care in a setting like that, I think you told us a moment ago, is capable, at least under the state model, of generating activity which can be purchased?

MS SMITH: Yes. So primary care is in scope of our purchasing model and the state ABF model, but we wouldn't receive any Commonwealth revenue for that activity.

MR MUSTON: Unless you were able to come up with a 19(2)

exemption that the Commonwealth would agree to pay you the MBS money.

MS SMITH: Yes.

MR PORTELLI: Yes, that's correct.

(All other witnesses nodded)

MR MUSTON: Park that bit of it. An LHD takes the view, "We think delivering primary care to these members of our community is a better way of dealing long term with their health needs than picking it up down the track when they present to emergency without having received that primary care, but we can't do that immediately because we've had a period of time now where people have not been getting primary care and, as your growth formula tells you, there is an immediate population of people who will be presenting to emergency sicker because they have not had the benefit of good primary care." How would a discussion with the LHD happen along those lines, "We still need to have you purchasing activity from us for emergency, because we have an immediate need to deliver emergency care to these people, but we have a proposal whereby if you increased some more activity from us in the form of primary care" - and over to Mr D'Amato and his team to try to secure some 19(2) exemptions from the Commonwealth for that - "but we would like to deliver both, with a 10-year view to ideally reducing emergency presentations and perhaps even closing some emergency departments and replacing them with a primary care service of this type on a more permanent basis"? How would that discussion work --

MR PORTELLI: That could have happened previously in the purchasing discussions prior to COVID, where there was that flexibility where we've given a certain allocation for their hospital needs and then there was some room for those kinds of initiatives.

Post-COVID and also - and pre-COVID as well to some extent, there are other programs or other avenues in which those discussions can be had, so the integrated care program, collaborative commissioning program, urgent care services program, all these programs were designed to help bridge the gap, the potential gap, between our hospital system and the primary care market. They all try to do different things - I can talk about the urgent care service

one, for example, but essentially, they were provided that avenue to be a bit more experimental without cutting the cost to their current health needs of delivering hospital services.

So through those programs, you could have that discussion. We have an evaluation framework behind it. It's a lot more structured than the purchasing model, which is more about providing a fair allocation of resources using the best data available to enable districts to make that discretionary allocation of their health service needs and delivery on their clinical services plan. But certainly through that avenue those discussions can be had.

Those discussions have to fit within the program goals. For example, with our urgent care program, it was about trying to get patients access to care outside of the emergency department before they get there, through various means. And so as long as that kind of program that they had in mind was able to deliver that outcome, we were very open to those discussions.

MR MUSTON: You said that is something that could happen before COVID. Why can't it happen now?

MR PORTELLI: Post-COVID, the envelope for this particular process has been smaller, and if you think about the continuum of care in our community for health services, you've got the really acute pointy end, which is EDs, ICUs. NSW Health is pretty much the primary provider of those services and there aren't too many others who can do that. As you move to elective surgery there's a little bit more of a private market; if you look at - you know, as you go along to the primary care market, we're basically very small players.

What we're talking about in those kinds of programs are areas that - there could be potentially other providers, but if it comes at a cost of a service that only we provide, that's not a tenable solution for chief executives to make. So where the envelope is smaller, all of the money goes there. Health will always prioritise the most urgent patients. So when you have a smaller envelope from which to purchase, not only do districts and networks - you know, they may have those desires but they know roughly - they get the gist of, "We're in a low growth environment. We know that if we apply for this, it's

probably not going to get through."

MR MUSTON: You mentioned a moment ago where there are other providers - accepting that NSW Health is probably going to be the ultimate, the only, provider of care in that emergency setting - certainly not putting to you any sort of suggestion that LHDs should be opening primary care centres in every town that they have within their catchment because it would be great for the community to have choice, but there will be towns and communities where a market-based model for the delivery of primary care is never going to be available, in 2024 or any time going forward. Would you accept that?

MR PORTELLI: Yes, generally, yes.

MR MUSTON: To the extent that the market is capable of providing, say, primary care services in a community either on its own or with a limited amount of support from the LHD, it's clearly going to be in the LHD's and community's interest for that to continue, so as to enable, as you say, the limited budgetary envelope available to health to be deployed in areas where it's actually more needed?

MR PORTELLI: I would agree.

MR MUSTON: But in areas where you can't get a market-based solution to provide primary care, then that does ultimately leave it to the LHD to ask itself: "Someone has to provide this care. Yes, we have to provide emergency care and intensive care and the like, but as part of our assessment of what is going to best meet the health needs of our community, where do we think this money should best be spent?"

MR PORTELLI: That's correct.

MR MUSTON: As part of the roadshow negotiations or the activity purchasing negotiation, is there any discussion of that type along the lines of - I mean, primary care is one example, but a range of other examples no doubt exist where an LHD might say, "Here's what we have assessed as the total needs of our community. Here are all of the services which we think ought be provided within the realms of reality to meet those needs. We don't have enough activity at the moment to deliver on them. We would like more" --

MR PORTELLI: I can't recall a conversation where --

MR MUSTON: -- almost on a service by service basis?

MR PORTELLI: Yes, I can't recall a conversation where we've had an in-total review of their health service need. I don't think any LHD would potentially have that. As we've discussed, or as has been discussed, health needs are infinite and where do you draw the line on what our role is and what other people's roles are? Certainly they come up with proposals for particular services or where they think their highest needs are, and through that discussion we can say, "Well, look, this is not going to be funded through purchasing process but maybe there's another program where there is funding available and we can link you up or help you evaluate that." So that would be --

MR DALY: And I think there have particular examples over the last couple of years in particular, with the failing primary care market that you have alluded to, and that is like the Medicare Urgent Care Clinics, and we would have advance notice because we negotiated the location of those, you know, in a good partnership with the Commonwealth; also the Commonwealth-funded virtual GP services, so people can get referrals, scripts and virtual consultations with GPs, which we operate through our single digital front door, but the Commonwealth actually funds it.

So we would inform those conversations, because you're quite right, some towns are really struggling, in particular in rural and regional New South Wales, and, you know, that's not our remit, but working in partnership with the Commonwealth, we've actually started to make some good strides forward in the last couple of years. I don't often sing the Commonwealth's praise but on this occasion they have been responsive and partnered with NSW Health really well, I think.

MR MUSTON: Putting to one side that continuing to do what we did last year, in terms of procedures that were offered, clinics that were offered and other services that were offered, which generated a particular amount of activity, is there discussion around the appropriateness of that mix of activities to meet the health needs of the community, particularly taking into account, say, the extent to which those needs might be met by other parts of the New South Wales health system, say, from within other LHDs?

MS SMITH: I'm happy to take that one. Every year we do have a discussion about whether the activity that we're purchasing in each line item, say, for example, whether it's a non-admitted or ED or admitted - whether that's the right mix, and districts do have the opportunity to think about whether or not they're likely to want to move some services out of, say, an admitted setting into a non-admitted setting, and vice versa. So we do have that conversation, because they are, you know, instituting and enacting their clinical services plan, which does make changes to the way they deliver care, and so the model is responsive and flexible to that degree.

MR MUSTON: I'm just trying to explore the relationship between the amount of activity that's being purchased and what's actually being delivered for that activity. I understand - I think you gave an example, or one of you gave an example a while ago, of some additional funding being provided to reduce elective surgery waiting times, but otherwise, is there any discussion, as part of this process, about precisely what sort of activities or services are going to be delivered from the activity, or is that left largely to the LHDs to decide once they've been given their allocation of activity?

MR PORTELLI: Largely, yes, it's given - like, the devolution model that we have is that the best people to make a decision about what services should be provided are with the districts, so the people closest to the hospitals working with clinicians. So the framework itself and the way that we allocate funding is to enable that.

We try to have a statewide view about who has what and how equitable it is, but largely having an allocation that is untied, so to speak, gives the districts the ability to enact and bring to life their clinical services plan and address the needs of their population and do it in a much more real time than what we could possibly do with central datasets.

So if they decide that they have a failing primary care market and they get an allocation of untied funds, they could go, "Well, actually, we can do enough elective surgery this year. We don't need to necessarily expand it as much and we can direct some of those funds to do some of the primary care work that we think is emerging and will

continue to emerge". So that's the structure of it, so we tend not to get too much into a lot of those conversations, only where the model doesn't address, you know, to a certain extent, the growth, because of a new service, for example.

MR MUSTON: There are some linkages, though, between what you do and what the LHDs do. For example, the amount of money that they have allocated to them obviously influences what they can actually do to meet, in a devolved way, what they perceive to be the health needs of their community.

MR PORTELLI: Yes.

MR MUSTON: And to the extent that there are KPIs and other requirements - for example, waiting times in emergency, waiting times for elective surgery - complying with those KPIs means the funding that is delivered is, at least in part, whilst not strictly tied, in a practical sense, they have no choice but to divert it in particular ways in order to achieve those KPIs?

MR PORTELLI: That's correct.

MR MUSTON: If the funding envelope is very tight and the funding that's available only just allows you to meet those KPIs, for example, it doesn't really leave you much room to do much in terms of adapting the services or changing the services to meet the needs of what you might perceive in a devolved way to be the immediate needs of your community?

MR PORTELLI: Yes, that's correct. I mean, we do review the KPIs every year. We give the districts and networks the opportunity to comment and say what should or shouldn't be included. But it would be fair to say that, you know, hospital access targets for emergency departments, elective surgery, are pretty bread and butter expectations from the community on a state's health service.

MR MUSTON: Can I ask why that is?

MR PORTELLI: I think, again coming back to provider of last resort, not many other people provide the service, we expect, you know, that kind of level of service - the community would expect that level of service from NSW Health.

MR MUSTON: But from the point of view of seeking to utilise the funding that you have available to best meet the health needs of the population, why do those ones matter more than others?

MR PORTELLI: I'd just again repeat what I said about few other providers doing it. I think people are - they're the most urgent need; you need response quickly. Often there's a whole range of infrastructure that goes into emergency services. I think that's what people expect from our health service.

MS SMITH: There's a lot of evidence and research around about the link between timely access to care in the emergency department and good outcomes, clinical outcomes, for individuals. So I think we have those in the service agreement not because we want to really focus on those as an outcome in and of themselves but because we know the safety and quality impacts of extended stays in the emergency department. So they do have a basis in that desire to achieve longer-term outcomes that are positive for the community and for the people that seek care in our hospitals.

MR MUSTON: Let me explore a few aspects of that. Let's look at the Brighter Beginnings program. For people suffering from some level of socioeconomic disadvantage, the public health system is also the system of last resort for paediatric and allied health care for their children, who might be identified through the Brighter Beginnings program as requiring some intervention. Would you agree with that?

MR PORTELLI: Agree.

MR MUSTON: In exactly the same way as the public health system is the system of last resort for people who need a knee replacement and can't afford to go to a private hospital or choose not to go to a private hospital to receive that care?

MR PORTELLI: Correct.

MR MUSTON: Whilst I don't have it available, I have very little doubt that there is no doubt a wealth of research out there that says intervening in developmental problems that children suffer before they start school and start to

fall behind probably has good clinical outcomes in exactly the same way as you could say time to care within the emergency department produces, within an evidence-based time frame, good clinical outcomes. Would that be right?

MS SMITH: They might be of a different size and scale so they might - you're right, but there is a link between sort of things like mortality rates for people waiting too long in the emergency department, I think, that are probably slightly different than some of the outcomes that you're describing, but still catastrophic if the outcomes are not positive.

MR MUSTON: And again it's all matters of degree. Someone who presents to the emergency department with chest pain needs to be seen reasonably quickly --

THE COMMISSIONER: That's life threatening.

MR MUSTON: -- otherwise they potentially have a bad outcome.

MS SMITH: That's right. Exactly.

MR MUSTON: Someone who presents to the emergency department with a broken arm, if they're not given care or surgery soon, within a particular parameter, no doubt there is some evidence out there that says the outcome in terms of their functionality might be compromised in some way.

MS SMITH: Correct.

MR MUSTON: Just as a child, within a wide ranging spectrum of different conditions and parameters, no doubt children who require paediatric interventions before they start school, if they don't get them within a particular window, there will potentially be a less optimal outcome.

MS SMITH: A bad outcome. Absolutely agree.

MR MUSTON: That less optimal outcome, whilst not immediately measurable by the health system, as someone whose arm is a little bit less functional than it was a month or two months ago, from an economy-wide perspective, that could be the difference between a productive member and tax paying member of society, on the one hand, as opposed to someone who is then, and

perhaps multiple generations of their family, dependent on welfare or are a burden to the justice system.

MS SMITH: Agree.

MR CARR: If you go back 15 years or so ago or 20 years, the statewide infant screening hearing program, SWISH, was a good example of that, where they were testing children, I think it was at six months or a year, to see whether they could hear, that was seen as being a really important development, early intervention for children in their learning.

MR MUSTON: No doubt the very reason that money is spent on SWISH, Brighter Beginnings and First 2000 Days is because there is an evidentiary base that says identifying these problems early and dealing with them is of real benefit both for these children and, when one is making priority decisions around how to spend budgetary money, a benefit to society more generally, associated with doing it?

MS SMITH: Yes.

MR MUSTON: When we come to our KPIs and service level agreements - I will come back to a question I asked earlier - why do we include, say, waiting times for elective surgery and waiting times in emergency and prioritise those over waiting times for seeing a community-based paediatrician, for example?

MR DALY: They may not necessarily not be included in their service agreements. Is it in that top tier? I mean, I think there are about 100 KPIs in the service agreements. I run a performance management process of meeting either monthly, if an LHD is performing poorly, or quarterly if they're performing within certain parameters, and they are prioritised, they are prioritised around the key government priorities, which are around access to emergency treatment and planned surgery.

That covers over two-thirds of admissions into our public hospitals, those two pathways alone. So that may be partly the reason why it's such a priority, but together with safety and quality indicators and some financial indicators, and indicators around mental health, Aboriginal health, and we'll probably look, at those meetings, at

about 20 KPIs in total, but this is where, you know, the board's responsibility also comes into play, that they've signed off on the service agreement, inclusive of those 100 KPIs.

