

**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

1 MR MUSTON: Commissioner, this morning, we've got another
2 largish panel. Sitting in front of you, from your left to
3 right, Alfa D'Amato is back, Steven Carr, Neville Onley,
4 Matthew Daly, Joe Portelli and Sharon Smith.
5
6 THE COMMISSIONER: Can we treat Mr D'Amato as on his
7 former oath?
8
9 MR MUSTON: We can, but we are told that all of them wish
10 to give an oath.
11
12 THE COMMISSIONER: I'll leave it up to him.
13
14 <ALFAISTER DAVIS D'AMATO, on former oath: [10.00am]
15
16 <STEVEN CARR, sworn:
17
18 <NEVILLE ONLEY, sworn:
19
20 <MATTHEW DALY, sworn:
21
22 <JOE PORTELLI, sworn:
23
24 <SHARON SMITH, sworn:
25
26 MR MUSTON: I might ask each of you, perhaps excepting
27 you, Mr D'Amato, because you've already told us, but
28 everyone else, if you could just go down the table and give
29 your full name for the record and identify the role that
30 you hold within the ministry.
31
32 MR CARR: Thank you, Steven Carr. I'm the executive
33 director, system financial performance and deputy CFO at
34 the Ministry of Health.
35
36 MR ONLEY: Neville Onley, the executive director of
37 activity based management.
38
39 MR DALY: Matthew Daly, deputy secretary for system
40 sustainability and performance.
41
42 MR PORTELLI: Joe Portelli, executive director of the
43 system purchasing branch.
44
45 MS SMITH: Sharon Smith executive director of system
46 information and analytics branch.
47

1 MR MUSTON: Thank you.

2

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

5

6 MR D'AMATO: That's correct.

7

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

10

11 MR CARR: Yes.

12

13 MR ONLEY: Yes.

14

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

16

17 MR D'AMATO: Yes.

18

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

21

22 MR ONLEY: That's right.

23

24 MR CARR: Yes.

25

26 MR MUSTON: Likewise, Mr Daly, Mr Portelli and Ms Smith,
27 you have prepared for us a statement also dated 14 November
28 2024. You've had an opportunity to review it before coming
29 to give your evidence today and are satisfied that its
30 contents are true and correct?

31

32 MS SMITH: Yes

33

34 MR DALY: Yes.

35

36 MR PORTELLI: Yes.

37

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

40

41 MS SMITH: Yes.

42

43 MR MUSTON: That's exhibit M4, Commissioner.

44

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

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

5
6 MR DALY: I'm happy to start in terms of the process. It
7 is very much an overlapping one between the system
8 purchasing performance and --

9
10 MR MUSTON: Can I say in that respect, for the benefit of
11 all of you, you should treat this process as largely
12 conversational. For the benefit of these two people who
13 are taking down what is said, it's great if we could try
14 and speak as slowly as possible and leaning towards the
15 microphones. But, equally, don't feel that if a question
16 has been directed at one of you or one of you has given an
17 answer, that that precludes others from either contributing
18 further thoughts on the same topic or expanding on the same
19 topic or even asking one another questions along the way,
20 if there are things that you think would be usefully
21 fleshed out by asking one another questions about your
22 respective areas of endeavour. That is definitely
23 permissible.

24
25 With that interruption, Mr Daly, if you want to kick
26 us off?

27
28 MR DALY: Sure. Well, as I said, it's a process that
29 starts in about October of the financial year before,
30 that's largely led through Joe Portelli and Sharon Smith,
31 for their respective responsibilities, and firstly,
32 in October, it's about firstly reviewing the current year's
33 service agreements in terms of learnings to bring back to
34 inform any changes to the service agreements.

35
36 MR MUSTON: So when you talk about "learnings", what sort
37 of learnings are you seeking to obtain through that
38 process?

39
40 MR DALY: I'll let Joe give you some specific examples.

41
42 MR PORTELLI: Yes, basically any kind of learnings to do
43 with the process, the model, maybe inclusions that we
44 wanted to have for the current financial year but, with
45 timing, we couldn't, so we might want to hold them over to
46 the next financial year - so anything, any kind of either
47 process or model related --

1
2 MR MUSTON: Could you give us some examples of the sorts
3 of things - when you talk about process or model-related
4 things, what sorts of things are we talking about?

5
6 MR PORTELLI: So the timing of the meetings are really
7 important. If we don't have information at a certain point
8 in time there's no point having a meeting, so we will try
9 to shift that timeline and, you know, make sure that the
10 next year we've got more information to have more fulsome
11 discussions with the districts and networks. That's
12 a process example.

13
14 A model example might be that we want to include
15 a different purchasing adjuster into the model, and that is
16 predicated or that is calculated using historical data. So
17 if we implement it at a certain point in time, there is no
18 time frame in which the districts can actually act and
19 respond to that adjuster, which means they may get
20 a financial penalty or a financial reward, however minor,
21 but without any ability to change.

22
23 So we might decide to go, "Well, we've agreed and
24 discussed it with districts and networks. We think it's
25 a good idea, but we will implement that next year because
26 then they've got time to actually respond to the incentive
27 rather than just be hit with the consequence of it without
28 ability to respond."

29
30 MR MUSTON: So in terms of process, we're talking about
31 the process by which discussions lead ultimately to or the
32 process by which the service level agreements and budgets
33 are ultimately set. So the meeting that you refer to might
34 be if particular data about a service is not available to
35 the LHDs at a particular point in time, and that's been
36 revealed through the process, you might, for future service
37 level agreement discussions, adjust the timing of that
38 meeting?

39
40 MR PORTELLI: That's correct.

41
42 MR MUSTON: And in terms of the adjusters that you were
43 talking about, that's more substantive in terms of the
44 budget that LHDs might ultimately be receiving. What
45 information is informing you about, in that example, the
46 adjusters that may or may not be included.

47

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

10
11 So one example is this year we decided that we thought
12 it would be a good idea to double the incentive for virtual
13 care, given the benefits. However, by the time we got to
14 the decision, because of various factors, there was no time
15 for the districts to change any models of care to respond
16 to that incentive, so instead we decided to delay it and
17 communicate it, and then that way, that kind of decision
18 will be factored in to this process in October where we go,
19 "Okay, well, what did we learn from the last process? What
20 are we going to do differently this year?"

21
22 MR MUSTON: Just teasing out that example, there's
23 a particular way in which virtual care is remunerated under
24 the agreement as a form of activity; is that right?

25
26 MS SMITH: Yes. So I'm happy to take that one. Virtual
27 care, if it's in scope of the activity that we deliver
28 across districts and networks and in scope of national
29 weighted activity units, it's already remunerated but we do
30 incentivise certain things in a relatively minor way, but
31 to provide, I guess, an additional payment to districts to
32 do those kinds of activities that we think have value and
33 that are going to derive longer-term value for the New
34 South Wales health system.

35
36 We use data that we have available already that
37 identifies where a service might be delivered by virtual
38 care but because it's historical, as Joe said, we need to
39 make sure that the district has time, so that when we do
40 look at the data just before the purchasing process begins
41 again, that if they wanted to increase the amount of
42 virtual care that they deliver, that that's evident in the
43 data, otherwise we're using data from before they knew that
44 we wanted to incentivise it.

45
46 MR MUSTON: I'm just trying to understand that, and we
47 will get into the details a little bit more, but why would

1 it not be equally advantageous to say, "From this point
2 forward we're going to incentivise the use of virtual care
3 for the delivery of activity", and then give districts
4 the benefit of that incentive and that uptick in income, to
5 the extent that they can achieve it during the immediate
6 12-month period, during which time they can then increase
7 their capacity, perhaps with the benefit of the additional
8 funding that they've got, to deliver more virtual care?
9 Why delay it?

10
11 MR PORTELLI: It's timing. So when we release the budget
12 we want to give certainty to the districts as much as
13 possible. We don't want shifting budgets within the year,
14 as much as possible, and then steps taken to try and reduce
15 supplementations throughout the year so districts have as
16 much certainty as possible, which means, with these
17 adjusters, we set them at the point of budget day and
18 that's based on the data that we have available. So for
19 the next 12 months, they will have adjusters based on their
20 performance in the last 12 months.

21
22 So having that time lag to say, "Right" - if we said
23 on budget day, "We're going to increase the virtual care
24 adjuster", the districts will be living with the
25 consequences of actions from 12 months prior, before they
26 knew that was going to happen.

27
28 So the positive adjuster is probably, you know, fine,
29 people get a windfall; but if it was a negative adjuster,
30 that's a material thing because they haven't had any
31 opportunity to change models of care or maybe change
32 behaviours in a way that would help them avoid that
33 penalty.

34
35 MS SMITH: I think it's important to note, though, that
36 the adjusters are fairly small in the general scheme of
37 things. So, for example, the virtual care adjuster
38 might have been a million dollars across the whole of the
39 17 districts and networks, and there are other ways in
40 which funding to support some of those initiatives does
41 flow to districts, but it's part of the purchasing model to
42 signal what is important to us as a system and the things
43 that we value and want districts to continue to do.