We also have programmatic areas within the ministry that would also have a direct involvement and influence in monitoring the delivery of those other KPIs, so it's a matter of crafting the engagement and oversight process, depending on which of those 100 KPIs are in the service agreement being monitored.

MR MUSTON: I'm not necessarily advocating the inclusion of more KPIs, and I'm also happy to be corrected if I'm wrong, but I don't recall seeing in any of the service level agreements a KPI that measures waiting times for, for example, public clinics for paediatrics, endocrinology, any of the array of services that are being delivered through public clinics.

MS SMITH: No, that's right. We actually don't currently have that data available to us but we're moving in the direction of having that data available to us.

But a program like Brighter Beginnings, which is, as we've all agreed, a really important initiative, does have a monitoring and evaluation plan. So whilst it might not yet be a KPI in the service agreement, we are looking at the outcomes for the children that are part of that program and also using linked datasets to be able to identify screening and then what services occur after that child has been screened. So potentially in future service agreements, once we have established data sources and we've identified what a target might need to be for that particular population, it could potentially become a KPI. So it may just simply be that we're in the trajectory of implementation of that program, we're just not ready yet for a KPI in service agreements. It doesn't mean it won't happen.

MR MUSTON: But for it to become a KPI that's able to be achieved, it would require a funding envelope that enabled it to be achieved at the same time as you're achieving the others - for example, waiting times in emergency, delay times for elective surgery, et cetera?

MS SMITH: Yes, the usual process of developing a KPI is

looking at what the current performance is and identifying what the reason uplift over time would be to achieve that, and funding for those types of services would form part of that decision-making.

MR PORTELLI: It's probably also worth flagging that for elective surgery there's a very robust process about who goes on the waiting list and for what, how patients are classified in clinical urgency category, and then the times expected for that. Those are national standards, which we align to. There isn't that same kind of infrastructure with outpatients, and as you get more down the outpatient route, the blur between what is our responsibility and what is delivered in the community is very - well, muddles decision-making quite a lot.

We don't have good data, I would suggest, about how much care is actually provided in the community already. We know it's a lot. We know that patients still rely on our service. But any kind of investment that we would make in outpatients would need to be married up with, well, what is the expectation and how do we know that we're going to target those people that would actually benefit from it, versus people who would just prefer not to pay an out of pocket and come to an public health clinic.

MR MUSTON: That's no different, is it, to elective surgery? I could choose to have a piece of elective surgery and I could choose to be a public patient, and whilst I might wait a while for it, I would be entitled to it?

MR PORTELLI: That's correct.

MR MUSTON: And that wouldn't cause you to give pause for thought as to whether or not waiting times for elective surgery should be adjusted to take that into account?

MR PORTELLI: We have more confidence over the wait list data for surgery because it's standardised. We know who should be on it, who shouldn't be on it. We don't have data on wait lists - we don't have centralised datasets for outpatient clinics, and if we did we would need to have some kind of - and we're developing it at the moment under the statewide referral criteria program; we're slowly rolling out those criteria to make sure that once we do have a data source, patients that are referred to clinics

are referred for appropriate conditions, so patients aren't just escalated very quickly, which can consume patients' time, can lead to bounce-around in referrals, patients who are referred to a specialist where they shouldn't have been, they should have been investigated first. All of these kinds of things are being worked through. But without that kind of robust infrastructure behind it, investments in that space can actually deliver the same, if not no, outcome benefit to the community.

MR MUSTON: What we have been told during some of our roundtables is that the wait times that we're talking about here are not wait times for secondary treatment but, rather, wait times between being identified as someone who requires an intervention or an appointment, say, with a paediatrician, and actually getting that appointment, sometimes, running to years. That would be capable of being measured without too much trouble, wouldn't it - that is to say, someone who has been screened and identified as requiring at least a review and the date at which that review is able to be provided?

MS SMITH: So for this particular program that we've been discussing, Brighter Beginnings, that's exactly what we're doing, but again, early days, and that data is just becoming available. But it's not something that's done routinely across the outpatient sector.

MR MUSTON: Why is that?

MS SMITH: We don't have, really, as Joe said, those clear criteria for referral to outpatients, but also we don't have a system, an electronic system, that allows us to capture the time of referral versus the time of first treatment, and so those are being developed.

MR PORTELLI: We're on the pathway, it's certainly something that we are interested in, there's no doubt. I think the reality is - coming back to what we were saying before about the spectrum of services and where, with a certain level of funding, we're able to invest. A lot of these outpatient clinics, I think describing NSW Health's role in those is important and I think we will get there with the work that is being done. However, with the funding available, these services should be core business - some of these, you know, within certain parameters should be core business for NSW Health, but they are in the more

preventative end of the spectrum than, say, emergency department or elective surgery procedures, particularly, say cancer surgery, category 1 type surgery.

MR MUSTON: Let's put emergency departments to one side because people who walk through the door in an emergency need to be treated - I think we can all accept that. But even elective surgery, certainly some types of elective surgery, there seems to be an acceptance that that has to be core business whereas some of these other outpatient services should be core business but aren't yet. I'm just wondering why, within a confined budgetary envelope, we're not having discussions around, if we had to prioritise, say, elective surgery - I'm not saying all elective surgery but there would undoubtedly be parameters that you could set, age parameters, functionality parameters on the one hand - and providing an outpatient service which might actually, at least in the mind of the operator of a local health district, provide better long-term benefit for their community, why aren't we having those discussions?

MR DALY: I think we are. One of the outcomes of the Surgical Services Taskforce that the government has set up to support the system returning to unplanned surgery breaches beyond their clinically recommended date, which we were successful in doing in getting back to pre-pandemic levels, was also about greater prescription, really under the principles of "Leading Better Value Care", of: we just won't do these types of surgeries - and they are quite prescriptive - except with the formal approval of the district director of surgery, because there will be exceptions. Even something that might sound quite cosmetic may have a very sound clinical reason, quality of life reason. And this group continues to meet and it's continuing to drive those principles and pushing the envelope in order to ensure that only those with the strongest clinical efficacy and evidence base are being performed in our public hospitals. But it's a journey, it's not a destination, because technology and models of care change all the time, but this group of surgeons and anaesthetists that I co-chair are actually leading that process as we speak.

MR MUSTON: As a perhaps unstated premise of my question, assume that low value care is actually taken out of the equation - that is to say, we're not talking about providing elective surgery to people who really shouldn't

be getting elective surgery, even people who would get clinical benefit from their elective surgery - is there any process whereby the clinical benefit and the system-wide, societal-wide benefit of delivering that clinical benefit to them through their elective surgery is being compared with the potential clinical benefits, societal benefits of delivering, say, a public outpatient clinic for paediatrics, endocrinology, whatever it might be within a particular community, bearing in mind that within the existing funding envelope we can't offer both?

MR DALY: Certainly not by the surgical services committee.

MR MUSTON: That's unsurprising.

MR DALY: I mean they're surgeons and they're there to cut. No, they're very focused on their specialty.

ACI does an enormous amount of work in this area and they guide policy decisions where there is the right evidence nationally or internationally. So I have no doubt that they are working in their various networks on those types of questions.

THE COMMISSIONER: Can I just ask - sorry, I just wanted to ask a question before we have a break but I don't want to interrupt you if you were finishing --

MR MUSTON: I was going to ask one more just on that topic.

THE COMMISSIONER: You ask your question.

MR MUSTON: You've now made me forget what it was.

THE COMMISSIONER: In fairness, I think that's the first time I've done that to you. You will think of it at the break.

Can I just ask Ms Smith a question. Yesterday afternoon we had Professor Duckett giving evidence, who no doubt you are probably aware of. He's an economist. Part of the discussion was about whether there is any work done on rates of return or cost benefit analysis for investment in health services that might be, for example, early interventions in some sort of paediatric service, and - no

criticism - no doubt it was a very good question from Mr Chiu, which was along the lines of it's very difficult to measure outcomes. You have mentioned Brighter Beginnings and First 2000 Days, amongst other groups, and we've had a submission from Minderoo which is related to sort of interventions in the first 2000 days of life or of kids' lives before they get to school, although more related to learning than necessarily health issues, although they can, of course, be related, but the Brighter Beginnings material from health tells me that late interventions cost the state $15 billion a year, and that for every dollar invested, we get $13 back. Where would we find the economic analysis that justifies that? I'm accepting that it's no doubt true but I'd like to see it.

MS SMITH: I am going to make an assumption, because for all of the new policy proposals that we put forward to the expenditure review committee of government, we need to --

THE COMMISSIONER: You need a business case, yes.

MS SMITH: We need to do a business case which has that economic analysis around benefit cost ratios and other assessments of cost benefit. So I am going to assume, but Alfa might be able to confirm, that for that program's funding, a CBA was done.

THE COMMISSIONER: Given the topic has been raised and this program has been raised, we might like to see that business case, because, I mean, as a matter of obviousness on those figures, it sounds like it's an excellent spend of money and perhaps the same sort of secondary benefits of that sort of investment might be applicable in other health services. So we might seek that. Other than that, is that a convenient time?

MR MUSTON: That reminds me of my question, Commissioner, if I could ask it.

Mr Daly, you made the point that the surgeons obviously are focused on cutting and they identify where, through doing more cutting, they can provide good benefit to patients, which is no doubt right, but every craft group within the health sector is no doubt in a position where it's able to say, "If I had a little bit more money devoted to what I'm doing or if there was a clinic set up which enabled me to do more of what I'm doing, I'd be able to

provide a good health benefit."

MR DALY: Yes.

MR MUSTON: As the Commissioner has just alluded to, there was an economic analysis done of Brighter Beginnings which has apparently revealed that for every dollar spent on it, if it's followed through, we get a $13 benefit to the economy, which no doubt for every intervention that's being done by different craft groups it would be possible - difficult in some cases, perhaps, but possible - to build an economic case for doing it, whether it be an economic case around the advantage of operating on people's sore knees and replacing them in a timely way or intervening in the development of children, there would be a way - an economist could put a value on it. Would you accept that as a broad proposition?

MR DALY: Probably.

MR MUSTON: No doubt even, say, endocrinological care, managing people's diabetes and preventing them from losing their feet and having all of the sorts of comorbidities that come with poorly managed diabetes might also be something which, not only from a general health point of view but from an economic point of view, could be modelled and a business case could be stood up for providing greater levels of endocrinological care to people and communities.

MS SMITH: There is a really good example of that. There is a high risk foot clinic proposal under the "Leading Better Value Care" initiatives that did exactly that, that looked at early intervention in people who had foot ulcers and other sorts of diabetes-related foot issues, and has definitely demonstrated a reduction in things like amputations, which is a very positive outcome.

MR MUSTON: Which brings me back to a question I asked a bit earlier: as part of the negotiation of either KPIs or the purchase of activity, is there a weighing up of the costs and benefits of all of these various services? That is to say, we seem to be prioritising elective surgery and having our waiting list KPIs for elective surgery is effectively driving us in a way that requires us to keep doing that, even if the local operator of a health district thought, "I think what my people need more than knee replacements is a paediatric outpatient service and

endocrinology care to mean we don't need to set up, long-term, a foot clinic" - of the type you have just described - "because, whether it be on health grounds or economic grounds, we think the benefits associated with those outpatient clinics outweigh the benefits associated with elective surgery, if we can't have all of it." Does that discussion happen as part of the budgetary process?

MS SMITH: I think it would be difficult to say that we don't need both. I don't think we get into the conversation about either/or. I think, you know, the reality is that we need to keep doing what we're doing and invest, separately, in what we're not currently doing.

MR MUSTON: But can I ask this question: do you need to keep doing it everywhere?

MR PORTELLI: No. I mean, I think districts have a pretty good grasp of what they need to be doing, what services they need to provide for their community and have the understanding that, actually, it doesn't need to be provided in every single hospital in every part of their district.

MR MUSTON: Does it need to be provided in every district?

MR PORTELLI: Well, we have certainly looked at other avenues. So we have statewide services that have always been around and they do provide services for - you know, when heart-lung transplants come up. But say, for example, virtual care hubs, that was something that was clearly of benefit to the system. Some districts decided that they would want to spin off their services. Great, innovative. A lot of great innovative ideas come from on-the-ground solutions to problems. But given it was of value to the state, we've now established or are establishing two central hubs that provide services across the state. So, yes, we do consider things where some things don't have to be provided by every district and they can either be provided by two districts on the behalf of the state or - with ministry involvement.

MR MUSTON: From a system planning point of view, insofar as the LHDs are making their local plans and working out what they should be asking for from a budgetary sense, to what extent is that system-wide planning informing that process, putting to one side statewide services like

heart-lung transplants and those things that you obviously can't get in a place like Narrandera?

MR PORTELLI: In the roadshow process that I've discussed, any kind of programs where we have that system lens to it are discussed in those initial discussions in February and March, just so we can set the scene, "This is what's happening, this is what you might see in your district", and that will then colour or maybe modify what the districts request of us. They go, "Well, actually, we probably don't need this anymore." Often that doesn't happen because it has already been announced and discussed in other forums. So there is the senior executive forum with chief executives and ministry where some of these programs may have already been announced and discussed, so that before they even get to that stage of the roadshows, they know that they don't need to invest in it.

MR MUSTON: I note the time, Commissioner.

THE COMMISSIONER: Yes. We will adjourn until 5 past 12.

SHORT ADJOURNMENT

THE COMMISSIONER: When you are ready.

MR MUSTON: Could I just come back to paragraph 7 of the statement prepared by Messrs Daly, Portelli and Ms Smith, just to make sure I have understood this correctly.

Paragraph 7(a) tells us about the fact that the service agreements include the level and mix of services to be purchased. So am I right in my understanding that the way in which the level and mix of services being purchased is set out in those service level agreements is there is a bundle of activity which is purchased, and the quantum of that activity is the historical base plus the growth factor that has been applied to the LHD?

MS SMITH: Plus any other initiatives that we might be purchasing over and above either of those things.

MR MUSTON: In relation to that, that's almost the equivalent, at the ministry to district level, of the NPP process, is it, where the district will say, "We've got this new idea", or "We've got this different way that we think we want to go about doing something. In order to do

it, we'll require a little bit more activity to be purchased from us"; you give consideration to that proposal and decide whether or not to, as it were, adjust the base going forward by that, by the amount of activity that has been requested?