44
45 MR MUSTON: Accepting the distinction between positive and
46 negative adjusters, I'm still struggling - and it might be
47 me - to understand why withholding the benefit of

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

3

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

10

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

18

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

23

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

26

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

28

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

31

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

37

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

45

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

1 of reviewing learnings that can be obtained from past
2 budgetary negotiations. Where do we go from there, once we
3 have learned what we can learn?
4

5 MR DALY: I might get Joe to continue through, including
6 the overlap of finance and then the actual allocation of
7 budgets. I think that might be a bit more productive, if
8 that's okay.
9

10 MR PORTELLI: So after that point we hold a purchasing
11 workshop in December. In November we also talk with
12 finance as well around what some of the NPP proposals might
13 be. We share some modelling around population, ageing and
14 equity --
15

16 MR MUSTON: Pausing there, first thing, the workshop, is
17 that a workshop that's attended by all of the LHDs or are
18 we talking about separate workshops with each of them?
19

20 MR PORTELLI: No, we have a system-wide workshop, so all
21 the LHDs, pillars and all the statewide services are
22 included. We include relevant policy branches from the
23 Ministry of Health. Finance is obviously there and
24 presenting with us. It's sort of setting the scene for the
25 next budget process.
26

27 MR MUSTON: Then the next thing you told us about was
28 liaising with finance about NPPs that might be on the
29 horizon. Do we take it from that that the purpose of that
30 discussion is to work out what the existing envelope of
31 funding delivered by treasury is, probably get an
32 understanding of the extent to which it might be adjusted
33 by growth, but, equally, if there are new policy proposals
34 which have been put forward to treasury, getting some sense
35 of the likelihood of them being met with favour at treasury
36 and, if so, the consequences in terms of the overall
37 budgetary envelope that you have to distribute to the LHDs?
38

39 MR PORTELLI: Yes. I mean, I can talk you through --
40

41 MR D'AMATO: It's perhaps best if we step back a bit,
42 because that process is about one component of a budget, it
43 is not the whole budget.
44

45 So, for instance, as I described in my statement at
46 56, the overall budget is set on four key components. One
47 is the base, and I think it's fair to say that the

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

15
16 The third part of this, which is the part that is
17 associated with the work at the purchasing workshops and
18 the allocation, that component of the budget, is related to
19 the activity growth, which treasury describe to be this
20 1.5 per cent on the overall 4 per cent, that at the
21 treasury level is allocated to health.

22
23 Then the final part is the specific initiatives, and
24 this includes a number of things, but - and just reflecting
25 back to your comment about the NPPs. So there might be
26 NPPs being worked up at this time of year, around December,
27 where they may have activity included or may attract an
28 extra activity, as in extra NWAUs, and at that point, the
29 conversation with the purchasing team is to reflect, okay,
30 we might ask treasury for additional funding for this
31 particular initiative. If it is then reflected into
32 activity, that is included into the purchasing envelope.

33
34 Normally the policy area, so the branches in the
35 ministry, may have a say in respect to where and which area
36 of the system may receive this funding, and that's how it
37 is basically - and the sum of all of these is the budget.

38
39 MR CARR: The NPP process does provide, in the early
40 stages, a context for when we go around - and I attend with
41 Joe and Sharon to the different districts - a bit of
42 a context when we're talking to districts about what
43 they're saying they need, but also that helps us guide some
44 of those discussions. The NPP process early on might
45 change towards the end, but it does provide some context
46 for those discussions.

47

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

5
6 MR CARR: That's right.

7
8 MR MUSTON: Which, ultimately, the process that Mr D'Amato
9 has just talked us through, coupled with the outcome of any
10 NPPs, will form the budgetary envelope that's available
11 from treasury?

12
13 MR CARR: Yes.

14
15 MR D'AMATO: That's correct.

16
17 MR MUSTON: Mr D'Amato, when you were telling us a moment
18 ago about the base and the adjustment to the base on
19 account of, say, a hospital or a facility that has been
20 brought in-house, to use a simple term, is that
21 a discussion that's happening with treasury or are we
22 talking about a discussion that's happening at the district
23 level about their base?

24
25 MR D'AMATO: It's at the district level. And there is an
26 opportunity for the district to reflect changes
27 around February, so then we finalise the base
28 by March/April, and then we can start the calculation in
29 regards to what there is then to be allocated as what we
30 call "cost escalation".

31
32 MR MUSTON: The base that is made available to each of the
33 LHDs, is that informed at all, and, if so, to what extent,
34 by the base which is made available to the ministry in
35 general by treasury?

36
37 MR D'AMATO: Historically there is a relationship,
38 absolutely. Obviously, the bases inside the districts move
39 according, then, to decisions in regards to the purchasing
40 and some of the movements are more pronounced when there is
41 a new hospital, for instance.

42
43 MR MUSTON: We heard evidence on Monday from treasury and
44 Mr D'Amato about the somewhat mysterious history of the
45 base as identified by treasury. Can I ask in respect of
46 the base which is applied to each of the LHDs - it's
47 a figure which, subject to the sorts of adjustments that

1 Mr D'Amato has just told us about, is a historical figure;
2 would that be right?
3
4 MR PORTELLI: Yes.
5
6 MR D'AMATO: I think the challenge - sorry - to go back to
7 the base --
8
9 MR MUSTON: I think there was some nodding. If you want
10 to say "Yes", you have to say it out loud, so it gets onto
11 the transcript.
12
13 MR PORTELLI: I mean, from an activity point of view, yes,
14 but, like Alfa said, there is more to it.
15
16 MR D'AMATO: If I go back to when the bases were set, it
17 was when the area health services were split, basically.
18 They formed the base and at that point then we introduced
19 activity based funding through the NHRA. So from there on
20 we just started, where there was activity, new policy
21 proposals and the like.
22
23 MR MUSTON: Even at that point, was the historical
24 sequence that there were area health services which had
25 their own base of sorts?
26
27 MR D'AMATO: Yes, that's correct.
28
29 MR MUSTON: Albeit based on a different approach -
30 approach through a different funding lens?
31
32 MR D'AMATO: Yes.
33
34 MR MUSTON: LHDs were created by the carving up of those
35 area health services - that's correct?
36
37 MR D'AMATO: That's correct.
38
39 MR MUSTON: The funds that were traditionally made
40 available to those area health services, or the base that
41 existed within those area health services, needed to be
42 carved up and divided amongst the LHDs?
43
44 MR D'AMATO: That's correct.
45
46 MR PORTELLI: That's correct, yet.
47

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

5
6 MR D'AMATO: That's correct.

7
8 MR ONLEY: So it formed the funding model, basically.

9
10 MR MUSTON: In terms of the extent to which the base which
11 has historically been applied to each of the LHDs reflects
12 the cost of meeting the particular health needs of the
13 community within those catchments, does anyone know when,
14 in the past, an assessment was made of that and whether or
15 not that was an adequate amount of money, at some point in
16 the past, to meet all of the health needs of the community
17 within either those area health services or more recently
18 the local health districts?

19
20 MR DALY: I could comment as a chief executive of two
21 previous area health services, when they were the big
22 beasts that they were, that there was far less local
23 influence and alteration; most of the activity was
24 routinely in place through traditional arrangements of VMO
25 appointments, both in terms of numbers and specialties and
26 sub-specialties, which is what drives your activity, and
27 then there would be, and was, programmatic influence from
28 the ministry or Department of Health, as it was at the
29 time, just as there is today, around particular areas -
30 could be mental health, could be drug and alcohol or health
31 prevention and promotion. But the influence or the
32 conscious decisions around changes to profile was less
33 active than certainly the devolved model that I've observed
34 since being back in the ministry for the last two and a
35 half years particularly.

36
37 MR MUSTON: Because we've heard evidence this week, and
38 again I'll invite any of you to disagree with this
39 proposition, but health is one of those areas where, "if
40 you build it, they will come", and with perfect efficiency
41 you could continue to spend money on standing up services
42 and there would be demand for those services within
43 communities.

44
45 MR DALY: Largely, yes.

46
47 MR MUSTON: And not only is it services that they would

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

5
6 MR DALY: Yes.

7
8 MR ONLEY: Yes.

9
10 MR MUSTON: But within the real world where we've got
11 a limited budgetary envelope which needs to be distributed
12 amongst the various priorities of government - health,
13 education, community services, transport, et cetera - there
14 is always going to be a confined portion of money which is
15 available to the health sector?

16
17 MR PORTELLI: Yes.

18
19 MR MUSTON: And that confined portion of money needs to be
20 used in a way which ideally delivers those services which
21 those running the health service think are, of the universe
22 of services that could be provided, those which are best
23 provided within the budgetary envelope - that is to say --

24
25 MR PORTELLI: Yes.

26
27 (Mr Onley and Mr Daly also nodded)

28
29 MR MUSTON: -- "We'll be given a bucket of money and we
30 will do with it what we think is the best we can do with
31 it", accepting it's not everything.

32
33 MR CARR: Trying to achieve the best value for money is,
34 I think, one of our objectives.

35
36 MR MUSTON: "Best value for money" in what sense?

37
38 MR CARR: Value in terms of patient outcomes; in terms of
39 looking at our - we have a range of KPIs in our service
40 agreement, which we try and achieve those, because they are
41 tied to our "Future Health" strategy, so we try and tie it
42 to those.

43
44 MR MUSTON: We might come back to them a little bit later.

45
46 Mr D'Amato?

47

1 MR D'AMATO: May I make a comment in regards to what you
2 were describing about having to work with a finite resource
3 and the way we allocate this?
4

5 I think it's important that we reflect on the approach
6 we have established in New South Wales in that decisions
7 around the budget allocation for new services or extra
8 activity is not a matter for finance. I think we
9 established this process where we're two divisions, two
10 clear distinct divisions, working collaboratively to then
11 determine how to distribute the new money, being the
12 activity.
13

14 I think it is important to reflect on that, because
15 activity based funding, ultimately, is a mechanism. It
16 doesn't drive the strategy. We just use the best possible
17 way to optimise efficiencies, to create the transparent
18 environment where there's benchmarking, when there is an
19 opportunity also to engage, probably also be more
20 accountable from both sides, be it the districts or the
21 ministry, but ultimately the decisions are separate to the
22 finance decision to the degree that there is an envelope
23 and that is always going to be the case, but how the
24 envelope is allocated, distributed, the mechanism and the
25 priorities are set by a different division. I think it's
26 important we reflect on that, because we are unique in
27 Australia in the way we implement activity based funding.
28

29 MR MUSTON: We might come back to that as well.
30

31 In terms of this discussion around the base, at some
32 point in the past when the area health services had their
33 base identified, it was presumably an amount of money which
34 reflected an assessment made at that point in time of the
35 best way, across the whole state, of distributing the
36 limited budgetary envelope that was available to deliver
37 the public health system, that confined suite of the
38 universe of services that we could be delivering, which we
39 decided was the public health system at that time.
40

41 MR DALY: Well, that was how the eight area health
42 services were formulated, which ironically was from the
43 28 previous area health services being amalgamated into the
44 large eight area health services, and it was literally
45 a matter of pulling the budget bases of those existing area
46 health services - sometimes two, sometimes three, sometimes
47 more, of those smaller area health services - in to create

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

5
6 MR MUSTON: So just taking it all the way back to that
7 point in time, accepting that the number or the figure that
8 reflected the total base spread across those 28 units might
9 have been an - I was going to say, "an arbitrary figure",
10 but a figure which was not necessarily informed by careful
11 assessment of precisely what amount of money was needed to
12 meet all of the health needs of the state.