MR PORTELLI: That would be correct. Again, that was a material number - well, that would have been a material number overall pre-COVID. Post-COVID not so much.

MR MUSTON: Not so much because there's just not enough money to provide - to deliver the activity or to purchase the activity that might be proffered by the districts?

MR PORTELLI: Correct.

MR MUSTON: Other than that broad description or the broad allocation of an amount of activity, the way in which that activity is divided up in the sense of the level and mix of services that is referred to in paragraph 7(a), it's pretty high level, is it? I think, for example, if we go to paragraph 26 of the other statement, there's a useful example of Murrumbidgee LHD's budget. That's on page 6 of the statement prepared by Mr D'Amato et al.

We see there that it seems to be divided up between acute admitted, mental health admitted, et cetera - each of those items there. That's the extent to which the service and mix of services to be delivered through the activity is carved up?

MR PORTELLI: That's correct.

MR MUSTON: So not to the level of, "These are the sort of outpatient clinics; these are the sort of procedures that you should be offering through your LHD"?

MR PORTELLI: No.

MR MUSTON: And I gather that that's because, in the devolved arrangements, a degree of flexibility, at least within those broad budgetary headings, needs to be given to the LHD to decide what, within those headings, is best going to meet the needs of their communities?

MR PORTELLI: That's correct.

MR MUSTON: How does the divvying up even into those headline items happen? How do we decide whether a particular LHD, in this case Murrumbidgee, should get 43,000,365 NWAU for acute admitted care as opposed to a little bit less than that in the acute admitted space, but a little bit more in the mental health admitted, for example?

MS SMITH: We calculate growth at a stream level. So, as I described before, we look at all of the different factors that might drive growth, but then in the service agreement process during the roadshows and in between the roadshows we give the district the flexibility to decide how they would like to carve up their total NWAU into these streams.

Of course, we have discussions about whether that's reasonable and feasible and makes sense, but they do have some flexibility which allows them to flex a little bit if their service models are going to change in the coming year.

So, for example, in years where there might have been a lot of elective surgery catch-up they might have wanted to put more activity in acute, but once they've caught up they might want to move it back out into non-admitted, for example. So that flexibility is there for them, but the growth itself is calculated at a stream level but they can move between streams and we agree that through that negotiation process.

MR MUSTON: So when you say that they are able to carve it up but there's still a discussion that happens to work out whether it's reasonable and achievable, what is it that makes it reasonable and achievable? What's the difference? Let's say, an LHD's made a decision that it wants to substantially reduce its acute admitted but increase its mental health non-admitted, hypothetically?

MS SMITH: So we would like to understand what changes to service delivery are going to occur in line with that and we would want, if it has a particular policy impact, to discuss that with the policy area before we go ahead and effect that change in their service agreement.

MR MUSTON: But doesn't --

MR CARR: I was also going to say, Sharon, you'd also look

at your historical performance there, as well, compared with those targets.

MS SMITH: Yes.

MR MUSTON: In what sense is the historical performance important?

MS SMITH: If they've always delivered the majority of their activity in that stream and now they are suggesting that that is going to change, we'd want to know what material changes are going to occur so that that is reflected in their activity monitoring throughout the year.

MR MUSTON: I think we've accepted that whichever of those headline items you were to allocate the activity to, and whichever way you were to choose to distribute it, you would be able to - they would be able to generate the activity.

MS SMITH: Absolutely. And in fact, now in this year's service agreement and going forward, we don't actually have a KPI for each of those service streams; it's a total KPI for their entire service agreement total. So we're not actually necessarily holding them to account for each of those service streams' activity, but when we publish the service agreements, as a requirement under the NHRA, the Commonwealth requires us to itemise the activity into service streams. So we're following that requirement from the Commonwealth.

MR MUSTON: And that certainly would account for the top five service streams, which are the ABF captured service streams?

MR PORTELLI: That's correct.

MR ONLEY: Yes.

MR MUSTON: I think earlier, Mr Portelli, you indicated that there are KPIs - KPIs not necessarily for each service stream but at least two KPIs, one for the ABF captured activity and one for the non-ABF?

MR PORTELLI: That's correct. So what Sharon was mentioning around the total, it would be the total NWAU as per I think schedule 5 in the service agreement, whereas

the second KPI about in-scope activity would be related to the numbers in this schedule, the total --

MR MUSTON: When, Ms Smith, you talked about if there was a proposal for a significant change in the allocation of the activity from one of the categories to another, there would be a discussion with them around what the service change was going to be, what would that discussion involve? Perhaps give us some examples.

MS SMITH: Largely, we'd just be trying to understand why that was occurring. We're not in a position, necessarily, to approve or decline that request, but it's really just so that we're informed about those changes and we have ensured that the rest of - I guess, the system manager role is informed that those changes are about to occur.

MR MUSTON: What's the relevance of that from a system manager role perspective? How does that feed in to the task of managing the system?

MS SMITH: So if, for example, we were going to move a lot of activity out of mental health, for example, into another service stream, then most definitely, mental health branch would be interested in understanding the reductions that that might equate to in mental health services for that particular district.

MR DALY: And in addition to that, chief executives don't have delegation to close services or shut facilities. That rests with the secretary. So if they wished to do that - and I have no doubt every chief executive would have a list of services that they would like to cease - then they need to seek secretary's approval. So that's another reason.

MR MUSTON: You say you've got no doubt that all of the chief executives would have a list of services that they would like to cease. That, presumably, is because they, from their perspective, have come to the view that the budgetary envelope they have available to them would be better utilised for the benefit of the community without those services and redeploying those funds into other services?

MR DALY: Mmm, well, it plays directly to the conversation we were having just before the break around disinvestment. Disinvestment in health is really, really hard and it

requires an enormous amount of will and political acumen to actually secure that, not just through the medical politics but also the community politics and then macro politics.

But yes, I'm sure, I have no doubt, every chief executive would have a view of disinvestment in (a) for the purposes of reinvestment in (b), for their real or perceived better benefit or service to the community. No doubt.

MR MUSTON: But at the moment, there are impediments to that, perhaps political impediments, to that being achieved?

MR DALY: I wouldn't say "capital P" political but certainly community pressure, and particularly in rural areas which may have a greater scope for those disinvestments for a whole host of reasons, many being critical mass of investment, that is just really hard to get through communities. It's hard enough in metropolitan areas, let alone in those regional communities.

MR MUSTON: But the effect of that is, that compromises the ability of those running local health districts to actually utilise the limited budgetary envelope that they have available to them in the way that they think, in a properly informed way, actually best meets the health needs of their communities; would that be right?

MR DALY: Well, I guess it would depend on the view of both the chief executive, but also of their board, that is made up of community members, as to whether they believed that was right and/or achievable.

MR MUSTON: Perhaps one of those "lower case p" political challenges that we could theorise about is closing an emergency department in a small country hospital that a view might have been taken - as we have been told in evidence around the state, there are a number of them - that chief executives think really should not be open, and replacing them with a primary care provider of some description. The chief executive would think that that is what's in the best interests of the community and perhaps best going to meet its health needs.

MR DALY: Mmm, or deliver the same services, you know, through virtual means, hence the virtual GP, virtual ED

physicians that we have available, and changing the service model with nurse practitioners being on site, rather than, you know, haphazard GP VMOs, who also need a break and need to leave town for a holiday, and they go, and there is no medical coverage. That is not an uncommon set of circumstances, but the uptake of virtual services is bridging that gap in many, not all, cases.

MR MUSTON: Is there an extent to which those "lower case p" political forces are at play in the decisions around which KPIs to include in service level agreements - for example, emergency department waiting times and elective surgery waiting times?

MR DALY: I don't know if it's political but, as I said, just those two pathways oversee over two-thirds of admissions into our public hospitals, so from a governance perspective, you would be wanting to make sure both those pathways, in all our LHDs and hospitals, are operating well, because that's where the big bulk of your activity is.

MR MUSTON: Let's put emergency departments to one side, though. In relation to elective surgery, that's forming the proportion of the services that we're offering at the moment because they are the people who we're letting through the front door and offering a service.

MR DALY: Sorry, what was the second bit?

MR MUSTON: That is because they are the people, or that's the service, we are prioritising when we're letting people through the door and offering them an operation. It could just as easily be the case - just coming back to the now well-trodden example of the community paediatrics picked up through Brighter Beginnings, but the same proportion of services could be offered through there, if that's where we were deploying our resources. I'm not suggesting that we necessarily would, but the fact that that, at the moment, makes up a large proportion of our patients is because that's the service we've chosen to deliver, isn't it?

MR DALY: I'm not sure it's of the same proportion, but it would be a number I'm not familiar with, the number going through those outpatient services.

MR MUSTON: I'll move on. So we've got the activity based

funding component that we've looked at. We then have an adjustment of the price which is paid for that activity to represent the state efficient price, we're told; is that right?

MR D'AMATO: Yes. So effectively, that adjustment formerly known as the transition grant was in place as one of the many, if you want, local adjustments to the activity based funding model, so that no significant penalties or significant shifts in funding were applied specifically to regional hospitals or regional health districts. That effectively is simply measuring the difference between the state price, the state efficient price, and the cost of delivering care for the particular LHD. Because ultimately if you were to apply a pure ABF model, these districts operating above the average that - we used to price the average as the - to inform the state efficient price - would have had to lose a significant amount of funding.

MR MUSTON: So is that what you tell us about in paragraphs 21 and 22 of your statement, Mr D'Amato?

MR D'AMATO: That is an extra component to it. As I mentioned, there are multiple components that we introduce as local adjustments. One is what we called the transition grant, which we now call CPA or cost price adjustment.

In addition to that, in identifying the variance between the state efficient price and the cost of delivering care, we also identify what we identify as recognised structural cost. That is effectively applicable to regional LHDs, where we acknowledge that no matter what level of efficiencies they can achieve, they're never going to be able to be the same state efficient price that the rest of the system is operating at.

So we probably have used some - back then we used the cost, for instance, of transport that is impacting on regional districts more than others. This is also to compensate where the national model doesn't accurately reflect the cost, a cost structure, for instance.

MR MUSTON: Let's step it through. We've got the national efficient price, which is a dollar figure per activity unit?

MR D'AMATO: Okay.

MR MUSTON: New South Wales, on average, is able to deliver that unit at a slightly cheaper price than the national average because of --

MR D'AMATO: So perhaps, if I may, let's park the national efficient price to the, side only because the national efficient price has really two objectives: one is to determine the funding flow between the Commonwealth and the states; and the other one is a signal. Potentially it's probably a signal more for jurisdictions that operate above the national efficient price than jurisdictions like us that historically have always operated below the national efficient price.

So once we park that aside, our reference point is what we call the state efficient price, which is expressed in the same denomination as the national efficient price, in NWAUs, but uses more relevant - more recent costing data and also uses our costing data. So it is not subject to other states' or territories' cost structure, for instance. So using our cost structure, then we are a little bit more confident that the average or the state efficient price is reflecting the services that we deliver in our state.

MR MUSTON: And as you tell us in paragraph 19, under the NHRA, the state is able to work out what, in the case of New South Wales, its state efficient price is and use that as the value which is applied and delivered to its local health districts?

MR D'AMATO: That's correct.

MR MUSTON: Now, if a local health district is able to deliver the activity that it delivers for less than the state efficient price, as adjusted by the CPA and the RSC, then it gets the benefit of the money that it's saved and it can deploy that --

MR D'AMATO: That's correct.

MR MUSTON: -- in a discretionary way within the LHD to meet the health needs of its community.

MR D'AMATO: Yes, and I have, I believe, a roadmap in my statement that kind of illustrates all the steps we put in

place to get to the state efficient price. It's certainly not something that we introduced from day one because we acknowledge - and this is in section 63 of our statement, it clearly identifies that in the first few years, we really wanted to create an environment which was safe for everyone to understand, if you want, the different levers or the mechanics of activity based funding, and in particular as we were moving away from a block funding arrangement, which was the LHDs base budget, to the ABF.

Then we also witnessed a significant convergence into the average - the average cost of delivering care, which was a good outcome. At that point we started, if you want, recognising some of the different cost structure, because we recognise that certain LHDs will never be, you know, performing at the same level of efficiencies as metro districts. We then introduced a program of translating part of the transition grants - that's what we called it then - into activity. So, again, to drive more efficiencies in the system.

Obviously, since then, we started working from the very beginning with the different aspects of the purchasing, and again, as I made a comment before, I think our approach has been one that is trying to reach a balance between a state price, efficiencies that we can drive under the price using benchmarking information, and the purchasing strategies on what we need to deliver, in particular trying to make sure that there is an input from the population base of the population needs into the equation.

Then ultimately we moved to what we call now the state efficient price, which is effectively something that even the national model had aspirationally intended to achieve at the right time, where they wanted to move away from an average to set the price into something that is more reflective of efficiency, and at that point we set the price, and then COVID happened. So basically, that's where we are now.

MR MUSTON: In terms of the concept, if COVID hadn't intervened, we were told by Professor Duckett yesterday that within any health service there are going to be areas where you will have efficiencies that you can deliver services at below the average price and make some savings, as it were, or bank some money.

MR D'AMATO: Yes.

MR MUSTON: And then other parts of the health service where you're always going to have an overspend over and above your average, and in a well-functioning system, if the average is right, they net one another out.

MR D'AMATO: Yes, I think that's a good comment, because ultimately it's an averaging model and it's averaging whether at the state, at the district level - even at the districts, you would have an hospital performing above the average and an hospital below, but, you know, to mitigate the shocks, we always aggregate at the district level.

At the national level, having an average at the national level kind of removes all sort of, if you want, peculiarity about the costs of delivering care in certain hospitals.

In acknowledging that, you know, there are winners and losers as always in an averaging model, we also introduced other steps to mitigate, if you want, and prevent the unintended consequence of ABF.

One of those steps was what we call the highly specialised services. So through, again, the purchasing model, there was an opportunity for districts to identify and require further adjustments in regards to providing certain care which either was new, in that it was new to the degree that there wasn't a proper classification to identify the cost of this care, and a good example was probably the St George example.

MS SMITH: Peritonectomy.

MR D'AMATO: Yes, sorry. At the very beginning, for instance, that particular procedure ended up in multiple DRGs, so it was difficult to say that we could price accurately, and nor at the Commonwealth or IHPA, and so at that point we identified a cost for these group of patients, we identified the lowest cost ratio, being that the cost of delivering these procedures was above what we paid for, and at that point, we had provided for additional funding for the districts that were performing this procedure.

MR ONLEY: Heart/lung transplants were a classic example. When we started the cost differential was rather large compared to the price weights. After a couple of years, once we were getting the data right, the price weights actually came close to the cost and it dropped off our highly specialised services program because they were adequately funded, and other things then, like the peritonectomies, came on because they are new procedures at very high cost.

MR MUSTON: Putting to one side those highly specialised treatments, heart-lung transplants and peritonectomies, the business-as-usual type procedures, Professor Duckett also indicated that large metropolitan hospitals that have a higher turnover of procedures are usually able to deliver that care in a way which is more efficient and therefore means the larger metro centres tend to get themselves under the average, whereas smaller centres, who perform procedures less, will tend to be the ones that are over the average. Would that be correct?

MR D'AMATO: Yes, that's exactly right. Probably in section 67, the chart that illustrates the transition grants over time gives evidence to support that claim, in that, as you can see, when we started the journey, we identified a large component, being the green, reflecting the transition grants in the metro LHDs, versus the dark blue, which was the transition grants originally identified in rural and regional LHDs.

Over time, and particularly in a relatively quick turnaround, if you want, over three years, you can see that the green amount reduced significantly, and that was obviously because of volume; because of data also, in terms of in introducing ABF from day one there were probably significant data improvements that contributed to this, and ultimately, you know, the ability of districts to start benchmarking their costs and identifying opportunities to deliver that care at the more efficient cost.

MR ONLEY: But it also recognised, too, that we had acknowledged the cost structure in those rural ones, and you see the RSC component has increased in its place, and there is a difference between the RSC and the transitional cost price. One, you had to drive efficiencies through the growth; the RSC was a recognition that your cost structure is higher and there's no penalty, so --

MR MUSTON: So the RSC is introduced in an attempt to account for the fact that larger metropolitan hospitals will have a greater capacity to deliver that care at a price under the average than their rural equivalents and it seeks to level the playing field; is that right?

MR ONLEY: Yes, and it is to recognise that the rural equivalents, as you said, have a higher cost structure because of lack of volume or location, lack of resources, whatever the various things are.

MR PORTELLI: The NWAU model already adjusts for that slightly, as well. There is a rural adjuster for the same service delivered in a rural facility versus a metro facility. So when we look at the average cost per NWAU we're already looking at a ratio that acknowledges that delivery in care in a rural setting is more costly, but, you know, then there are these other methods that top that up again.

MR MUSTON: Evidence received in our rural hearings has suggested that there's at least a perception amongst rural LHDs that the adjustments that are made don't actually adequately capture the increased cost of delivering care in those settings, such that they are, as it were, disadvantaged and it's costing them at or above the average, the adjusted average, whereas metro-based LHDs with high volume are able to benefit from the system. What is your response?

MR D'AMATO: In my opinion, it is a fair comment now, as in now after COVID, and particularly due to workforce challenges. As a result, we also started introducing further adjustments as of this year in recognition that the challenges have been heightened by the post-COVID environment compared to before.

But just to reflect on the size of the adjustments, in section 35 of our statement, I've tried to describe the components of the NWAU and what that looks like in dollar terms and how this impacts, if you want, rural LHDs versus metro LHDs.

So, for instance, the top line, reflecting around 16.84 billion, reflects what is the base NWAU. Then on top of that, the relevant adjustments are reflecting the

paediatric adjustments, for instance, 81 million, and you can see in the last two columns how these have been allocated to the different groups of LHDs.

So, for instance, in that particular case, the paediatric adjustment, we have reflected that of the 81 million, 10 million is allocated to the rural LHD. That will be Hunter New England, because this adjustment is only allocated to recognised paediatric services, and the 71 million, as you would expect, is all going to the kids' network.

Then if you go further down, you can see there's a remote area adjustment, and you wouldn't be surprised that out of the 64 million, 54 million is actually allocated in the budget of the rural LHDs, and so on. Just to give you a sense of how, once we unpack the formula that you can see below, it is reflected in the budget allocation of the districts.

MR MUSTON: Putting the rural LHDs to one side for a moment, you tell us in paragraph 31 of the statement that you have made an application to IHACPA for some adjustments to be added to the weightings to take into account the fact that treating patients from a culturally and linguistically diverse community was, as it were, more expensive.

MR D'AMATO: Yes. So the IHACPA process allows jurisdictions to provide feedback throughout their consultation period, which normally happens around December/January, where states and territories have 45 days to submit requests for additional adjustments or additional elements that might not be captured in the national efficient price determination or the national efficient cost determination.

In the past, we have escalated the CALD as a particular adjustment because of the feedback we received from the districts. So in particular, in some of our regions - namely, Western Sydney, South Western Sydney - there have been suggestions that this is a significant impact on the cost of delivering care.

The challenge for us has always been - probably one or two, but the number one challenge is - to identify the data. You see, the difficulties in identifying the data relate to us providing evidence to IHACPA that is

sufficient enough to be material enough, if you want, that nationally they can introduce something like this.

The challenges for this particular group of patients are that often they might use interpreters; there is an assumption that some might stay longer, in terms of length of stay, but some of the evidence actually has been showing the opposite, in that they don't tend to stay longer than the average length of stay, because at times there is an assumption that they might not understand the staff and they don't understand the workforce, so they prefer going home and being treated by family.

So ultimately, the evidence that we were able to provide wasn't conclusive enough at the national level to convince IHACPA to introduce this particular adjustment.

MR MUSTON: Can I ask in relation to that, was the evidence that you were able to gather conclusive enough at a state level to at least persuade you, within the state, that the cost of delivering care to the CALD community, even though it might be difficult to identify precisely which patients are within the CALD community and which are not, having regard to the sorts of questions you might need to ask to work that out, was higher than delivering care to people who were not within that community?

MR D'AMATO: We did the work a while ago.

MR ONLEY: Look, I think on the CALD stuff, we have looked at that several times. As Alfa said, getting the actual data is problematic.

MR MUSTON: Can I ask why that is, why getting the data is problematic?

MS SMITH: I'm happy to take that, if you like. So we definitely have strong data at a population level, so we know from the census data, for example, in different parts of the state, the number of people born overseas, those who use a language other than English, et cetera. But in our hospitals data, which is what we are required to submit to IHACPA to provide the evidence, it isn't as strong, as in particularly the proportion of people that speak a language other than English, it's not an item that nationally is well collected. So having a really strong evidence base that identifies all of the patients in that category is

difficult.

MR MUSTON: In fairness, asking a patient whether they speak a language other than English wouldn't necessarily, in 100 per cent of cases, at least, be an indication of how difficult it would be to treat them.

MS SMITH: That's right. Again, it's degrees. So is it interfering with the person's care or is it making the care more difficult?

MR D'AMATO: Sharon, correct me if I'm wrong, but your equity adjustment may account locally, to a degree, for this particular challenge, if you want?

MS SMITH: It does, Alfa, but the way that we implement that is we buy more activity. So it's not necessarily reflecting the additional cost of that unit of activity.

So in recent years in our discussions with districts and networks we have given them the option, instead of taking more activity, that they can take the money and use that to support the delivery of services to people that might come from a background where this is more challenging.

MR MUSTON: Just to test that, purchasing more activity, where it was being put forward that the cost of delivering activity was higher than the state efficient price by reason of the community that was being served, would mean the LHD was required to deliver more activity at a loss and thereby increase the size of the black hole that was opening up beneath them; would that be right?

MS SMITH: Exactly. So that's an argument that was put forward by a number of chief executives, one that is probably still in this room, a former chief executive, that came with a good evidence base that we did respond to and made a change in the model.

MR MUSTON: We are told in evidence that has been given that there is still a disconnect between the state efficient price, adjusted as it is, and the cost of delivering care to particular communities - for example, South Western Sydney, the community of South Western Sydney - and that that results in an inequitable distribution of funding across the system.

MR D'AMATO: Can I make two comments on that?

MR MUSTON: Yes.

MR D'AMATO: One is that the state efficient price and the state price is all informed by the cost of delivering care provided to us by the districts. So there is a strong relationship, to the extent that the quality of the cost provided to us is strong enough to make sure that we can inform and set the state efficient price --

MR MUSTON: Can I ask you about that before you make your second point?

MR D'AMATO: Yes

MR MUSTON: Does that mean that if, say, South Western Sydney says, "Here is what it has cost us to deliver this level of activity to our community", that, in turn, informs what they get paid next year to deliver that care to their community, or does that just, as it were, push up the average which is enjoyed by every LHD?

MR D'AMATO: Push up - actually that particular case pushed down the average. So that meant that at times, in particular during the period of convergence when we were buying activity at the state price, meant that that particular LHD was paid for extra activity at a price which was above the cost, the average cost, of delivering care, and I again stress that the average cost of providing care was provided by the district to us; it was not the ministry making those averages.

But the other part I want to reflect on is our experience in South Eastern and Illawarra probably now 15 years ago. Mr Onley and I worked at South Eastern and Illawarra Area Health Service where it was large enough to have a good representative sample of hospitals to introduce what we called then "episode funding", and throughout that process we established a number of steps that are currently in our model. But one step that we used there, and we learned a big lesson, is that sudden movements don't get - they are dangerous.

So we had a number of hospitals there. I think we had at least five ABF or B1 hospitals, and there was one, very

efficient, and at that point there was a call made to pay everyone at the same price. That meant that we had to take money out of other hospitals to give it to these hospitals, and as a result, everyone's budget blew up. That's because the hospital that was efficient realised that to get more money, they just had to do more activity, and the hospitals that were inefficient couldn't achieve the efficiencies overnight and, as a result, kept being inefficient.

So as a result of that particular lesson, experiment, when we stepped into the ministry we introduced this concept of transitioning, so over time, and we've seen that in the average cost, that the convergence has certainly been as a result of an effort to maintain a system that's safe and operating and, if you want, moderate some of these risks. So that's one aspect that I think we need to reflect on, and it worked for us in this case.

MR MUSTON: Does that also apply in relation to, say, service change more generally, if you want to disinvest in a particular service and invest in a new one, so you take the view that the community doesn't really need something that's always been done as much as it needs another service which is not currently being provided, but obviously you can't turn around overnight and say, "We're going to cancel this one and start up the new one", because that (a) might come up against some of the "lower case p" political challenges that have been alluded to; and (b), from a workforce point of view, you've got human beings who are delivering a particular form of care and not another one and there's a period of transition that you need to go through in order to change the shape of your workforce to change the services you are delivering?

MS SMITH: If I pick up on your example before the break of knee surgery versus paediatric services in the community, you can't turn an orthopaedic surgeon into a speech pathologist, for example, overnight, so it would be a transition if you were to disinvest in one and start another.

MR MUSTON: Does that mean you effectively need some headroom, in terms of your funding, in order to scale one of them down while you are building the other one up?

MS SMITH: Absolutely.

MR MUSTON: Because you can't scale down your knee surgeons to the point where they have all retired and not been replaced with registrars and new knee surgeons and then overnight say, "Now we want to hire a whole lot of speech pathologists and paediatricians"?

MS SMITH: Not to mention that that could take 20 years.

MR MUSTON: Yes. But that probably gets us to an important point: service planning, and funding decisions which support good service planning, needs to be done ideally on, say, a five- or 10-year horizon, does it not?

(All witnesses nod)

MR DALY: Yes.

MR MUSTON: It's dynamic and needs to be reassessed, if not constantly, year on year to work out whether changes in technology have meant that maybe we didn't think that we'd need - well, we thought we'd need some cardiothoracic surgeons but now technology has changed and we think, instead, we need cath labs, and we can roll them out, but subject to those sorts of changes, it needs to be something which is being thought about system-wide, but also within each local health district across a 10-year or longer horizon?

MR DALY: Yes, and that is something that the secretary and the ministry executive have identified, and we've started work on it with some new role configurations across a number of branches in the ministry.

The genesis for it - sorry to go back to the past - was a very clear, in fact, direction from government, from the minister at the time, as part of the devolution to the LHDs, to disinvest, to support local service planning, which initially I'm sure occurred, because the appropriate branches of the ministry were dissolved and some of that skill set went into the LHDs, but over the last decade, since that devolution in 2010, I think there's been a fair degree of disinvestment in those planning resources, such that there's not the strength that there used to be centrally, and it's patchy, to be kind, across the LHDs, so --

THE COMMISSIONER: This is the "missing middle", is it,

that Mr Minns was talking about when he gave evidence, in terms of what you are talking about in terms of planning --

MR DALY: I'm sorry, I'm not familiar with what Phil said, but it's sounding like it.

THE COMMISSIONER: I think it is, yes.

MR MUSTON: It's a regular target for efficiency drivers, isn't it, that middle management?

MR DALY: You can disinvest in management but you can't disinvest in service. That's a lot tougher.

MR MUSTON: Just to make sure we've understood correctly, the discussions that are happening at the moment, driven by the secretary, are, what, a rebuilding of that capability within the ministry?

MR DALY: Strengthening it, yes. It's there to the extent of where it informs some of our capital programs. Is it there to the extent of providing evidence-based guidance to each of those LHD service plans on national, international or professional best practice? It's not strong enough for that, and for a chief executive to deliver a clinical service plan that may or may not inform a capital redevelopment, there inevitably will be changes in profiles that can often be very difficult to be accepted by some professional groups, hence the need for the evidence base to demonstrate the efficacy of preference in a service profile for that particular population group, and whilst there is that there, to a component to inform our capital developments, I think as an executive - and certainly the secretary doesn't believe it's strong enough to inform better clinical service planning, so that's a journey we're just starting on at the moment.

MR MUSTON: It goes beyond capital planning, though, doesn't it?

MR DALY: Oh, yes.

MR MUSTON: It's not just, "Should we build a new hospital and what should it contain"; it's also, "What services should we be offering at the existing hospitals and, in fact, should we continue to do what we've always done just

because we've always done it?"