13
14 MR DALY: Other than in programmatic areas, yes, it was
15 largely just an historical feature for those 28 --

16
17 MR D'AMATO: I think perhaps we also need to reflect back
18 then, at the area health service level, there was
19 a different funding model, which was the RDF, so that would
20 have influenced the way ultimately that the eight area
21 health services received their portion of the budget.

22
23 MR MUSTON: But the budget itself was, effectively,
24 a political figure, a figure that was determined as the
25 amount which would be applied to the delivery of health, as
26 compared with education, transport, the various other
27 competing demands on the budget, and in that day, the RDF
28 figure was the means by which the ministry used to, in
29 effect, divide it up amongst its geographic constituent
30 parts.

31
32 MR D'AMATO: Yes. Fundamentally, that's what it was.

33
34 MR MUSTON: And that historical approach to the funding
35 has come to inform, in a way, the way in which the money is
36 divided up amongst the LHDs, albeit instead of using that
37 formula as a currency, we're now using activity as
38 a currency?

39
40 MR D'AMATO: That's correct. The activity we've used then
41 from when we, call it, jumped off from the area health
42 services, the ABF has effectively allowed us to do the same
43 work but to distribute the new money across the system.

44
45 MR MUSTON: It might be useful, I'm reminded, if whichever
46 of you is best qualified could just give us the 100 words
47 or less description of what the RDF approach to funding

1 was?

2

3 THE COMMISSIONER: Can anyone remember?

4

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

11

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

16

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

18

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

27

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

33

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

38

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

47

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

14
15 MR MUSTON: So at that point in time, the efficiencies
16 that were derived, ideally, meant that the limited
17 budgetary envelope that was available was able to deliver
18 more in terms of precisely what the public health system
19 was at that point in time?

20
21 MR DALY: Yes, and they remained in those communities
22 under that now new area health service.

23
24 MR MUSTON: Accepting there have been carve-ups,
25 adjustments and growth applied to the base, we've heard
26 some evidence to the effect that the rate at which the cost
27 of delivering health care to the population over the past
28 five, 10 years, has increased at a rate which exceeds the
29 growth factor which is applied to the base. Would you
30 agree with that?

31
32 Maybe let me break it down into its constituent parts.
33 There has been a range of changes in the way health has
34 been delivered over the past decades. There's a lot more
35 we can do in terms of interventions, that's - you have to
36 say "Yes" out loud.

37
38 MR D'AMATO: Yes.

39
40 MR PORTELLI: Yes.

41
42 MS SMITH: Yes.

43
44 MR DALY: Yes.

45
46 MR MUSTON: Those interventions are keeping people alive
47 for longer?

1
2 MR D'AMATO: Yes.

3
4 MS SMITH: Yes.

5
6 MR MUSTON: It's costing more to deliver those
7 interventions than it once cost to do the less-advanced
8 interventions that were available in times gone past,
9 perhaps when the base was originally identified?

10
11 MR DALY: I wouldn't say always, no.

12
13 MR PORTELLI: No, not always.

14
15 MR DALY: It's like, you know, as a pup in health, we were
16 warned, if not threatened, that if health continued to grow
17 at the rate that it was, it would move from taking over
18 a third of the state's budget to the whole state's budget
19 within 20 years.

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

36
37 THE COMMISSIONER: Population growth and ageing are the
38 consequences of that.

39
40 MR DALY: Yes, indeed.

41
42 MR MUSTON: But those efficiencies aside, it's not the
43 case, is it, that the rate of growth that has been applied
44 to the standard base has enabled us to continue to
45 deliver - well, the cost of delivering the care that we are
46 delivering to people across the board - that is, the cost
47 of running a health system - has continued to increase at

1 a rate that exceeds growth, has it not?

2

3 MR DALY: Yes, in my experience.

4

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

8

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

15

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

19

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

22

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

29

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

36

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

46

47 MR MUSTON: We've heard some evidence about screening

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

8
9 MS SMITH: There are certainly new programs - I think you
10 are talking potentially about Brighter Beginnings and The
11 First 2000 Days program, which does a lot of screening of
12 younger children, identifying any sorts of issues that they
13 might have, before they go to school, which is obviously
14 a better outcome both for the child, for the family and for
15 the community if we can address those sorts of issues
16 early.

17
18 But I think we've just touched on some of the
19 workforce supply issues. Even if we did have the funding
20 available, the envelope available, to increase those types
21 of services once a child with needs is identified, we have
22 workforce limitations. Being able to identify allied
23 health and nursing staff that might be able to deliver care
24 or deliver those developmental services, for example, is
25 challenging in the current environment since COVID as well.

26
27 MR MUSTON: So challenging in the current environment, but
28 just coming back to the starting proposition, say, the
29 Brighter Beginnings has identified a number of children
30 within the community who would benefit from an intervention
31 of some sort, either through allied health or paediatric
32 care?

33
34 MS SMITH: I believe that's the case, so that's the
35 purpose of the program, is to screen children early and
36 identify those that could do with intervention.

37
38 MR MUSTON: Other screening programs include, for example,
39 the bowel screening which the Commonwealth Government has
40 championed, which has a knock-on effect in terms of the
41 state health system, where someone gets a letter back
42 saying, "You should go and get a test, a further test, or
43 intervention performed"; it's the state that needs to do
44 that.

45
46 MS SMITH: That's correct and similarly with BreastScreen
47 and other types of screening programs.

1
2 MR MUSTON: Current discussions around chest x-rays and
3 the screening for lung cancer presumably will have the same
4 consequence, where something is detected in an x-ray that
5 needs closer examination, there will be a need for the
6 public health system in New South Wales to actually deliver
7 that intervention or that further test to work out whether
8 this patient has lung cancer or just an abnormal shadow on
9 their x-ray?

10
11 MS SMITH: That's right. I guess those patients would
12 have potentially always flowed to our system but they might
13 have come into our hospital system later in the trajectory
14 of their disease. The benefits of the screening programs
15 are that we would be seeing them, hopefully, sooner and so
16 that the complexity of their disease might be lower and
17 they would have a better outcome.

18
19 MR MUSTON: In that respect, is there a bit of
20 a distinction that can be drawn between, say, the bowel
21 screening, breast screening and lung screening programs on
22 the one hand, which ideally aim to identify an illness
23 early rather than when it's progressed, as opposed to, say,
24 The First 2000 Days or the Brighter Beginnings, where
25 children who don't get picked up through that screening
26 program might not actually end up in the health system;
27 they might end up in a different system?

28
29 MS SMITH: That's correct, and the consequences might not
30 have been felt in the health system but perhaps education,
31 justice and other parts of government services.

32
33 MR MUSTON: I think I have distracted us significantly
34 from our narrative walk through the budgeting process.
35 Perhaps can I come back to that. So you have your workshop
36 with all of the LHDs?

37
38 MR PORTELLI: That's correct.

39
40 MR MUSTON: Where do we go from there?

41
42 MR PORTELLI: We digest that information. We think about
43 what, if any, changes to the model are appropriate. Then
44 we have a roadshow discussion where we meet with every
45 district chief and their executive --

46
47 MR MUSTON: What does that involve?

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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

1 come to health, but at that point we only have the
2 information at the aggregate, so only the state position,
3 we don't know what is supposed to come to us at that point.
4

5 MR MUSTON: So you've given the context through that part
6 of the roadshow presentation. What's next?
7

8 MR PORTELLI: It's probably worth at this point drawing
9 a line between what would happen pre-COVID and what has
10 happened post-COVID, because the information and the
11 experience is different.
12

13 Pre-COVID, we would have had a number to give them in
14 terms of what we have allocated for population, ageing and
15 equity, and that would have given at least some certainty
16 to districts and networks about what their growth envelope
17 is going to look like.
18

19 That's very important for them because it might change
20 what they request from us. If they have demands for, say,
21 core business, BAU type of services, say, increasing
22 presentations to the emergency department, they might look
23 at that envelope and go, "Right, well, that's what that
24 growth rate is for: we've got a growing population, an
25 ageing population, and there is an allocation for that in
26 that number. So we've got the discretion to allocate some
27 funding to address those demands."
28

29 MR MUSTON: I might just unpack that a little bit. So
30 before COVID they were given, or assumed, did they, that
31 they would get the base that they had got in the past?
32

33 MR PORTELLI: Correct.
34

35 MS SMITH: Yes.
36

37 MR MUSTON: And then this number that you're talking about
38 is a number that you were previously able to give them
39 which reflected the increase on that base that you
40 anticipated they would be getting as part of their growth
41 funding?
42

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

1 should be adjusted in different districts, and then again
2 addressing sort of that longer-term move towards an
3 equitable model from what funding we have.
4

5 Then we talk about any other strategic initiatives
6 that have come through, any kind of NPP that we know that
7 we're rolling out, maybe an NPP that was approved in a
8 previous year but is coming through in an enhanced second
9 year of funding, that we need to reallocate some more
10 funds. We talk about any changes to the purchasing
11 adjusters, and then we have a section that they can raise
12 any other issues that they would like.
13

14 So often what has come up recently has been
15 particularly the new builds, any kind of redevelopment that
16 has come open, just because of the scale and size of them.
17

18 Prior to COVID, those were quite small and so that
19 conversation was probably more about, you know, "I've a got
20 a particular demand in the system and I would like to
21 address it with a significant step up." I say
22 "significant", maybe because the service didn't exist and
23 so there is no base from which it can grow, so it is
24 establishing a new service or maybe doubling a service
25 because the need was greater than they anticipated.
26

27 MR MUSTON: Just pausing there, what's the currency that
28 these discussions are taking place in relation to? Is it
29 "Here's a budgetary envelope in dollars that we will give
30 you to deliver on what you consider to be the best use of
31 these funds for meeting the health needs of the community",
32 or is it activity?
33

34 MR PORTELLI: It is both activity and block. We err
35 towards activity, because actually a lot of services can
36 actually be classified as activity. So I think a lot of
37 services - and my colleague Sharon can correct me if I'm
38 wrong - any kind of interaction between a clinician and
39 a patient that has a therapeutic or clinical benefit can be
40 counted under the financial model.
41

42 I think a lot of people think because a patient is not
43 admitted, it has to be block funded, which is not the case.
44 So that part of that discussion is fleshing that out,
45 whether or not the service can be counted and costed and
46 classified and priced using the NWAU model.
47

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

7
8 MS SMITH: There's a slight difference between the
9 national model, particularly in the non-admitted space that
10 Joe's just spoken about. There are a number of services
11 that whilst IHACPA might have a clinic
12 classification for those services, it doesn't have an NWAU
13 from the national perspective, so that we don't receive
14 national funding under NHRA for those services - things
15 like primary care or general counselling, would be
16 examples - but we have a state weight that we use and we
17 still purchase that activity from districts and networks.
18 So, in fact, we purchase more from the districts and
19 networks than is in scope for ABF at a national level. So
20 our model is slightly different.