MR DALY: Yes, and it's that point that you just alluded to, the stage zero capital planning, that actually informs the capital planning, but if that's not strong enough, the tail can wag the dog.

MR MUSTON: When you refer to "the tail", how far down the dog are you going, within the health system?

MR DALY: I'm sorry I used that.

MS SMITH: At least the kidneys.

MR DALY: Oh, I'm not sure how to answer that.

MR MUSTON: Well, are we talking about decisions about services which are offered at LHDs or the shaping of services being offered at facilities in LHDs being informed by clinicians on the ground or being informed by that sort of mid-tier strategic planning being done at the LHD level? The tail is obviously a long way away from St Leonards, I'll take that for granted, but --

MR DALY: Do you want to answer?

MR D'AMATO: No, no, I will leave this one to you, by all means; it is purchasing.

MR DALY: I think in the absence of skilled professional clinical service planning and planners generally, the assertive voice of clinicians can be sometimes too difficult for a chief executive to get around, and many, in private, would say that quite honestly to you.

MR MUSTON: A skilled service planner, would they be able to manage that, balance the competing requirements of autonomy that drives innovation on the part of your clinicians and potentially allows your service to evolve on the one hand but, on the other hand, not enabling that autonomy in decisions made by clinicians about the way they want their particular craft group or their particular section of the service to evolve to then shape the way the service looks in the way that maybe has happened now?

MR DALY: And in the past it was traditionally a very strong role of the ministry.

MR MUSTON: A strong role of the ministry which is being restrengthened now, you tell us, through the direction of the secretary. What about at the LHD level? Do they require resourcing to enable that sort of capacity to be built within the LHD to enable them to resist the forces that might be operating within various facilities and various departments that have, for good or bad, the practical effect of shaping the way our services look and are delivered?

MR DALY: This is an opinion, and Alfa, who oversees the capital program, might have a more empirical answer to you, but I think I used the word "patchy" quite intentionally, because I think where there has been a strong capital program within an LHD in recent times, by necessity, they may have needed to maintain a stronger planning presence than those LHDs that may not have had a very strong and/or active capital program and hence disinvestment probably occurred.

MR MUSTON: Does anyone have anything they want to add to that?

MR D'AMATO: No, apart from the fact that I agree with the comment. It is patchy and it is certainly, you know, more the result of the - whether it is the capital program, whether it is the CE or there is an historical capacity and capability that they retain at the district level, because ultimately when we were in area health services there was one group, and when we split then the groups, you know, ended up in one part and - you know, so at times from - and again, like, my experience, some of the more experienced ones ended up in one part of the district.

MR MUSTON: The connection between potential planning capacity within the districts and a capital project suggests the two are closely connected across the board, but the planning capacity that might exist within the districts which have a new build happening, is that service planning which is being done LHD-wide or system-wide or is it more targeted to, "What are we going to do with the, as a result of escalations, increasingly small pool of money that we have to build this large hospital?"

MR CARR: My general - working in Central Coast more recently, I think there's one or two people there doing

that planning and they take up a fair bit of their time dedicated to the new works and new capital works or looking at the planning associated with new builds and that type of thing. You know, there is limited resources there.

MR MUSTON: So it's limited resource for them and limited funding resources to be making these transitional decisions about disinvesting and changing the shape of the health system to better meet the evolving needs of a particular community, in any event, even if it was part that was well resourced; would that be right?

MR CARR: Yes, that's a bigger, higher-level piece of work.

MR MUSTON: But ultimately you could have all of the planning resources, the best service planning resources in the world, but unless you actually have the funds available to give effect to that planning, it's - it looks good on paper; is that so?

MR D'AMATO: Just on a general comment, I think there are also opportunities to focus more on the strategic planning side of things, not just the capital planning, because I think at the moment it is relatively fragmented, and I agree with the comments being made, but there is an opportunity in better integrating these strategic plans that could help us going forward.

MR MUSTON: So, for example, and not wanting to put up a hypothetical example that shocks the people of the south coast, but, for example, there might be particular services which could adequately be delivered to people within the southern LHD, or at least the eastern half of the southern LHD, through, say, Wollongong, which would enable Southern NSW LHD to disinvest in an expensive and inefficient form of care and perhaps redivert those moneys into other areas, but that sort of system-wide planning, where precisely what's being offered at different LHDs in the way in which you might have, whether you call them centres of excellence or just centres where particular procedures are done in a more efficient way, that's not happening, I gather, at the moment?

MS SMITH: I think ideally we want a balance between those that have local knowledge of the community and the services that are delivered and then those that have oversight of

everything that's happening across the state, and good connections between them, so that you can have both something that delivers local need but also best outcome for the whole state.

MR MUSTON: You say "ideally". Do I gather from the word "ideally" that we're not there yet?

MS SMITH: I think that would be a reasonable assumption, yes.

MR MUSTON: Which bit is missing?

MS SMITH: I think, as Matthew has alluded to, the secretary has given the direction that that's where we need to be, but we're not there yet.

MR MUSTON: I'm about to move to another topic, Commissioner, if that's a convenient time.

THE COMMISSIONER: It certainly is. We will adjourn until 2 o'clock. Adjourn until then.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, when you are ready.

MR MUSTON: So if I can move on to another aspect of the funding model, which is the block funding of smaller hospitals, that's something, as we understand it, that flows through the ABF system from the Commonwealth. So to the extent that the Commonwealth is funding or has identified a hospital with a particular level of activity as a block funded hospital, the state funds it via that mechanism; is that right?

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

MR MUSTON: In terms of the size of the block of funds which are allocated to the hospital, is that a state-based block or a Commonwealth-identified block?

MR D'AMATO: If I may, in our statement, when you look at the service agreement for Murrumbidgee, it identifies an item for small hospitals.

MR MUSTON: That's paragraph 26 on page 6.

MR D'AMATO: Thank you. That's the allocation. That particular allocation sits above the line in that, above the state-only block, so that component is actually in scope for Commonwealth. The total allocation in this case for Murrumbidgee is 265.8 million. Murrumbidgee has around 28 small hospitals, amongst the whole group of hospitals. In fact, the majority of those small hospitals are within five LHDs. So we have 108 small hospitals across the state. That includes also the regional ones and the regional predominantly are Hunter New England, 25; Southern, six; Murrumbidgee, 28; Western New South Wales, 32; and Far West, six.

The overall allocation is, at the state level, in expense, gross expense, around 757 million, and we have conducted an analysis as a result of a recommendation from the regional inquiry in regards to the funding allocated to the small hospitals, and that review identified that there were significant diseconomies of scale that weren't quite well accommodated within the current funding model and therefore --

MR MUSTON: Just pausing there, the block of funds which had been identified for, say, the hospital in Batlow - which, if my memory serves me correctly, was a block funded hospital - was identified as, through this process, not quite being enough to actually operate that hospital and deliver the services being delivered through that hospital?

MR ONLEY: I can't remember whether Batlow is an MPS or a small hospital. I think --

MR MUSTON: I think it is an MPS, now that you say that.

MR ONLEY: So MPSs didn't fit into the small hospital category that Alfa was talking about. The numbers that are on the statement here, they're funded - the same as they're funded on the state price, small hospitals are funded on the New South Wales funding small hospital model.

MR MUSTON: Is the New South Wales figure lower than the Commonwealth figure --

MR ONLEY: No, it actually --

MR MUSTON: -- much like the national efficient

price versus the state efficient price?

MR ONLEY: No, it actually varies. So the Commonwealth actually picked up the New South Wales model when they introduced it. We've moved on a little bit further from there. But in terms of the block funding for New South Wales, it's really based on their last year's average cost plus whatever initiatives might have been allocated in the budget process. So whilst we still have a fixed and variable component to it, they don't get less than what the average cost was of the previous year.

Now, MPSs are fed into that same model except two years ago, recognising the limitations of that, they were pulled out of the methodology for small hospitals and directly block funded.

MR MUSTON: So the MPS facilities no longer have that blend of --

MR ONLEY: Correct.

MR MUSTON: -- block funding and activity based funding?

MR ONLEY: Correct, yes.

MR MUSTON: The blend of block funding and activity based funding is intended to, what, keep those fixed costs which are unavoidable covered but, to the extent there are variable costs, achieve the efficiencies that the ABF system --

MR ONLEY: The model actually came about as a result of particularly the rural LHDs. They were saying that they were disadvantaged when they utilised their small hospitals for ABF type activities, so if they moved activity, as they were wanting to do then, out of their ABF facility into a small hospital, because the small hospital was fixed block funding, they didn't get any extra NWAU for it; in fact, they lost NWAU, that came out of the ABF facility.

So we developed the model so that they weren't penalised by moving activity from one to the other. Mind you, if it comes back the other way, they win, because they are able to get the ABF activity but we don't reduce the block amount. That's really how the model came about.

It's similar to how IHPA do it in terms of looking at the correlation, the line of best fit, et cetera, through all the average costs in striking a fixed and variable component.

The variable component doesn't necessarily line up exactly with the New South Wales state price or state efficient price, but it's close to it, so that there's not enough variation to create a disincentive.

MR MUSTON: The decision about which hospitals are block funded and which are ABF, is that driven by the state or the Commonwealth?

MR ONLEY: We follow the Commonwealth modelling.

MR D'AMATO: That's been set by IHACPA, and a number of years ago we argued that the definition back then had to be changed, but we were unsuccessful with the argument. We argued that the definition should apply only to admitted activity rather than all activity, only because of the volatility of some of the non-admitted and community health, in particular in the regions, but we didn't win the argument. So as a result, the threshold is 3,500 NWAUs across all activity labels, whether it is subacute, mental health or ED.

MR MUSTON: We have heard evidence in our travels around the regions to the effect that there are hospitals that sit above that threshold but are, nevertheless, relatively small hospitals, for example, Cooma Hospital, which it is said is not well met by or well funded through the ABF model because of the nature of the services that are needed to be provided there because, of issues such as the geography and the demographic of the population, but the cost of providing those services on relatively small scales is not properly reimbursed through ABF.

MR D'AMATO: Can I just make a comment in regards to Cooma. So as we discussed before, we have local adjustments, and local adjustments have been put in place exactly for places like Cooma, because there are two different dimensions to be mindful of. One is the Commonwealth revenue, and effectively, when we do our analysis, in interrogating whether hospitals should be block or ABF, we take into account in terms of revenue are we better off where it is? And the answer at this stage in

most cases has been, "Yes, we're better off where it is in ABF." However --

MR MUSTON: Just pausing there, when you say "better off", better off in what sense?

MR D'AMATO: Revenue, as in the Commonwealth contribution, because the Commonwealth contribution is guided. Where there is ABF, there is a volume times price, times Commonwealth contribution rate to determine what is the revenue they will receive, otherwise there's a different formula for a block-funded hospital.

MR MUSTON: So from the perspective of the state, taking a hospital like Cooma, for example, keeping it in the ABF space rather than block funded means, system-wide, the state gets more money from the Commonwealth than it would if it were to convert it into a block funded facility?

MR D'AMATO: That's correct.

MR MUSTON: From the perspective of Cooma Hospital, though, or Southern NSW LHD, how does it work for them?

MR D'AMATO: Effectively because we are taking into account recognised structural cost, we're taking into account these economies of scale that may apply, that is accommodated from the expense side of this equation, so jumping to a conclusion whether the hospital should be in ABF or block, I think we should just unpack a little bit more of that equation to take into account these different dimensions.

I believe that, obviously, this is something that we review regularly, based on the feedback we get from the districts and again, going back to what Neville mentioned before, we did create an environment where the small hospitals are better connected in terms of funding and activity with the ABF hospitals, through the process of the purchasing they have in place, where they purchase everything, whether it is delivered from a small hospital or an ABF hospital.

So I think we try our best to accommodate and balance, the risks, but I think that, at times, we probably just need to recognise that these assessments need to be taken into account from the revenue, state perspective, versus

the expense.

MR MUSTON: Accepting that to some extent it's going to be a question of how much of the district's budget is at least notionally identified as being relevant to that hospital, Southern NSW LHD, I think takes a view that the way in which Cooma Hospital is funded does not see Southern NSW LHD receiving funds which equal the cost of delivering the services that need to be delivered at that hospital.

MR D'AMATO: I take the comment on board and I think we've been working very closely with the particular district for a number of years.

Effectively, the issue is not necessarily whether the hospital should be in scope for ABF or block; the reality is that the medical locum cost is disproportionate to a degree of what they can control. So even if it was a block, we wouldn't resolve the problem.

What we've done in the interim, as a result of the feedback we received from the districts, in particular this year, first, we made some changes to the small hospital funding model, so they received some additional funding this year.

Second, given that now we are out of COVID, we are making some adjustments to acknowledge that the impact on the workforce, in particular the premium labour workforce, is something that can't be addressed overnight. So they provide us with a plan on how they intend to step through over the next four years, and we've funded the plan.

MR MUSTON: Accepting it may be just one of the services within Cooma that fits into this category, the particular example they gave, which sounds like it sits outside the locum problem, is the need to run a 24/7 obstetrics service through a hospital that only delivers about 107 babies a year, but when they come through the door, you can't book them an appointment in Canberra and tell them to turn up on Tuesday.

MR D'AMATO: I think perhaps that's something more relating to the clinical planning side of things and also the supply side: do we actually have the workforce that is able to provide this service? I don't know. From the funding point of view, I --

MR MUSTON: While stretched, the workforce is apparently there, but from a funding point of view, what they say is when you take the amount of activity which is claimable for 107 deliveries and you add that to the state efficient price as adjusted, or multiply that by the state efficient price as adjusted, it doesn't come close to meeting the costs of running a 24/7 maternity facility.

MR D'AMATO: I would argue that that wouldn't necessarily be the correct formula either. In fact, if they were then able to then add recognised structural cost, which is on top of the state efficient price and all the block funding that we provide as part of their budget, might be a better assessment.

The other side of this is, ultimately, as we discussed, and Professor Duckett has mentioned, it's all about averages. At times there will be winners and at times there will be losers. This particular case, I think, is perhaps more complex than just simply saying it is an average, but I think we need to acknowledge that we try our best to balance the whole risk, and we can always do better, but it's not something we're ignoring at the aggregate - at the district level. That's the reason why we adjusted for the medical workforce this year and we provided some additional funding for the block funded hospitals. With that particular district, we've been monitoring their performance, financial performance, for a number of years.