21
22 MR MUSTON: We're jumping ahead a little bit, but to the
23 extent that there might be KPIs around activity generation,
24 do those KPIs - can they be satisfied through both types of
25 activity - that is --

26
27 MS SMITH: That's right.

28
29 MR MUSTON: -- national within scope and outside of scope
30 activity, so long as it's activity recognised by the state?

31
32 MS SMITH: That's correct.

33
34 MR PORTELLI: So, yes, we have two KPIs, one for in scope,
35 one for total - in scope for Commonwealth and one for
36 total. So those discussions then are worked through -
37 those discussions raise those issues, we discuss what we
38 can in the meeting and that usually happens around February
39 and March. We take that information back and we work
40 through that with various policy branches. Particularly if
41 there is, you know, a particular service that has a
42 statewide policy around it, we make sure that those are in
43 line. We assess them for dollar value, particularly if
44 they are requesting money above what an ABF model might
45 give. We don't say "No"; we just say "Why", and we explore
46 that, and then if there is value - sorry, like a viability
47 issue with the ABF model, then we will consider block

1 funding for that particular purpose. We then --

2

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

5

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

16

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

23

24 MS SMITH: That's right.

25

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

28

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

34

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

40

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

47

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

10
11 MR PORTELLI: It is determining that NWAU number that is
12 multiplied against the price.

13
14 MR MUSTON: Can I ask you to explain to us the way in
15 which the negotiation about how much activity operates?
16 How does it work year to year? What are the parameters of
17 negotiation?

18
19 MR PORTELLI: So again, I will talk about pre-COVID and
20 post-COVID. So pre-COVID, again, we started with a number,
21 that was largely the bulk of it, I think around 80 per cent
22 of our total envelope was allocated using the ageing
23 population and equity calculation. If you want a deep dive
24 into that, maybe I will pass to my colleague Sharon to talk
25 through that.

26
27 MS SMITH: Yes. Would you like to hear about the way that
28 those calculations occur?

29
30 MR MUSTON: Yep.

31
32 MS SMITH: So we take into consideration in the growth
33 model three factors, so changes year on year in the size of
34 the population in a local health district; secondly, we
35 take into consideration the age composition of that
36 district, so some districts remain very stable, population
37 size, but their population is ageing, which impacts the
38 demand on health service that we can expect to occur in the
39 coming year; and the third component takes into
40 consideration sociodemographic factors that are linked to
41 demand for health services and utilisation of health
42 services, over and above the size and age composition of
43 a local health district. So we make an adjustment to the
44 activity purchased so that those sociodemographic
45 characteristics are taken into consideration.

46
47 MR MUSTON: And presumably that's a formula of some sort,

1 or formulae, that you apply to do that?

2

3 MS SMITH: Yes.

4

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

8

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

18

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

26

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

30

31 MS SMITH: That's correct.

32

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

34

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

38

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

1
2 The final kind of step in the process is getting
3 approval through the ministry executive meeting where the
4 deputy secretaries and the secretary would look at the
5 overall envelope, the model, how it's being allocated,
6 cutting it different ways, getting an equity lens over it
7 at the service level, because you may have really equitable
8 decisions on each of the components but overall, you know,
9 if the model has delivered a really bad outcome, you might
10 need to reevaluate some things. Generally not, because
11 generally the model works pretty well. So that would then
12 lead to the final NWAU allocation that would go out to the
13 districts and networks in the final model. That would be
14 usually around the end of May, beginning of June, and then
15 the final budget is then released on budget day.

16
17 Now, that's pre-COVID.

18
19 So post-COVID, with all the uncertainty and the timing
20 issues, we have not been able to provide that level of
21 information to districts until well into May, often after
22 we've had the second meeting, and the level of activity
23 that we've been able to purchase from them has been
24 substantially lower, and so overall, we've had to take
25 a proportional value of what the population and ageing
26 component of our allocation was, and that's not to say that
27 they haven't been given funding increases, and my
28 colleagues can talk more to that.

29
30 MR MUSTON: So when you say "lower", they've got their
31 base, say, in the COVID year, which was - let's say it's at
32 100 just to use an easy number --

33
34 MR PORTELLI: Yes.

35
36 MR MUSTON: -- it wasn't a situation that in the following
37 year they got 98?

38
39 MR PORTELLI: No.

40
41 MR MUSTON: But whereas they might have got 104.5 --

42
43 MR PORTELLI: Yes.

44
45 MR MUSTON: -- the adjusters might give them 104.5 or the
46 calculations, but instead, they're going to get 102?

47

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

9
10 MR MUSTON: Putting aside the new hospital that's built
11 which has an obvious impact on the amount of activity that
12 is able to be generated - more basally, the amount of money
13 that the district needs to deliver care - the adjusters
14 that you are using for your growth figure, are they based
15 on an analysis of the actual identified needs of the
16 community in terms of its health needs from one population
17 to another or are they the high level things like
18 population growth, overall levels of particular disease and
19 the like?

20
21 MS SMITH: There are those three components. So
22 population growth is one component, so we do that, push
23 that, put that aside; the ageing component, that's
24 calculated and then put aside; but the equity component
25 looks at, I guess, the prevalence of particular factors
26 within a local community that we know drive increased
27 health needs.

28
29 So we look at what the expected health utilisation or
30 health service utilisation is of the community, once it's
31 adjusted for their underlying issues that might drive
32 additional need, and we compare that to their actual
33 consumption of health services, and where there's a gap -
34 so if they're consuming fewer health services than we would
35 expect - then that's where we would look at providing the
36 top-up or the additional activity purchase into that local
37 health district so that we bring them closer to their
38 expected utilisation as compared to their actual
39 utilisation.

40
41 THE COMMISSIONER: What does "particular factors within
42 a local community" mean? What are examples of that?

43
44 MS SMITH: It includes a lot of sociodemographic matters
45 like SEIFA status. We look at Aboriginality. We look at
46 number of people born overseas and in particular born in
47 countries that are high health service utilisers. We look

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

8
9 THE COMMISSIONER: Yes.

10
11 MR MUSTON: The index of GP attendance, just maybe develop
12 that a little bit. What is it you are looking at there?

13
14 MS SMITH: We use information that is either published by
15 AIHW or the bureau of statistics in most of our modelling,
16 so that would have been produced and reported on by AIHW.
17 So it's looking generally at MBS billing rates within local
18 communities, and we would aggregate that up to a district
19 and network to look at whether or not that district has
20 a lower utilisation of GPs, versus other parts of the
21 state.

22
23 MR MUSTON: What do you do with that information? Say the
24 district that's got a lower utilisation of GPs, what does
25 that do --

26
27 MS SMITH: We would expect that district to utilise ED
28 services at a higher rate than others and we would give
29 them some additional ED growth to compensate for the fact
30 that they have lower utilisation of GPs.

31
32 MR MUSTON: So you identify the absence of or a thinning
33 market of GPs within that community as resulting, down the
34 track, in an increased level of --

35
36 MS SMITH: Demand.

37
38 MR MUSTON: More people going to the emergency department,
39 sicker, and so you increase the amount of emergency
40 department activity that is being purchased?

41
42 MS SMITH: That's correct.

43
44 MR D'AMATO: And that step is actually a step from the RDF
45 formula. So we've already kind of blended, a little bit,
46 our ABF approach by incorporating this extra step.

47

1 MS SMITH: But the way would express that additional
2 activity is in NWAU terms. So that's where the ABF
3 component comes in.
4

5 MR MUSTON: So is this process happening as part of
6 a collaborative service planning that you're doing with
7 each LHD or is it being done centrally and based on
8 a pocket of data, population data, which is available to
9 you centrally?
10

11 MS SMITH: It is being done centrally but it is certainly
12 something we discuss with local health districts. They
13 will often come to us with ideas about the way in which we
14 can improve the model or factors that we can incorporate
15 into that equity calculation.
16

17 MR MUSTON: Is there any process at this stage of the game
18 where you sit down with LHDs and have them identify for you
19 what they think, based on the information they've got, the
20 information you've got, perhaps even the information
21 contributed by, say, the PHN and other bodies, what the
22 health needs, actual health needs of that particular
23 community are, the services that the LHD thinks,
24 prioritising a spend of a limited budgetary envelope, would
25 best meet the needs, health needs of that community and
26 what it's potentially going to cost to deliver those
27 services?
28

29 MR PORTELLI: So probably indirectly, would be my answer.
30 We wouldn't specifically talk about the health needs, in
31 these discussions; we would talk about the services that
32 they would like to establish. The idea that we allocate
33 funding to districts is so they have that, I'm going to
34 call this, discretionary budget, the population ageing and
35 equity model gives them the ability to attribute resources
36 to their areas of need.
37

38 We have a central planning function that helps them do
39 their clinical services planning and they have to do
40 a joint planning process, and it escapes me at the moment,
41 but with the PHNs around what that looks like for both the
42 parties, and it's through understanding that that the
43 districts then would come to us and say, "Well, according
44 to our plan, we would want these things."
45

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

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

10
11 Again, post-COVID, when that allocation hasn't been
12 provided to them or that certainty hasn't been provided to
13 them up-front, and, you know, their general and financial
14 environment and the focuses on COVID and the response,
15 those conversations probably haven't been as fulsome as
16 they have been in the past, but that's easily rectifiable
17 with certainty in the February meeting, because that has
18 worked pretty well in the past.