MR ONLEY: I think it's important too that the ministry funds the districts, the districts fund the facilities. So whilst we might provide a level of funding to the district, I don't know what, then, the district provides to the facility, and we have had instances where it may not be the same.

MR MUSTON: That raises another issue, which is: it has been suggested to us in our travels by chief executives around particularly the regions but also more widely, that there is a lack of transparency in the way in which these funding allocations are made, which might mean they don't understand, because of the nature of the communications that are happening, exactly how these decisions are made and what dollars are attributed to what parts of their service.

MR ONLEY: The general process has been that subsequent to the budget going out they get a workbook which details, from their costing information right through to the allocation process to the facilities, how we have allocated the budget, and then there's provision in all of that for them to reallocate as they need to. That goes to the finance people. What they tell the CEs --

MR MUSTON: So to use that example, the example we've just been talking about, as part of the overall budget delivery process, there would be a handbook which is provided that says, "This is the amount of dollars that we have provided to you on account of the anticipated costs of running Cooma Hospital"?

MR ONLEY: It's not a handbook, it's a series - it is one spreadsheet with a whole series of workbooks in it, which goes through the RSC calculation, the cost price adjustment calculations, the allocation splits from the costing and savings into the budget format that we've got here, for example, so they can trace back.

MR MUSTON: Do you find, as part of that process, you get feedback from the districts whereby they say, "You've identified X dollars that we've managed to trace back through was referable to this facility. Our costing suggests that the facility costs 1.5X. Why the disparity"?

MR ONLEY: We're using their costings, so it shouldn't be different.

MR MUSTON: But while accepting that that maybe should be the case, do you get that feedback from them, or is there that level of engagement with the districts where they have managed to trace back through the figures and identify figures referable to facilities and particular cost centres and raise with you the potential disparity between what they perceive to be the real costs and those which have been allocated?

MR ONLEY: I think each year there's been one-on-one discussions with all the districts to finance about the workings and how it works, and obviously feedback, but the budget to that extent is indicative for them, that they're able to reallocate the total bucket that they've got available there, and the workbook provides for them to make

adjustments and reallocate as they need. The end result is we just need to know what they've done.

MR D'AMATO: It probably is fair to say that we have had some challenges over the last few years, particularly because at each time of these iterations we need to then back out all the one-off funding, particularly one-off funding related to COVID, and it wasn't an easy task.

Again, going back to before COVID, this exercise was very - it's all been transparent, but it was much easier to be interpreted by the local districts. I think that tracing back through the costs and the cost data in the submission was much easier because we didn't have to, again, remove all these one-offs, whether it was for PPE or whether it was for additional testing, COVID testing and the like, and it creates some significant challenges.

However, from this year, now, again, we're stepping into this new post-COVID environment, I met with every CE and at times with the chair, the board chairs, to step them through their budget schedule and all of the additional funding that we are allocating to the budget this year, and to recognise that, at times, there are challenges in comparing, if you want, last year's financial results to the new budget, precisely because a number of the results included one-off funding or the results of one-off initiatives that had to be backed out.

MR MUSTON: In relation to the one-off initiatives, the next aspect of the funding that we've heard something about is program specific funding.

MR D'AMATO: Mmm.

MR MUSTON: Could you explain where that fits into the equation?

MR D'AMATO: There's a number of program specific funding - Brighter Beginnings or First 2000 Days is a good example, or palliative care, mental health, drug and alcohol. All are associated to either new NPPs that required establishment costs up-front, in which case then we'd provide this funding into the budget but outside the actual NWAU, with an expectation that, with time, these will form part of the base and through the NWAU.

Normally, these are monitored throughout the normal process that we put in place, depending on the subject. The ice inquiry, for instance, the outcome of the special inquiry into the drug ice, was an initiative that is governed by Dr Chant. So, for instance, under her unit, there is a drug and alcohol unit, and they're normally instructed where to send the funding in their service agreement or - as well as outside the service agreement.

What I mean by "outside the service agreement" is simply because at times these initiatives are approved through the budget cycle, and at times these are very late decisions, so the unit or the policy area are not in a position to allocate the budget in the service agreement, because they had to then develop an implementation plan, so we'll do subsequent adjustments to the budget to take into account that at that point the branch has decided where to send money, just to give you some examples.

MR MUSTON: What's the usual time frame for some of these program specific funding streams? They're not forever funding, I assume?

MR D'AMATO: Well, no, that's a good point. I think at times they are four-year, so they go over the forwards. Then it becomes a concept of, as identified through the process of the four-year with treasury, then determining whether these should be continued or stopped - or increased, at times, when there is evidence that supports the actual expansion of these services.

MR MUSTON: It's been suggested to us sometimes that the period of time that the funding is in place for is often not enough to actually work out, in an evidence-based way, whether it is something that should or shouldn't be continued, which leads, almost inevitably, to a conclusion that the evidence does not support the continuation of the funding. That might be a cynical view. Do you have a comment on that?

MR D'AMATO: Look, I believe that at times it's true, that not all initiatives are allocated over period of four years; at times it would be two years. At times, for instance, if I take into account an initiative close to maybe Mr Daly's portfolio, urgent care services, so the original allocation was for a three-year period and now this has been extended by an extra two years. Again, the

it would be ideal to have some certainty, but this is probably the best we have been able to achieve as a result of the process.

MR MUSTON: These are some of the items which have been referred to us by the LHD CEs, as "soft funding" - that is, funding that sort of exists and might come back, but it's not sufficiently certain to enable you to employ the people that you need, for example, on a long-term basis, to provide that service.

MR D'AMATO: Look, I'm aware of some the challenges. I do think that some of these need to be taken into consideration on what is available overall, and some of the evidence, as we discussed this morning, should be provided back into the roadshow process, the purchasing environment, so we can then take into account whether some of this activity is actually delivered and will continue to be delivered through the activity targets and therefore purchased, or is outside. At times some of this is also outside because it might be clinical research or the like, which has a different funding source altogether.

MR MUSTON: Some of the project specific funding or tying funding to a particular project enables funding to be used to distribute resources in a way that achieves particular priorities or strategies of NSW Health.

MR D'AMATO: That's correct.

MR MUSTON: Are there other ways in which the funding structures are used to achieve priorities or advance strategies of NSW Health?

MR D'AMATO: I think the main vehicles for us to distribute funding are either through the purchasing, therefore, through activity targets, or specific initiatives. Specific initiatives are normally guided by policy areas, they instruct us where to send the money and how long for, and they are responsible for the evaluation of those programs as well.

MR MUSTON: In relation to the purchasing, is there a way in which the purchasing of activity is used to further particular strategies or achieve key priorities within the health sector?

MR PORTELLI: I mean, yes. The inclusion of some of the NPPs themselves can get included into the service agreement as well, so if they are related to activity that will achieve that strategic outcome, then we include them into the service agreement.

We again rely on the districts and their clinical services planning and the service agreement structure itself around the districts aligning to the strategic priorities of an organisation, so our future health strategy, the regional health strategy where relevant, and through that linkage, it's up to the districts, with that general discretionary pool, to, you know, allocate resources according to what they think are the strategic priorities in line with those guides.

We have in the past also used the purchasing framework to push some other statewide programs that weren't done through NPPs. So the "Leading Better Value Care" program that Sharon spoke to before, is a good example of where we have used that structure in order to further the objective.

MS SMITH: Another example would be the deferred care package where there was specific funding provided to the state to deal with the backlog of elective surgery post-COVID. That was time-limited, and the money and the expected activity formed part of the activity targets for that particular year in which it was relevant.

MR MUSTON: To the extent that, at least in the post-COVID environment, I think you've told us that budgetary constraints are such that there is very little headroom to make changes to the system or adjust the array of services that are being offered as opposed to just dealing with the fire hose of business as usual, there isn't a huge amount of scope, is there, to use funding decisions around at least the purchasing of activity to steer the health service in any particular direction?

MR PORTELLI: No. I would say it's significantly reduced. The issue was also around timing, so we don't necessarily know what we will get. Over the last four years, we have only been given - sorry, most of the time we've been given information around late May, so even if we did want to make a decision around shifting priorities or taking a different approach in the purchasing framework, or using the purchasing framework, it's too late. We can't model

scenarios on what that envelope looks like.

You know, like I said previously, pre-COVID, the bulk of the money that we would allocate through the purchasing framework would have been known and communicated to the system in February, giving districts and networks months to plan for that and giving us a little bit of further time as well to look through any requests that come through.

MR MUSTON: Other than in terms of the adjusters that are brought to bear in identifying what portion of growth is to be allocated from one LHD as opposed to another, what ways are the size and health needs of the population resident within a particular local health district being taken into account in deciding how much activity, say, to purchase from that district?

MS SMITH: It forms the bulk of those kinds of growth decisions, because the size, the age distribution and the underlying drivers of health consumption that might exist within that community, as we said, in the past have been the main drivers of allocation. So, you know, the remainder, the new initiatives or other factors, are really on top of that, but that's been the core of what we've actually distributed.

MR MUSTON: That's the growth. Maybe I was not clear enough in my question. So those are factors you're taking into account in deciding how much a particular district's budget should grow by. To what extent are those factors - that is to say, size and health needs of the population resident within the area of the local health district - being taken into account in deciding what the base figure should be?

MS SMITH: So every year when we look at that equity component of the model, so we are looking at the whole base at that point, and that does drive the adjustment, the equity adjustment, that I spoke about earlier, between the districts and networks. So if a district overall is delivering or the residents are consuming less health services than we would anticipate, then they will be allocated more growth. So there's a reassessment of that base every single year.

Now, to be honest, the amount that we've had available to allocate on an equity basis has been relatively small,

and so the idea of nudging the health system towards that greater equity has been a fundamental part of our model, but the quantum of funds that we've had in order to deliver that has been relatively small, so it does take time.

But taking time is not always a bad thing, because districts can't scale up really quickly, they need to identify workforce in order to scale up. So it's a bit of a balance between identifying that they need more activity in their model and giving them the amount of time that they might require to scale up to the level that we would want them to be at.

MR MUSTON: Just in terms of the period of time over which that equity might be introduced, on the current funding trajectory, what sort of time scale are we talking about? Is it a few years or --

MS SMITH: Yes.

MR MUSTON: -- decades?

MS SMITH: No. So the model works by dividing whatever that quantum is by eight and then spreading that over the eight years, even though it's recalculated every year. So it might go up and down depending on what has happened in that district in the previous 12 months.

For example, if they've had a new build open and they have returned a lot of people that might have been seeking health services outside of their district to their district, then we might see that gap close quickly, but in other cases, we might see it close very, very slowly.

MR MUSTON: What about the extent to which health services are provided to patients from outside the LHD? How are those sort of cross-boundary issues dealt with at the moment?

MS SMITH: The activity is counted at the site that it is delivered. So a really good example would be Royal Prince Alfred Hospital, as one of our large hospitals in Sydney. About 30 per cent of the unplanned activity that occurs at Prince Alfred Hospital is actually residents of other local health districts.

Now, that's not just because they have specialised

services there, it's also because a lot of people drive past Royal Prince Alfred, or people that have accidents or illnesses in the city are often taken to Royal Prince Alfred, whereas other hospitals might have, you know, 2, 3, 4 per cent of their activity from residents from other parts of the organisation or other parts of the state.

So that's in their base activity because they've always delivered that activity for residents outside of their local health district.

MR MUSTON: And so if we enhanced our planning capabilities a little bit and we potentially had a more strategic system-wide distribution of work across the network to make sure it was being delivered as efficiently and equitably as was practicable, then adjustments would need to be made, and could be made, to the underlying funding models to enable the place at which care was being sought to be the place at which funding was delivered?

MS SMITH: We already do that to a large extent with statewide services, so for example, ICU, level 6 ICU services are networked across the state. So we take that out and fund that separately. It's not just part of the normal activity and growth model, it's funded first.

So there is an element of that. It doesn't mean we couldn't consider further services as part of that approach, and by doing that, we would make sure that if there was a networked approach, if that's what is being suggested, then the funding would go to the site that is actually delivering that service on behalf of others.

MR MUSTON: Can I raise another topic, which is the supplementation of budgets. If I've understood the evidence that we've gathered so far, LHDs get given a particular envelope of money within their service level agreements.

MR D'AMATO: That's correct.

MR CARR: Initial budget.

MR MUSTON: Initial budget. Throughout the year, as events arise, that budget is supplemented with a further injection of capital, depending on - or not capital, a further injection of funds --

MR D'AMATO: Yes

MR MUSTON: -- depending on what has happened in the district?

MR D'AMATO: Depending on - the process follows, at the highest level, the processes we have in place with treasury, in that there is a supplementation specifically for technical items, and one good example will be depreciation. So as the value is adjusted throughout the year, at the end of the financial year, and then recognised in our books by October, then the depreciation gets recalculated. So that means at times we need to just adjust the depreciation budget across the districts just to match the actual, so there is no, if you want, adverse impact on the performance, financial performance of a district. For that reason we keep a provision centrally so that we can adjust according to the needs of the districts, if you want.

Another one similar to that is high-cost drugs. High-cost drugs is an item funded by the Commonwealth, so expense matched by revenue, and it's very difficult to predict. A few years ago when a new drug was introduced for epilepsy, very expensive, very material, so we were monitoring on a regular basis the consumptions across the system and then adjusting accordingly, again with a view that we didn't want this to impact the performance, the financial performance, of a district.

Then the second part of the adjustments are more related to policy proposals that were not issued throughout the budget cycle, as in the service agreement, because the policy unit needed more time to determine where to send the money, and so this could come out and could be issued throughout the year. Our approach at the moment is to encourage all these to be processed by December, so that we want to provide, as much as possible, certainty for the districts.

Before COVID, I must say, it was a bit challenging, because each policy unit was kind of running almost their own race and trying to use funding as a stick. What we're trying to create now is a bit more of a discipline around the process, so that we want the policy unit to focus more on outputs and outcomes rather than using inputs as a way

to encourage the districts to deliver what they need to deliver. I think it is just a game of trying to find the right balance.