19
20 MR MUSTON: Could I just pick up the example that you gave
21 of the GP presentations being low within an area resulting
22 potentially in an increase in emergency presentations and
23 more activity purchased for that.

24
25 An LHD might come to you and say, "We've got a thin or
26 failing GP market in our town, or in towns within our
27 catchment. We think the best way of dealing with that
28 problem in terms of meeting the health needs of the
29 community is for us to" - in some but not all of those
30 towns - "either stand up or in some other way support the
31 delivery of primary care in a way which is potentially
32 efficient and can utilise resources that are being utilised
33 in the delivery of acute care. It's going to cost this
34 much money."

35
36 First question: is the amount of money that could be
37 delivered or generated through - I'll take it back a step.
38 The delivery of primary care in a setting like that,
39 I think you told us a moment ago, is capable, at least
40 under the state model, of generating activity which can be
41 purchased?

42
43 MS SMITH: Yes. So primary care is in scope of our
44 purchasing model and the state ABF model, but we wouldn't
45 receive any Commonwealth revenue for that activity.

46
47 MR MUSTON: Unless you were able to come up with a 19(2)

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

3
4 MS SMITH: Yes.

5
6 MR PORTELLI: Yes, that's correct.

7
8 (All other witnesses nodded)

9
10 MR MUSTON: Park that bit of it. An LHD takes the view,
11 "We think delivering primary care to these members of our
12 community is a better way of dealing long term with their
13 health needs than picking it up down the track when they
14 present to emergency without having received that primary
15 care, but we can't do that immediately because we've had
16 a period of time now where people have not been getting
17 primary care and, as your growth formula tells you, there
18 is an immediate population of people who will be presenting
19 to emergency sicker because they have not had the benefit
20 of good primary care." How would a discussion with the LHD
21 happen along those lines, "We still need to have you
22 purchasing activity from us for emergency, because we have
23 an immediate need to deliver emergency care to these
24 people, but we have a proposal whereby if you increased
25 some more activity from us in the form of primary care" -
26 and over to Mr D'Amato and his team to try to secure some
27 19(2) exemptions from the Commonwealth for that - "but we
28 would like to deliver both, with a 10-year view to ideally
29 reducing emergency presentations and perhaps even closing
30 some emergency departments and replacing them with
31 a primary care service of this type on a more permanent
32 basis"? How would that discussion work --

33
34 MR PORTELLI: That could have happened previously in the
35 purchasing discussions prior to COVID, where there was that
36 flexibility where we've given a certain allocation for
37 their hospital needs and then there was some room for those
38 kinds of initiatives.

39
40 Post-COVID and also - and pre-COVID as well to some
41 extent, there are other programs or other avenues in which
42 those discussions can be had, so the integrated care
43 program, collaborative commissioning program, urgent care
44 services program, all these programs were designed to help
45 bridge the gap, the potential gap, between our hospital
46 system and the primary care market. They all try to do
47 different things - I can talk about the urgent care service

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

5
6 So through those programs, you could have that
7 discussion. We have an evaluation framework behind it.
8 It's a lot more structured than the purchasing model, which
9 is more about providing a fair allocation of resources
10 using the best data available to enable districts to make
11 that discretionary allocation of their health service needs
12 and delivery on their clinical services plan. But
13 certainly through that avenue those discussions can be had.

14
15 Those discussions have to fit within the program
16 goals. For example, with our urgent care program, it was
17 about trying to get patients access to care outside of the
18 emergency department before they get there, through various
19 means. And so as long as that kind of program that they
20 had in mind was able to deliver that outcome, we were very
21 open to those discussions.

22
23 MR MUSTON: You said that is something that could happen
24 before COVID. Why can't it happen now?

25
26 MR PORTELLI: Post-COVID, the envelope for this particular
27 process has been smaller, and if you think about the
28 continuum of care in our community for health services,
29 you've got the really acute pointy end, which is EDs, ICUs.
30 NSW Health is pretty much the primary provider of those
31 services and there aren't too many others who can do that.
32 As you move to elective surgery there's a little bit more
33 of a private market; if you look at - you know, as you go
34 along to the primary care market, we're basically very
35 small players.

36
37 What we're talking about in those kinds of programs
38 are areas that - there could be potentially other
39 providers, but if it comes at a cost of a service that only
40 we provide, that's not a tenable solution for chief
41 executives to make. So where the envelope is smaller, all
42 of the money goes there. Health will always prioritise the
43 most urgent patients. So when you have a smaller envelope
44 from which to purchase, not only do districts and
45 networks - you know, they may have those desires but they
46 know roughly - they get the gist of, "We're in a low growth
47 environment. We know that if we apply for this, it's

1 probably not going to get through."
2

3 MR MUSTON: You mentioned a moment ago where there are
4 other providers - accepting that NSW Health is probably
5 going to be the ultimate, the only, provider of care in
6 that emergency setting - certainly not putting to you any
7 sort of suggestion that LHDs should be opening primary care
8 centres in every town that they have within their catchment
9 because it would be great for the community to have choice,
10 but there will be towns and communities where
11 a market-based model for the delivery of primary care is
12 never going to be available, in 2024 or any time going
13 forward. Would you accept that?
14

15 MR PORTELLI: Yes, generally, yes.
16

17 MR MUSTON: To the extent that the market is capable of
18 providing, say, primary care services in a community either
19 on its own or with a limited amount of support from the
20 LHD, it's clearly going to be in the LHD's and community's
21 interest for that to continue, so as to enable, as you say,
22 the limited budgetary envelope available to health to be
23 deployed in areas where it's actually more needed?
24

25 MR PORTELLI: I would agree.
26

27 MR MUSTON: But in areas where you can't get
28 a market-based solution to provide primary care, then that
29 does ultimately leave it to the LHD to ask itself:
30 "Someone has to provide this care. Yes, we have to provide
31 emergency care and intensive care and the like, but as part
32 of our assessment of what is going to best meet the health
33 needs of our community, where do we think this money should
34 best be spent?"
35

36 MR PORTELLI: That's correct.
37

38 MR MUSTON: As part of the roadshow negotiations or the
39 activity purchasing negotiation, is there any discussion of
40 that type along the lines of - I mean, primary care is one
41 example, but a range of other examples no doubt exist where
42 an LHD might say, "Here's what we have assessed as the
43 total needs of our community. Here are all of the services
44 which we think ought be provided within the realms of
45 reality to meet those needs. We don't have enough activity
46 at the moment to deliver on them. We would like more" --
47

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

2

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

4

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

17

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

28

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

38

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

1
2 MS SMITH: I'm happy to take that one. Every year we do
3 have a discussion about whether the activity that we're
4 purchasing in each line item, say, for example, whether
5 it's a non-admitted or ED or admitted - whether that's the
6 right mix, and districts do have the opportunity to think
7 about whether or not they're likely to want to move some
8 services out of, say, an admitted setting into
9 a non-admitted setting, and vice versa. So we do have that
10 conversation, because they are, you know, instituting and
11 enacting their clinical services plan, which does make
12 changes to the way they deliver care, and so the model is
13 responsive and flexible to that degree.

14
15 MR MUSTON: I'm just trying to explore the relationship
16 between the amount of activity that's being purchased and
17 what's actually being delivered for that activity.
18 I understand - I think you gave an example, or one of you
19 gave an example a while ago, of some additional funding
20 being provided to reduce elective surgery waiting times,
21 but otherwise, is there any discussion, as part of this
22 process, about precisely what sort of activities or
23 services are going to be delivered from the activity, or is
24 that left largely to the LHDs to decide once they've been
25 given their allocation of activity?

26
27 MR PORTELLI: Largely, yes, it's given - like, the
28 devolution model that we have is that the best people to
29 make a decision about what services should be provided are
30 with the districts, so the people closest to the hospitals
31 working with clinicians. So the framework itself and the
32 way that we allocate funding is to enable that.

33
34 We try to have a statewide view about who has what and
35 how equitable it is, but largely having an allocation that
36 is untied, so to speak, gives the districts the ability to
37 enact and bring to life their clinical services plan and
38 address the needs of their population and do it in a much
39 more real time than what we could possibly do with central
40 datasets.

41
42 So if they decide that they have a failing primary
43 care market and they get an allocation of untied funds,
44 they could go, "Well, actually, we can do enough elective
45 surgery this year. We don't need to necessarily expand it
46 as much and we can direct some of those funds to do some of
47 the primary care work that we think is emerging and will

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

6
7 MR MUSTON: There are some linkages, though, between what
8 you do and what the LHDs do. For example, the amount of
9 money that they have allocated to them obviously influences
10 what they can actually do to meet, in a devolved way, what
11 they perceive to be the health needs of their community.

12
13 MR PORTELLI: Yes.

14
15 MR MUSTON: And to the extent that there are KPIs and
16 other requirements - for example, waiting times in
17 emergency, waiting times for elective surgery - complying
18 with those KPIs means the funding that is delivered is, at
19 least in part, whilst not strictly tied, in a practical
20 sense, they have no choice but to divert it in particular
21 ways in order to achieve those KPIs?

22
23 MR PORTELLI: That's correct.

24
25 MR MUSTON: If the funding envelope is very tight and the
26 funding that's available only just allows you to meet those
27 KPIs, for example, it doesn't really leave you much room to
28 do much in terms of adapting the services or changing the
29 services to meet the needs of what you might perceive in a
30 devolved way to be the immediate needs of your community?

31
32 MR PORTELLI: Yes, that's correct. I mean, we do review
33 the KPIs every year. We give the districts and networks
34 the opportunity to comment and say what should or shouldn't
35 be included. But it would be fair to say that, you know,
36 hospital access targets for emergency departments, elective
37 surgery, are pretty bread and butter expectations from the
38 community on a state's health service.

39
40 MR MUSTON: Can I ask why that is?

41
42 MR PORTELLI: I think, again coming back to provider of
43 last resort, not many other people provide the service, we
44 expect, you know, that kind of level of service - the
45 community would expect that level of service from
46 NSW Health.

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

5
6 MR PORTELLI: I'd just again repeat what I said about few
7 other providers doing it. I think people are - they're the
8 most urgent need; you need response quickly. Often there's
9 a whole range of infrastructure that goes into emergency
10 services. I think that's what people expect from our
11 health service.

12
13 MS SMITH: There's a lot of evidence and research around
14 about the link between timely access to care in the
15 emergency department and good outcomes, clinical outcomes,
16 for individuals. So I think we have those in the service
17 agreement not because we want to really focus on those as
18 an outcome in and of themselves but because we know the
19 safety and quality impacts of extended stays in the
20 emergency department. So they do have a basis in that
21 desire to achieve longer-term outcomes that are positive
22 for the community and for the people that seek care in our
23 hospitals.

24
25 MR MUSTON: Let me explore a few aspects of that. Let's
26 look at the Brighter Beginnings program. For people
27 suffering from some level of socioeconomic disadvantage,
28 the public health system is also the system of last resort
29 for paediatric and allied health care for their children,
30 who might be identified through the Brighter Beginnings
31 program as requiring some intervention. Would you agree
32 with that?

33
34 MR PORTELLI: Agree.

35
36 MR MUSTON: In exactly the same way as the public health
37 system is the system of last resort for people who need
38 a knee replacement and can't afford to go to a private
39 hospital or choose not to go to a private hospital to
40 receive that care?

41
42 MR PORTELLI: Correct.

43
44 MR MUSTON: Whilst I don't have it available, I have very
45 little doubt that there is no doubt a wealth of research
46 out there that says intervening in developmental problems
47 that children suffer before they start school and start to

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

5
6 MS SMITH: They might be of a different size and scale so
7 they might - you're right, but there is a link between sort
8 of things like mortality rates for people waiting too long
9 in the emergency department, I think, that are probably
10 slightly different than some of the outcomes that you're
11 describing, but still catastrophic if the outcomes are not
12 positive.

13
14 MR MUSTON: And again it's all matters of degree. Someone
15 who presents to the emergency department with chest pain
16 needs to be seen reasonably quickly --

17
18 THE COMMISSIONER: That's life threatening.

19
20 MR MUSTON: -- otherwise they potentially have a bad
21 outcome.

22
23 MS SMITH: That's right. Exactly.

24
25 MR MUSTON: Someone who presents to the emergency
26 department with a broken arm, if they're not given care or
27 surgery soon, within a particular parameter, no doubt there
28 is some evidence out there that says the outcome in terms
29 of their functionality might be compromised in some way.

30
31 MS SMITH: Correct.

32
33 MR MUSTON: Just as a child, within a wide ranging
34 spectrum of different conditions and parameters, no doubt
35 children who require paediatric interventions before they
36 start school, if they don't get them within a particular
37 window, there will potentially be a less optimal outcome.

38
39 MS SMITH: A bad outcome. Absolutely agree.

40
41 MR MUSTON: That less optimal outcome, whilst not
42 immediately measurable by the health system, as someone
43 whose arm is a little bit less functional than it was
44 a month or two months ago, from an economy-wide
45 perspective, that could be the difference between
46 a productive member and tax paying member of society, on
47 the one hand, as opposed to someone who is then, and

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

3
4 MS SMITH: Agree.

5
6 MR CARR: If you go back 15 years or so ago or 20 years,
7 the statewide infant screening hearing program, SWISH, was
8 a good example of that, where they were testing children,
9 I think it was at six months or a year, to see whether they
10 could hear, that was seen as being a really important
11 development, early intervention for children in their
12 learning.

13
14 MR MUSTON: No doubt the very reason that money is spent
15 on SWISH, Brighter Beginnings and First 2000 Days is
16 because there is an evidentiary base that says identifying
17 these problems early and dealing with them is of real
18 benefit both for these children and, when one is making
19 priority decisions around how to spend budgetary money,
20 a benefit to society more generally, associated with doing
21 it?

22
23 MS SMITH: Yes.

24
25 MR MUSTON: When we come to our KPIs and service level
26 agreements - I will come back to a question I asked
27 earlier - why do we include, say, waiting times for
28 elective surgery and waiting times in emergency and
29 prioritise those over waiting times for seeing
30 a community-based paediatrician, for example?

31
32 MR DALY: They may not necessarily not be included in
33 their service agreements. Is it in that top tier? I mean,
34 I think there are about 100 KPIs in the service agreements.
35 I run a performance management process of meeting either
36 monthly, if an LHD is performing poorly, or quarterly if
37 they're performing within certain parameters, and they are
38 prioritised, they are prioritised around the key government
39 priorities, which are around access to emergency treatment
40 and planned surgery.

41
42 That covers over two-thirds of admissions into our
43 public hospitals, those two pathways alone. So that may be
44 partly the reason why it's such a priority, but together
45 with safety and quality indicators and some financial
46 indicators, and indicators around mental health, Aboriginal
47 health, and we'll probably look, at those meetings, at

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

5
6 We also have programmatic areas within the ministry
7 that would also have a direct involvement and influence in
8 monitoring the delivery of those other KPIs, so it's
9 a matter of crafting the engagement and oversight process,
10 depending on which of those 100 KPIs are in the service
11 agreement being monitored.

12
13 MR MUSTON: I'm not necessarily advocating the inclusion
14 of more KPIs, and I'm also happy to be corrected if I'm
15 wrong, but I don't recall seeing in any of the service
16 level agreements a KPI that measures waiting times for, for
17 example, public clinics for paediatrics, endocrinology, any
18 of the array of services that are being delivered through
19 public clinics.

20
21 MS SMITH: No, that's right. We actually don't currently
22 have that data available to us but we're moving in the
23 direction of having that data available to us.

24
25 But a program like Brighter Beginnings, which is, as
26 we've all agreed, a really important initiative, does have
27 a monitoring and evaluation plan. So whilst it might not
28 yet be a KPI in the service agreement, we are looking at
29 the outcomes for the children that are part of that program
30 and also using linked datasets to be able to identify
31 screening and then what services occur after that child has
32 been screened. So potentially in future service
33 agreements, once we have established data sources and we've
34 identified what a target might need to be for that
35 particular population, it could potentially become a KPI.
36 So it may just simply be that we're in the trajectory of
37 implementation of that program, we're just not ready yet
38 for a KPI in service agreements. It doesn't mean it won't
39 happen.

40
41 MR MUSTON: But for it to become a KPI that's able to be
42 achieved, it would require a funding envelope that enabled
43 it to be achieved at the same time as you're achieving the
44 others - for example, waiting times in emergency, delay
45 times for elective surgery, et cetera?

46
47 MS SMITH: Yes, the usual process of developing a KPI is

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

5
6 MR PORTELLI: It's probably also worth flagging that for
7 elective surgery there's a very robust process about who
8 goes on the waiting list and for what, how patients are
9 classified in clinical urgency category, and then the times
10 expected for that. Those are national standards, which we
11 align to. There isn't that same kind of infrastructure
12 with outpatients, and as you get more down the outpatient
13 route, the blur between what is our responsibility and what
14 is delivered in the community is very - well, muddles
15 decision-making quite a lot.

16
17 We don't have good data, I would suggest, about how
18 much care is actually provided in the community already.
19 We know it's a lot. We know that patients still rely on
20 our service. But any kind of investment that we would make
21 in outpatients would need to be married up with, well, what
22 is the expectation and how do we know that we're going to
23 target those people that would actually benefit from it,
24 versus people who would just prefer not to pay an out of
25 pocket and come to an public health clinic.

26
27 MR MUSTON: That's no different, is it, to elective
28 surgery? I could choose to have a piece of elective
29 surgery and I could choose to be a public patient, and
30 whilst I might wait a while for it, I would be entitled to
31 it?

32
33 MR PORTELLI: That's correct.

34
35 MR MUSTON: And that wouldn't cause you to give pause
36 for thought as to whether or not waiting times for elective
37 surgery should be adjusted to take that into account?

38
39 MR PORTELLI: We have more confidence over the wait list
40 data for surgery because it's standardised. We know who
41 should be on it, who shouldn't be on it. We don't have
42 data on wait lists - we don't have centralised datasets for
43 outpatient clinics, and if we did we would need to have
44 some kind of - and we're developing it at the moment under
45 the statewide referral criteria program; we're slowly
46 rolling out those criteria to make sure that once we do
47 have a data source, patients that are referred to clinics

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

10
11 MR MUSTON: What we have been told during some of our
12 roundtables is that the wait times that we're talking about
13 here are not wait times for secondary treatment but,
14 rather, wait times between being identified as someone who
15 requires an intervention or an appointment, say, with
16 a paediatrician, and actually getting that appointment,
17 sometimes, running to years. That would be capable of
18 being measured without too much trouble, wouldn't it - that
19 is to say, someone who has been screened and identified as
20 requiring at least a review and the date at which that
21 review is able to be provided?

22
23 MS SMITH: So for this particular program that we've been
24 discussing, Brighter Beginnings, that's exactly what we're
25 doing, but again, early days, and that data is just
26 becoming available. But it's not something that's done
27 routinely across the outpatient sector.

28
29 MR MUSTON: Why is that?

30
31 MS SMITH: We don't have, really, as Joe said, those clear
32 criteria for referral to outpatients, but also we don't
33 have a system, an electronic system, that allows us to
34 capture the time of referral versus the time of first
35 treatment, and so those are being developed.