Then there are other items that might be issued throughout the year because of one-off initiatives that might be, you know, approved - a good example - well, actually this one, it was approved throughout the year, wages, policy, been approved by government throughout the year, then we adjust throughout the year, just to give you some examples.

MR CARR: Depreciation, high-cost drugs are big amounts of that. Like in '18 just to give you an example, '18/19 we allocated about 1.28 billion, or about 6 per cent of the initial budget. In COVID, that went up to 12 to 18 per cent, and last year it was about 8 per cent, or a bit over 2 billion. This year, up to year to date, October, we've allocated about 400 million, or about 1 per cent, so we've tried to really bring that amount of budget forward into that service agreement, so to give them greater certainty, it's one of our financial strategies for this year.

MR MUSTON: For the non-accountants amongst us, why is it that the depreciation can only be allocated by way of a supplementation? Is it something that's not known until --

MR D'AMATO: It is only the variances. We're talking about the increases. So there is an initial budget including depreciation, but because the final, if you want, calculation of what is the new value of the assets, it normally is recognising books in the system by October, then the variances, whether it is up or down, are adjusted after the service agreement. So it is not the entire depreciation budget; we are only talking about variances, again, so that no-one needs to absorb these into their financial performance.

MR CARR: And the value of the asset is revalued every three years. So each year there might be a desktop revaluation, but then there will be an actual revaluation where people will go out and, based on that revaluation, the asset value will go up, or generally it will go up - it doesn't go down too much - and then there will be perhaps additional depreciation calculated on that revalued amount.

MR MUSTON: So that's depreciation. To the extent we're talking about policy proposals and the like, it would seem ideal if the system operated in a way that meant decisions around all of those sorts of things were made in advance of the allocation of the budget, such that a chief executive of a local health district knew, subject to some variation, what the bulk of their funding was going to be for the year, so decision-making could be informed by that certainty around the funding?

MR D'AMATO: I totally agree. I think that's certainly what we lack at the moment. Look, after four or five years of COVID where it was very challenging, it was very volatile, what we really need to focus on, and that's what we're trying to achieve this year with our financial strategies, is providing as much certainty as possible to the districts so they can plan. And at the end of the day, that concept should be applied by treasury to us so we can know a little bit earlier in the cycle what we can then set aside for population and ageing, and potentially also for prevention, as part of this what they call 4 per cent.

MR ONLEY: The initial elements of what you've just discussed, they're all in that Murrumbidgee schedule, so you can see the initial amounts there.

MR CARR: And the state budget is handed down, what, first or second week of June, so there's a little bit of time, and I think probably that's informed also by, I guess, the Commonwealth budget earlier on in April/May, yes. So there is a bit of a flow-on there, I think.

MR MUSTON: Can I ask, Mr D'Amato and Mr Carr and Mr Onley, that you go to paragraphs 81 and 82, the last two paragraphs of your statement. You've put forward the potential need for a rethinking of the funding model so as to produce something that's more of a blended funding model, retaining some of the benefits of ABF but recognising the importance and role of population equity, the need for greater investment in prevention, et cetera. What do you have in mind as a structure that you think might be a good transition from the existing structure?

MR D'AMATO: So, first of all, we've started a bit of a consultation internally with a number of CEs in respect to what our thinking is. The thinking at the moment is

moving towards something that perhaps could provide us more certainty over a longer period of time for what would be considered interventions related to prevention, if you want, or community health. So ideally this could look like two service agreements or a service agreement that has two components, but one component that provides for a longer period of time, maybe four years, versus the other component that can provide for the activity based funding component or the operational side, and that could be adjusted on a yearly basis.

I guess the thinking at the moment is that the operational side, you know, obviously combined with the purchasing approach, could focus on operational KPIs, versus the other part of the service agreement could focus on outcome KPIs, something that would take a little bit longer to monitor, and ideally can kind of provide us with that blended approach and a bit of a balanced approach, in that, from my point of view, having a good pipeline of investment in the prevention could actually see benefits in the other side of the service agreement, so they can complement each other.

At the moment I feel everything is relatively skewed to the acute settings, because that's the biggest component of a budget, so not necessarily decoupling the two but creating a strong link through certainty. That's one of the concepts that we are exploring at the moment.

MR MUSTON: Do those of you involved in the purchasing side of it have a view about how that might work?

MR D'AMATO: They're involved with the design of this, too.

MS SMITH: We are completely supportive.

MR PORTELLI: I concur.

MR MUSTON: Could I ask Mr Daly, and your colleagues who have subscribed to your statement, to go to paragraph 44 and following. I think we have probably largely covered this off, but the discretion that is referred to in paragraph 44 is dependent upon a degree of financial headroom.

MR PORTELLI: Correct. That would be what I referred to

before as having the untied funding where they have the discretion of what services they need to enhance.

MR MUSTON: Have I understood your evidence correctly that, at least in the post-COVID environment or the immediate environment that we are in, that untied pool of money that might be used for those discretionary purposes is not, in reality, available to the LHDs?

MR PORTELLI: Certainly not in the proportions that have been in the past, and it's linked to the statement by my finance colleagues in paragraph 54 - there is a chart that illustrates that reduction.

MR MUSTON: Perhaps I might invite your finance colleagues to just explain exactly what that chart is telling us in paragraph 54.

MR PORTELLI: I'm happy to. Yes, so it's basically the white chart - so the light blue bar is detailing the total sum of the activity purchased through the purchasing process; the red shows you the quantum attributed to new builds, so of the light blue, the red is new builds; the dark blue talks about the population ageing and equity funding that was contributed - that was, again, part of the light blue there, and as you can see, that dark blue was a pretty substantial portion, '18/19 it was well over 350 million, about just over 350 in '19/20, and then it decreased substantially as the years went on.

This is not the total funding allocation to the districts and networks, you know, my colleagues have spoken about other avenues, but certainly in terms of that discretionary pool of untied funds where the districts can again respond to their local needs, bring to life the clinical services plan, that number has substantially reduced.

MR MUSTON: Has it reduced to a level where - an amount of money which is provided for that purpose is, obviously, always going to be useful, but there comes a point where it's so small that it isn't actually enough to really achieve any significant change or benefit. Where are we at the moment?

MR PORTELLI: It's hard to say. Like my colleague Alfa has clearly shown, there are other bits of funding that

have been put into the system on a temporary basis. So it is difficult, looking at our information at the moment, to really decide, okay, of the activity that has been delivered, how much of this was funded through short-term funding and for what purpose, and then now that that is going to be ceased, how much more we need?

I don't think another year of this will be a sustainable way forward. I think we've got to a level now that we know we will need to continue the way that we have in the past. However, yes, it is difficult to know exactly, right now, given all the other bits and pieces flowing through, what the wash-up is of the last four years.

MR D'AMATO: I think going back to Joe's comments, the trend that you can see before COVID, in the last year, '18/19, we were looking at around 450 million-plus set aside to purchase activity. Now, since then, this amount has dropped significantly and I believe this is unsustainable. And that's what we're seeing across the system, in that what we issue, effectively, is not sufficient to meet the needs, and what we see is activity above targets, so there is going to be a bit of a challenge for us to live within this envelope.

MR MUSTON: And when we talk about activity there, just for clarity, we're talking about both the Commonwealth recognised activity and that activity which hasn't been identified by IHACPA but is recognised by the state for the purpose of funding decisions with its LHDs?

MR D'AMATO: Yes.

MS SMITH: Correct.

MR MUSTON: A number of LHDs, we are told, are above their budgets and often by a significant margin, which has resulted in a suite of efficiency regimes that have been rolled out across the LHDs. Could I just ask which part or branch of the ministry is responsible for delivering those efficiency reports and preparing the efficiency reports?

MR PORTELLI: My branch.

MR MUSTON: What's the process that your branch goes through in order to identify the particular efficiencies

which are to be harvested from the LHDs?

MR PORTELLI: "Harvested" is a strong word. Essentially, it's a mandatory process that has been around for over a decade, I understand. But essentially, as part of the process of the roadshows, we talk about the EIP process in the first meeting in February/March.

MR MUSTON: Pausing there, there's a process whereby, as part of their annual budget cycle, the LHDs themselves have to provide to you a plan which identifies efficiencies which they have found and think can be capitalised upon?

MR PORTELLI: Correct, and so we work through the process - it sort of kicks off with a discussion around budget forecasts and where they're going to land for that financial year and an estimate of what they think their planned targets will be for the next year, and then from April, May and June the teams work together to identify some of those strategies. The team then look at those strategies, look at whether or not they're robust, you know, whether there's an executive sponsor, they've appropriately attributed where they think that saving is going to be achieved, whether we think from an operational perspective that's going to cause issues, do we think that if they stop a service there's going to be a clinical risk, we shouldn't do that? There are those kinds of assessments.

Once the budget has landed, the wash-up between what they actually planned and what they actually need to achieve as part of their targets is then worked out and then any additional plans are worked through in the subsequent months. That process has been brought forward over the last couple of years, because generally districts didn't start until after they got their budget in July, in which case you take a couple of months of the financial year to make up those plans which then reduces the time in which you can find savings.

MR MUSTON: To the extent that LHDs find themselves over budget, though, there's then a further process where your team comes in and provides some more assistance in finding efficiencies; is that right?

MR PORTELLI: That's correct. It's supported by Matthew, with the financial recovery plan.

MR DALY: There's a number of performance improvement teams in my mobs, most of them are under Joe. One very busy one, obviously, is in relation to emergency departments, patient flow to improve back-of-house flow to support EDs; there's an improvement team around planned surgery, how to manage planned surgery wait lists, theatre lists; and there's also an efficiency improvement support team, the EIST.

That's a team that has a lot of operational experience, because it's the operations managers in hospitals that drive expenditure, and they provide an oversight and a consulting service, if you like, to the EIP - to the LHDs in relation to their EIPs.

They do, on occasion, go in and do in-depth reviews, sometimes at the chief executive's request, sometimes at Alfa's request, sometimes at the secretary's request, if she has concerns.

They also provide a lot of benchmarking data because they've got a whole-of-system view and can provide evidence around relative inputs for the outputs compared to other like-size LHDs and hospitals. So they do a lot of work around that.

MR MUSTON: We've been provided with a number of documents, produced by I think that team, that have identified areas of saving or potential areas of efficiency. I might take you to a table that summarises it in a moment if that is helpful, but one of the common themes is FTE realignment, whereby it is said that FTE has increased at a rate which outstrips the level of activity. That's said to be demonstrative of a lack of efficiency.

Whilst one can see at least the superficial appeal of that, what's the science that goes into working out whether, in a particular case, an increase in FTE which outstrips an increase in activity actually is reflective of inefficiency or, rather, reflective of just the way in which health care needs to be delivered in a particular setting?

MR DALY: Well, it has been a not uncommon feature of a number of LHDs, as I think you were pointing out, and in an ABM environment, if you have a mismatch between your

inputs and your outputs, you don't have to be really bright to work out that you are going to have a financial problem.

I think, in part, a major contributor has been a hangover from COVID, which, whilst the price was adjusted to pick up on additional costs around protective equipment, infection control, additional cleaning, all of that was added into the price to compensate, as we do these reviews, here we are now really two years into BAU post-COVID - if we will ever get to a BAU post-COVID - where we are still discovering there are FTEs on that have not come off and they were put on on time-limited funding for the COVID period and for the COVID outcomes, but there has also been a growth beyond, beyond their outputs, to deliver the outputs which otherwise were being delivered pre-COVID. So it has been a common feature.

MR PORTELLI: It's probably worth flagging that those recommendations were not really - they have gone in based on the benchmarking, based on data that the districts themselves may not have had, that the executive or the managers of the hospitals may not know; it's basically trawling through the data and saying, "Here are some areas where you might consider looking at whether or not these parts of the business are running efficiently." It is absolutely not saying, "You need to take steps in this area"; it is saying, "You might want to consider this." But often, as Matthew said, if you over budget and it is not matched by, you know, activity, it's not matched by anything else other than just being over budget, there is a question about efficiency compared to the rest of the state.

MR MUSTON: Is there not a possibility, though, that a system which, with a finite budgetary envelope, continues to deliver care perhaps at greater cost and across a wider range of areas as we can do more by way of interventions, results in the existing workforce and the existing level of care that is being provided being spread ever more thinly within that budgetary envelope, such that you get to a point where the workforce is stretched to breaking point?

MR DALY: If the outputs were - if the delta of the outputs to the inputs were not as large as what they are in too many cases, I would agree with you, but that's not the case.

MR MUSTON: Can I test this possibility: in the pre-COVID environment before these additional FTE were brought on, the existing workforce was able to deliver the care that was being delivered, but possibly not in a way that was sustainable in the long term, but they were still delivering it. But when you supplement that workforce and make it a little bit easier and a little bit less stretched to deliver that care, then it's hard to then turn around and say, "You've got to go back to the old days", and there might be a question about whether we should be saying, "You've got to go back to the old days", because maybe the old days weren't sustainable. What's --

MR DALY: I accept the human factor of the premise of your second comment. I've got no evidence that pre-COVID was unsustainable, having worked in this system for 30 years, so I don't see any evidence to that effect.

MR MUSTON: Well, the evidence that we've received in our hearings across the state suggests that the workforce - that there are serious pressures in terms of the workforce and the burden that is placed upon them across the facilities. I mean, questions might arise as to what is or isn't sustainable, but what's sustainable for them, I guess - well, when it becomes unsustainable for them, they will stop working, and that is a problem for the state.

MR DALY: Mmm.

MR MUSTON: How do we work out what is a reasonable level of efficiency and what is actually spreading things too thinly in terms of the extent to which we are resourcing the health sector to deliver a range of and a particular amount of activity? As the authors of the efficiency reports, you must have some answer to that.

MR PORTELLI: Yeah, look, you're talking about a concept that's very large and it would be very difficult to sort of quantify. A lot of the initiatives that the team look at go back to what the awards say, you know, for particular classes of staff. They look at the award ratios: are they in line with what the award says? In many cases, things are being done above the award and, you know, it's just about bringing it back into line.