36
37 MR PORTELLI: We're on the pathway, it's certainly
38 something that we are interested in, there's no doubt.
39 I think the reality is - coming back to what we were saying
40 before about the spectrum of services and where, with
41 a certain level of funding, we're able to invest. A lot of
42 these outpatient clinics, I think describing NSW Health's
43 role in those is important and I think we will get there
44 with the work that is being done. However, with the
45 funding available, these services should be core business -
46 some of these, you know, within certain parameters should
47 be core business for NSW Health, but they are in the more

1 preventative end of the spectrum than, say, emergency
2 department or elective surgery procedures, particularly,
3 say cancer surgery, category 1 type surgery.
4

5 MR MUSTON: Let's put emergency departments to one side
6 because people who walk through the door in an emergency
7 need to be treated - I think we can all accept that. But
8 even elective surgery, certainly some types of elective
9 surgery, there seems to be an acceptance that that has to
10 be core business whereas some of these other outpatient
11 services should be core business but aren't yet. I'm just
12 wondering why, within a confined budgetary envelope, we're
13 not having discussions around, if we had to prioritise,
14 say, elective surgery - I'm not saying all elective surgery
15 but there would undoubtedly be parameters that you could
16 set, age parameters, functionality parameters on the one
17 hand - and providing an outpatient service which might
18 actually, at least in the mind of the operator of a local
19 health district, provide better long-term benefit for their
20 community, why aren't we having those discussions?
21

22 MR DALY: I think we are. One of the outcomes of the
23 Surgical Services Taskforce that the government has set up
24 to support the system returning to unplanned surgery
25 breaches beyond their clinically recommended date, which we
26 were successful in doing in getting back to pre-pandemic
27 levels, was also about greater prescription, really under
28 the principles of "Leading Better Value Care", of: we just
29 won't do these types of surgeries - and they are quite
30 prescriptive - except with the formal approval of the
31 district director of surgery, because there will be
32 exceptions. Even something that might sound quite cosmetic
33 may have a very sound clinical reason, quality of life
34 reason. And this group continues to meet and it's
35 continuing to drive those principles and pushing the
36 envelope in order to ensure that only those with the
37 strongest clinical efficacy and evidence base are being
38 performed in our public hospitals. But it's a journey,
39 it's not a destination, because technology and models of
40 care change all the time, but this group of surgeons and
41 anaesthetists that I co-chair are actually leading that
42 process as we speak.
43

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

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

11
12 MR DALY: Certainly not by the surgical services
13 committee.

14
15 MR MUSTON: That's unsurprising.

16
17 MR DALY: I mean they're surgeons and they're there to
18 cut. No, they're very focused on their specialty.

19
20 ACI does an enormous amount of work in this area and
21 they guide policy decisions where there is the right
22 evidence nationally or internationally. So I have no doubt
23 that they are working in their various networks on those
24 types of questions.

25
26 THE COMMISSIONER: Can I just ask - sorry, I just wanted
27 to ask a question before we have a break but I don't want
28 to interrupt you if you were finishing --

29
30 MR MUSTON: I was going to ask one more just on that
31 topic.

32
33 THE COMMISSIONER: You ask your question.

34
35 MR MUSTON: You've now made me forget what it was.

36
37 THE COMMISSIONER: In fairness, I think that's the first
38 time I've done that to you. You will think of it at the
39 break.

40
41 Can I just ask Ms Smith a question. Yesterday
42 afternoon we had Professor Duckett giving evidence, who no
43 doubt you are probably aware of. He's an economist. Part
44 of the discussion was about whether there is any work done
45 on rates of return or cost benefit analysis for investment
46 in health services that might be, for example, early
47 interventions in some sort of paediatric service, and - no

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

15
16 MS SMITH: I am going to make an assumption, because for
17 all of the new policy proposals that we put forward to the
18 expenditure review committee of government, we need to --

19
20 THE COMMISSIONER: You need a business case, yes.

21
22 MS SMITH: We need to do a business case which has that
23 economic analysis around benefit cost ratios and other
24 assessments of cost benefit. So I am going to assume, but
25 Alfa might be able to confirm, that for that program's
26 funding, a CBA was done.

27
28 THE COMMISSIONER: Given the topic has been raised and
29 this program has been raised, we might like to see that
30 business case, because, I mean, as a matter of obviousness
31 on those figures, it sounds like it's an excellent spend of
32 money and perhaps the same sort of secondary benefits of
33 that sort of investment might be applicable in other health
34 services. So we might seek that. Other than that, is that
35 a convenient time?

36
37 MR MUSTON: That reminds me of my question, Commissioner,
38 if I could ask it.

39
40 Mr Daly, you made the point that the surgeons
41 obviously are focused on cutting and they identify where,
42 through doing more cutting, they can provide good benefit
43 to patients, which is no doubt right, but every craft group
44 within the health sector is no doubt in a position where
45 it's able to say, "If I had a little bit more money devoted
46 to what I'm doing or if there was a clinic set up which
47 enabled me to do more of what I'm doing, I'd be able to

1 provide a good health benefit."

2

3 MR DALY: Yes.

4

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

18

19 MR DALY: Probably.

20

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

29

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

37

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

1 endocrinology care to mean we don't need to set up,
2 long-term, a foot clinic" - of the type you have just
3 described - "because, whether it be on health grounds or
4 economic grounds, we think the benefits associated with
5 those outpatient clinics outweigh the benefits associated
6 with elective surgery, if we can't have all of it." Does
7 that discussion happen as part of the budgetary process?
8

9 MS SMITH: I think it would be difficult to say that we
10 don't need both. I don't think we get into the
11 conversation about either/or. I think, you know, the
12 reality is that we need to keep doing what we're doing and
13 invest, separately, in what we're not currently doing.
14

15 MR MUSTON: But can I ask this question: do you need to
16 keep doing it everywhere?
17

18 MR PORTELLI: No. I mean, I think districts have a pretty
19 good grasp of what they need to be doing, what services
20 they need to provide for their community and have the
21 understanding that, actually, it doesn't need to be
22 provided in every single hospital in every part of their
23 district.
24

25 MR MUSTON: Does it need to be provided in every district?
26

27 MR PORTELLI: Well, we have certainly looked at other
28 avenues. So we have statewide services that have always
29 been around and they do provide services for - you know,
30 when heart-lung transplants come up. But say, for example,
31 virtual care hubs, that was something that was clearly of
32 benefit to the system. Some districts decided that they
33 would want to spin off their services. Great, innovative.
34 A lot of great innovative ideas come from on-the-ground
35 solutions to problems. But given it was of value to the
36 state, we've now established or are establishing two
37 central hubs that provide services across the state. So,
38 yes, we do consider things where some things don't have to
39 be provided by every district and they can either be
40 provided by two districts on the behalf of the state or -
41 with ministry involvement.
42

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

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

3
4 MR PORTELLI: In the roadshow process that I've discussed,
5 any kind of programs where we have that system lens to it
6 are discussed in those initial discussions in February
7 and March, just so we can set the scene, "This is what's
8 happening, this is what you might see in your district",
9 and that will then colour or maybe modify what the
10 districts request of us. They go, "Well, actually, we
11 probably don't need this anymore." Often that doesn't
12 happen because it has already been announced and discussed
13 in other forums. So there is the senior executive forum
14 with chief executives and ministry where some of these
15 programs may have already been announced and discussed, so
16 that before they even get to that stage of the roadshows,
17 they know that they don't need to invest in it.

18
19 MR MUSTON: I note the time, Commissioner.

20
21 THE COMMISSIONER: Yes. We will adjourn until 5 past 12.

22
23 **SHORT ADJOURNMENT**

24
25 THE COMMISSIONER: When you are ready.

26
27 MR MUSTON: Could I just come back to paragraph 7 of the
28 statement prepared by Messrs Daly, Portelli and Ms Smith,
29 just to make sure I have understood this correctly.

30
31 Paragraph 7(a) tells us about the fact that the
32 service agreements include the level and mix of services to
33 be purchased. So am I right in my understanding that the
34 way in which the level and mix of services being purchased
35 is set out in those service level agreements is there is
36 a bundle of activity which is purchased, and the quantum of
37 that activity is the historical base plus the growth factor
38 that has been applied to the LHD?

39
40 MS SMITH: Plus any other initiatives that we might be
41 purchasing over and above either of those things.

42
43 MR MUSTON: In relation to that, that's almost the
44 equivalent, at the ministry to district level, of the NPP
45 process, is it, where the district will say, "We've got
46 this new idea", or "We've got this different way that we
47 think we want to go about doing something. In order to do

1 it, we'll require a little bit more activity to be
2 purchased from us"; you give consideration to that proposal
3 and decide whether or not to, as it were, adjust the base
4 going forward by that, by the amount of activity that has
5 been requested?
6

7 MR PORTELLI: That would be correct. Again, that was
8 a material number - well, that would have been a material
9 number overall pre-COVID. Post-COVID not so much.
10

11 MR MUSTON: Not so much because there's just not enough
12 money to provide - to deliver the activity or to purchase
13 the activity that might be proffered by the districts?
14

15 MR PORTELLI: Correct.
16

17 MR MUSTON: Other than that broad description or the broad
18 allocation of an amount of activity, the way in which that
19 activity is divided up in the sense of the level and mix of
20 services that is referred to in paragraph 7(a), it's pretty
21 high level, is it? I think, for example, if we go to
22 paragraph 26 of the other statement, there's a useful
23 example of Murrumbidgee LHD's budget. That's on page 6 of
24 the statement prepared by Mr D'Amato et al.
25

26 We see there that it seems to be divided up between
27 acute admitted, mental health admitted, et cetera - each of
28 those items there. That's the extent to which the service
29 and mix of services to be delivered through the activity is
30 carved up?
31

32 MR PORTELLI: That's correct.
33

34 MR MUSTON: So not to the level of, "These are the sort of
35 outpatient clinics; these are the sort of procedures that
36 you should be offering through your LHD"?
37

38 MR PORTELLI: No.
39

40 MR MUSTON: And I gather that that's because, in the
41 devolved arrangements, a degree of flexibility, at least
42 within those broad budgetary headings, needs to be given to
43 the LHD to decide what, within those headings, is best
44 going to meet the needs of their communities?
45

46 MR PORTELLI: That's correct.
47

1 MR MUSTON: How does the divvying up even into those
2 headline items happen? How do we decide whether
3 a particular LHD, in this case Murrumbidgee, should get
4 43,000,365 NWAU for acute admitted care as opposed to a
5 little bit less than that in the acute admitted space, but
6 a little bit more in the mental health admitted, for
7 example?