A lot of the FTE reductions aren't actually headcount

reductions, they are just better managing your service so you reduce your overtime, and there are triggers in the award to incentivise managers not to overburden their staff. So it's not necessarily about reducing the headcount; often the strategies are about better processes and better management of the existing resource that you have, which has the opposite effect of what you are sort of describing, about reducing the burnout of staff.

So it just depends on the case in point about what the benchmarking says, about how the protocols are. Health is extremely protocol driven and so, over time, protocols and practices can creep in that go above and beyond what was previously done and it's just, again, about providing an opportunity of a statewide team that looks across the different, you know, hospital sites and goes, "Well, actually, I've seen this work really well here. Have you considered looking at it?" And it's about, you know, then teaming them up with other sites as well where they can go "Well, they can do it; why can't we?"

MR MUSTON: Sometimes doing that work and identifying areas where hard efficiencies can actually be secured requires a little bit of financial headroom in order to actually do the work required to achieve that outcome, would that be right?

MR PORTELLI: I would agree with that.

MR MUSTON: As part of this process, is there a flying squad that comes in from the ministry to contribute to the FTE which is available on the ground in LHDs so as to achieve some of these objectives?

MR PORTELLI: There is a new team that has been spun up that looks at health roster efficiency and using the tools we have available to better use those tools to deliver better outcomes for our staff. Where the particular functionalities aren't being used properly, the team comes in and helps train staff to do that. So that would be one example, yes.

MR MUSTON: And are there others? Reading these efficiency programs, it does look like it requires a workforce of people to actually implement the recommendations, find the efficiencies and secure them, and at a time when there is already a massive budget blowout in

the LHDs, employing further FTE to do that doesn't sound like it's the best start on a path towards efficiency, but how does that get dealt with from a ministry level and in its dealings with the LHDs?

MR PORTELLI: I mean, LHDs do have a few teams in their existing structures, so they've got performance units, they have got people and culture teams, they've got nursing teams at the district level. So this, theoretically, could be appended to their existing workloads and actually should form part of their normal workloads. I know in my time at the district, we had these programs that we had to look into in my team and support them. Again, we've been doing this for over a decade. These aren't new programs. You know, I think this should just be folded into business as usual. As any kind of efficient healthcare system that tries to deliver high-quality care, these are constant mechanisms, and again, this is part of an evolution not revolution kind of formula, it is how we constantly keep our system efficient.

MR MUSTON: Is it not challenging for LHDs to do that, though, when they are operating in an extremely economically tight environment?

MR PORTELLI: I think everything is difficult in an economically tight environment, but yes.

MR D'AMATO: I just want to add some examples where we actually invested to make these changes on the ground, whether that is procurement, procurement reform, where we identified some challenges or some risks that could actually be not only identified through additional resources but actually free up further resources in regards to contract management, for instance. So we provide the funding to the districts to invest and improve their capabilities around the contract management.

We're doing something similar in regards to decommissioning of ICT platforms. Again, it is a very challenging process, locally, but the investment is worth it, given the return on decommissioning some of these, from the cybersecurity risks as well as the ongoing costs of maintaining certain systems that we don't use anymore. So this is just to give you some examples. We always consider whether there is a good opportunity to invest in the districts to then achieve further efficiencies or savings.

MR CARR: DeliverEASE is another one where we put in staff to create an improved clinical inventory management on the wards, so the staff can go in and find the particular consumable they need straightaway and then go out, otherwise, it was a storeroom of a whole lot of things.

MR MUSTON: Is there a risk, though, that linking the two things - that is, the growth of FTE in a way that's not necessarily connected with a growth in activity - makes vulnerable parts of the operation which, perhaps from the delivery of activity perspective, are not important - for example, a clinical nurse educator - but from the perspective of other aspects of the long-term viability of the system, workforce pipeline, training the next generation of the workforce, et cetera, is really important: by decoupling those two things, do we not run the risk that the short-term gains of bringing a budget within what might be seen as acceptable parameters for the purposes of doing business as usual in the immediate future, we cost ourselves significant money down the track because we can't, say, maintain a workforce through a workforce pipeline that we've developed, just as an example?

MR DALY: Health has been training its own workforce for 100 years, and where increased new graduates were coming on, the ministry has always been supportive - in fact, through the chief nurse directly funding additional nurse educators, as an example. But if the new graduate/new trainee numbers are not increasing again, commensurate with, take an educator of any ilk, then you've got to question why that's the case. And, you know, to Joe's point before, some of the practice is not about getting rid of FTE, it's about, in some cases, complying with the award, of which we don't have a choice, we're obligated to comply with the award - the relevant union knocks on your door if you are below the hours per day that are prescribed on a ward, but no-one knocks on your door to say that you are 25 per cent above the hours on that ward. And similarly, just practices that had to be adopted during COVID, such as the use of nurse specials - you know, early in COVID, appropriately, the system responded by specialling those COVID-infected patients, often on a one-to-one basis, but, you know, as our understanding of COVID, the management of COVID, and then as those admissions have dramatically reduced, we should be going

back to the practices of using specials. Some LHDs have increased their specials by three and four-fold and then, after COVID, never actually reverted because they got into a new regime of, "Someone needs a special, we bring in a special", as opposed to normal practices that have been running public health services for decades, that you'd cohort, say, two or three behaviourally disturbed patients and dedicate a pod, and so you'd manage those patients in that way, and similarly about similar like infections.

So it was all about - and this was with the full support of nursing executives and infection control experts - going back to practices that were pre-COVID, now that we're over, but COVID changed a whole lot of practices, some for good and should be for good, but others, there is no rationale for it.

MR MUSTON: Could I just come to two other parts of the health service that are the subject of funding decisions. The first is the ambulance service. We've been given some evidence to the effect that the ambulance service is block funded and has historically been block funded.

MR PORTELLI: That's correct. From a purchasing perspective, we don't purchase activity from NSW Ambulance. I understand, as we go through the discussions, there's often an NPP around that looks to increase the number of FTE within the ambulance service over - you know, a certain number per year for a four-year period, and that usually gives the bulk of their increase in funding, unless there are other specific items that are negotiated with finance.

MR D'AMATO: Yes, normally the process for ambulance is slightly different to the rest of the system in regards to the activities we've purchased, and more recently, the activities we've purchased have all been related to decisions of government to either invest in additional paramedics, whether in the metro region or in other areas; additional stations - so the previous government announced a number of additional stations; or wages increases. So that's pretty much the bulk of it.

Obviously there are, at times, other more technical considerations, in particular around the telecommunication and other infrastructure that ambulance uses that the rest of the system are slightly different in their approach, that's all.

MR MUSTON: The block of funding provided to ambulance, or the base of the block funding provided to ambulance, we're told, has not historically been adjusted for growth?

MR D'AMATO: The block amount has always been adjusted for cost escalation. The growth allocation was more related, again, to the components related to more paramedics, and effectively that is one of the key cost drivers in the ambulance service.

I think now probably five or six years ago there was an agreement to increase the number of paramedics through a program called "SWEP", and basically over the four years, we added more paramedics. When that concluded, then there was another program started, and that's the one we are going through at the moment.

So I'm not necessarily agreeing with the fact that the base has not been adjusted. We could always do more, don't get me wrong, but I think there has been recognition from the government of the ambulance service and the importance of ambulance services, and that's why they decided to invest not only in more paramedics but also more infrastructure to provide better services.

MR MUSTON: In relation to another block funded service, justice health --

MR D'AMATO: Yes.

MR MUSTON: -- at some point in the past, a base was identified as the cost of delivering health care within the prison sector. Does anyone here know what that was based on or what sort of medical service or medical care delivered to prisoners was seen as an appropriate level of care at the time that the base was arrived at?

MR D'AMATO: Look, I can't confirm, but I just want to note that justice health, unlike ambulance services, is also partly funded by the Commonwealth in respect of the forensic mental health that is in scope for the NHRA, whereas the service provided in prisons is actually state only, funded by the state.

In regards to the base, it's a bit difficult. From memory - I can't remember what it was, which area health

service, I think that - I'm sorry, I don't have an answer on the base.

MR ONLEY: No.

MR MUSTON: When one looks to justice health, you potentially have, by reason of your captive audience, as it were, quite a nice bubble that you could use to identify, in a fairly careful way, what are the health needs of this particular small population; what are the services that we should be providing to meet those health needs. One can do a cost benefit analysis of all of those services and form a view about the extent to which we as a public health system should be meeting those health needs and then allow funding to be informed by that process. Has that happened?

MR D'AMATO: Normally, the process happens through different branches within the ministry. So the mental health branch may at times allocate additional funding to justice, and the drug and alcohol service might be also investing in justice health. So these are the main drivers for increases in the budget, apart from a number of years ago where there was an uplifting to the base budget as a result of additional beds - whether there was an infrastructure development - that's when we adjusted the budget.

MR MUSTON: We're told in evidence that there is a process of changing the KPIs in the service level agreement that justice health has with a view to not just identifying targets for the delivery of service that meet a small part of the need but, rather, identifying the need and the extent to which it's unmet within the prison population so as to perhaps create greater focus.

MR DALY: That's exactly right. I'd asked the chief executive well over a year ago, because I chair their performance management, and the KPIs are predominantly green, which is a good thing, but then it does question about are we challenging ourselves sufficiently and pushing ourselves to maximise the input for that client base, and she agreed - we're now in furious agreement. I've yet to hear back from her as to what the new KPIs should be that will stretch corrections health, and they are wanting to be stretched.

MR MUSTON: In order to be stretched - I think they

probably currently feel a bit stretched - in order to stretch in a positive way, they would need a funding envelope to enable them to do it, presumably?

MR DALY: She has not raised that with me.

MR MUSTON: It has not been raised with you that the funding envelope made available to justice health is not sufficient to meet the health needs of the prison population?

MR DALY: Not in any performance meeting I've had in the last two years.

MR D'AMATO: One comment I need to make, their performance in respect to the financial performance has been very good, they have been on budget over a number of years, and I appreciate that that doesn't mean that they have met all the unmet needs, but financially they are performing very well compared to the rest of the system.

MR MUSTON: Financial performance might reveal good management and an effective way of doing the very best you can with an existing budgetary envelope and not trying to do more.

MR D'AMATO: I totally acknowledge that. As I say, just looking at one KPI alone doesn't mean that we have good visibility on what isn't met.

MR MUSTON: Coming back to an earlier question which I suppose flows from that, has any attempt been made to identify the extent of the health needs of the prison population, the cost of meeting those health needs and then making budgetary decisions informed by that, rather than continuing to give the excellent financial managers at justice health the same amount of money to keep doing, in an excellent way, what they have been doing?

MR D'AMATO: Not that I'm aware of, however, every opportunity that we have to identify any cross-collaboration - because I think we need to acknowledge that justice health plays a key role across multiple agencies, not only within health - we always raise that with treasury, as we discussed earlier this week, and that's where we try to link in, and particularly because we also need to acknowledge, in my view, that some of the

benefits are not realised by us, they are realised elsewhere.

MR MUSTON: How do those discussions happen? Perhaps to give as an example a diversion program that we were told about during the evidence whereby a mental health diversion at an early stage in the justice process, where justice health has people in courts, diverting people into mental health rather than into the correctional space, results in a reduction in recidivism which is nothing short of spectacular, but it's not currently available in all courts and it's not currently available in all rural courts where the overwhelming majority of First Nations youth are finding their way into the prison system.

MR D'AMATO: I would argue that the end of the sentence is "not available yet". I think there is always a process for us to prosecute these through the normal NPP processes. Now that we have the evidence, certainly it is an opportunity for justice health to raise this with us and let's see how far we can go. Again, this is probably one of those many initiatives that was a pilot through this cross-collaboration amongst and between agencies.

MR MUSTON: So I can understand, if it were made the subject of an NPP, it might potentially attract the favour of treasury, which would result in some further funding being provided that could be diverted into that program?

MR D'AMATO: That's correct and at times what happens, treasury may allocate the funds to a different agency, DCJ, for instance, and then DCJ issue the funding to us. In the past there's always been communication between agencies at the CE level, for instance.

MR MUSTON: If treasury says, "Thanks, but no thanks, we've got other priorities", what ability does justice health have to come to the ministry and say, "Well, I would like the potential benefits of this program to be weighed up against the potential benefits of a particular piece of elective surgery taking place in a particular regional hospital, for example, and invite the ministry to divert some funding from one to the other"?

MR D'AMATO: They always have an opportunity to advocate for the needs of additional funding with us.

MR MUSTON: How does that work in practice, though?

MR D'AMATO: It works in practice? Well, that's for --

MR DALY: I can give one example now with justice health. I mean, the provision of virtual services - it's a priority. It's a government priority. Why? It is a good return on investment by using those modalities to get patients to see the clinicians they need to see, and we've invested. I invested ministry money that I held off from recruiting positions, I converted that into capital for purposes to expand digital capacity across justice health services so they can provide those services and give them where gaols are located, and that provided immediate uplift in virtual activity, which means more patients are being seen by psychiatrists or other specialists who can be sitting in Long Bay, and hence servicing the state.

So that's just the type of collaboration and engagement that we have with our chief executives. You know, we haven't got the mortgage on bright ideas in St Leonards, I can guarantee you. There are far more bright ideas out there, which is why we've got to get off our bum and get out into the system and engage with these people, and their clinicians, more importantly, in order to find those new models and then find the resources, hopefully, to invest in. That's just but one small example.

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

THE COMMISSIONER: Just in relation to justice health, whilst I accept what you said in relation to more funding not being requested, Ms Hoey's statement, which is exhibit M3, I think any reading of it indicates that it is a request for more funding and an indication that wait times for certain services are beyond clinically appropriate times, et cetera, et cetera. So if a request for further funding hasn't been made to you, which I accept, I think it has been made to the Inquiry through that statement. So I just put that on the record.

Mr Chiu, do you have any questions?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: All right. Thank you.

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

<THE WITNESS WITHDREW

THE COMMISSIONER: We adjourn until - we don't know?

MR MUSTON: I think the ACCHO roundtables next Wednesday.

THE COMMISSIONER: That's online here at 10 o'clock.

MR MUSTON: Okay.

THE COMMISSIONER: We will adjourn until next Wednesday at 10 o'clock for the first ACCHO roundtable. Thank you.

AT 3.17PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 27 NOVEMBER 2024 AT 10AM

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