8
9 MS SMITH: We calculate growth at a stream level. So, as
10 I described before, we look at all of the different factors
11 that might drive growth, but then in the service agreement
12 process during the roadshows and in between the roadshows
13 we give the district the flexibility to decide how they
14 would like to carve up their total NWAU into these streams.

15
16 Of course, we have discussions about whether that's
17 reasonable and feasible and makes sense, but they do have
18 some flexibility which allows them to flex a little bit if
19 their service models are going to change in the coming
20 year.

21
22 So, for example, in years where there might have been
23 a lot of elective surgery catch-up they might have wanted
24 to put more activity in acute, but once they've caught up
25 they might want to move it back out into non-admitted, for
26 example. So that flexibility is there for them, but the
27 growth itself is calculated at a stream level but they can
28 move between streams and we agree that through that
29 negotiation process.

30
31 MR MUSTON: So when you say that they are able to carve it
32 up but there's still a discussion that happens to work out
33 whether it's reasonable and achievable, what is it that
34 makes it reasonable and achievable? What's the difference?
35 Let's say, an LHD's made a decision that it wants to
36 substantially reduce its acute admitted but increase its
37 mental health non-admitted, hypothetically?

38
39 MS SMITH: So we would like to understand what changes to
40 service delivery are going to occur in line with that and
41 we would want, if it has a particular policy impact, to
42 discuss that with the policy area before we go ahead and
43 effect that change in their service agreement.

44
45 MR MUSTON: But doesn't --

46
47 MR CARR: I was also going to say, Sharon, you'd also look

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

3
4 MS SMITH: Yes.

5
6 MR MUSTON: In what sense is the historical performance
7 important?

8
9 MS SMITH: If they've always delivered the majority of
10 their activity in that stream and now they are suggesting
11 that that is going to change, we'd want to know what
12 material changes are going to occur so that that is
13 reflected in their activity monitoring throughout the year.

14
15 MR MUSTON: I think we've accepted that whichever of those
16 headline items you were to allocate the activity to, and
17 whichever way you were to choose to distribute it, you
18 would be able to - they would be able to generate the
19 activity.

20
21 MS SMITH: Absolutely. And in fact, now in this year's
22 service agreement and going forward, we don't actually have
23 a KPI for each of those service streams; it's a total KPI
24 for their entire service agreement total. So we're not
25 actually necessarily holding them to account for each of
26 those service streams' activity, but when we publish the
27 service agreements, as a requirement under the NHRA, the
28 Commonwealth requires us to itemise the activity into
29 service streams. So we're following that requirement from
30 the Commonwealth.

31
32 MR MUSTON: And that certainly would account for the top
33 five service streams, which are the ABF captured service
34 streams?

35
36 MR PORTELLI: That's correct.

37
38 MR ONLEY: Yes.

39
40 MR MUSTON: I think earlier, Mr Portelli, you indicated
41 that there are KPIs - KPIs not necessarily for each service
42 stream but at least two KPIs, one for the ABF captured
43 activity and one for the non-ABF?

44
45 MR PORTELLI: That's correct. So what Sharon was
46 mentioning around the total, it would be the total NWAU as
47 per I think schedule 5 in the service agreement, whereas

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

3

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

10

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

17

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

21

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

28

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

35

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

44

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

1 requires an enormous amount of will and political acumen to
2 actually secure that, not just through the medical politics
3 but also the community politics and then macro politics.
4

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

10
11 MR MUSTON: But at the moment, there are impediments to
12 that, perhaps political impediments, to that being
13 achieved?
14

15 MR DALY: I wouldn't say "capital P" political but
16 certainly community pressure, and particularly in rural
17 areas which may have a greater scope for those
18 disinvestments for a whole host of reasons, many being
19 critical mass of investment, that is just really hard to
20 get through communities. It's hard enough in metropolitan
21 areas, let alone in those regional communities.
22

23 MR MUSTON: But the effect of that is, that compromises
24 the ability of those running local health districts to
25 actually utilise the limited budgetary envelope that they
26 have available to them in the way that they think, in a
27 properly informed way, actually best meets the health needs
28 of their communities; would that be right?
29

30 MR DALY: Well, I guess it would depend on the view of
31 both the chief executive, but also of their board, that is
32 made up of community members, as to whether they believed
33 that was right and/or achievable.
34

35 MR MUSTON: Perhaps one of those "lower case p" political
36 challenges that we could theorise about is closing an
37 emergency department in a small country hospital that
38 a view might have been taken - as we have been told in
39 evidence around the state, there are a number of them -
40 that chief executives think really should not be open, and
41 replacing them with a primary care provider of some
42 description. The chief executive would think that that is
43 what's in the best interests of the community and perhaps
44 best going to meet its health needs.
45

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

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

8
9 MR MUSTON: Is there an extent to which those "lower
10 case p" political forces are at play in the decisions
11 around which KPIs to include in service level agreements -
12 for example, emergency department waiting times and
13 elective surgery waiting times?

14
15 MR DALY: I don't know if it's political but, as I said,
16 just those two pathways oversee over two-thirds of
17 admissions into our public hospitals, so from a governance
18 perspective, you would be wanting to make sure both those
19 pathways, in all our LHDs and hospitals, are operating
20 well, because that's where the big bulk of your activity
21 is.

22
23 MR MUSTON: Let's put emergency departments to one side,
24 though. In relation to elective surgery, that's forming
25 the proportion of the services that we're offering at the
26 moment because they are the people who we're letting
27 through the front door and offering a service.

28
29 MR DALY: Sorry, what was the second bit?

30
31 MR MUSTON: That is because they are the people, or that's
32 the service, we are prioritising when we're letting people
33 through the door and offering them an operation. It could
34 just as easily be the case - just coming back to the now
35 well-trodden example of the community paediatrics picked up
36 through Brighter Beginnings, but the same proportion of
37 services could be offered through there, if that's where we
38 were deploying our resources. I'm not suggesting that we
39 necessarily would, but the fact that that, at the moment,
40 makes up a large proportion of our patients is because
41 that's the service we've chosen to deliver, isn't it?

42
43 MR DALY: I'm not sure it's of the same proportion, but it
44 would be a number I'm not familiar with, the number going
45 through those outpatient services.

46
47 MR MUSTON: I'll move on. So we've got the activity based

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

5
6 MR D'AMATO: Yes. So effectively, that adjustment
7 formerly known as the transition grant was in place as one
8 of the many, if you want, local adjustments to the activity
9 based funding model, so that no significant penalties or
10 significant shifts in funding were applied specifically to
11 regional hospitals or regional health districts. That
12 effectively is simply measuring the difference between the
13 state price, the state efficient price, and the cost of
14 delivering care for the particular LHD. Because ultimately
15 if you were to apply a pure ABF model, these districts
16 operating above the average that - we used to price the
17 average as the - to inform the state efficient price -
18 would have had to lose a significant amount of funding.

19
20 MR MUSTON: So is that what you tell us about in
21 paragraphs 21 and 22 of your statement, Mr D'Amato?

22
23 MR D'AMATO: That is an extra component to it. As
24 I mentioned, there are multiple components that we
25 introduce as local adjustments. One is what we called the
26 transition grant, which we now call CPA or cost price
27 adjustment.

28
29 In addition to that, in identifying the variance
30 between the state efficient price and the cost of
31 delivering care, we also identify what we identify as
32 recognised structural cost. That is effectively applicable
33 to regional LHDs, where we acknowledge that no matter what
34 level of efficiencies they can achieve, they're never going
35 to be able to be the same state efficient price that the
36 rest of the system is operating at.

37
38 So we probably have used some - back then we used the
39 cost, for instance, of transport that is impacting on
40 regional districts more than others. This is also to
41 compensate where the national model doesn't accurately
42 reflect the cost, a cost structure, for instance.

43
44 MR MUSTON: Let's step it through. We've got the national
45 efficient price, which is a dollar figure per activity
46 unit?

1 MR D'AMATO: Okay.

2

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

6

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

16

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

26

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

32

33 MR D'AMATO: That's correct.

34

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

40

41 MR D'AMATO: That's correct.

42

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

45

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

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

10
11 Then we also witnessed a significant convergence into
12 the average - the average cost of delivering care, which
13 was a good outcome. At that point we started, if you want,
14 recognising some of the different cost structure, because
15 we recognise that certain LHDs will never be, you know,
16 performing at the same level of efficiencies as metro
17 districts. We then introduced a program of translating
18 part of the transition grants - that's what we called it
19 then - into activity. So, again, to drive more
20 efficiencies in the system.

21
22 Obviously, since then, we started working from the
23 very beginning with the different aspects of the
24 purchasing, and again, as I made a comment before, I think
25 our approach has been one that is trying to reach a balance
26 between a state price, efficiencies that we can drive under
27 the price using benchmarking information, and the
28 purchasing strategies on what we need to deliver, in
29 particular trying to make sure that there is an input from
30 the population base of the population needs into the
31 equation.

32
33 Then ultimately we moved to what we call now the state
34 efficient price, which is effectively something that even
35 the national model had aspirationally intended to achieve
36 at the right time, where they wanted to move away from an
37 average to set the price into something that is more
38 reflective of efficiency, and at that point we set the
39 price, and then COVID happened. So basically, that's where
40 we are now.

41
42 MR MUSTON: In terms of the concept, if COVID hadn't
43 intervened, we were told by Professor Duckett yesterday
44 that within any health service there are going to be areas
45 where you will have efficiencies that you can deliver
46 services at below the average price and make some savings,
47 as it were, or bank some money.

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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.

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

10
11 MR MUSTON: Putting to one side those highly specialised
12 treatments, heart-lung transplants and peritonectomies, the
13 business-as-usual type procedures, Professor Duckett also
14 indicated that large metropolitan hospitals that have
15 a higher turnover of procedures are usually able to deliver
16 that care in a way which is more efficient and therefore
17 means the larger metro centres tend to get themselves under
18 the average, whereas smaller centres, who perform
19 procedures less, will tend to be the ones that are over the
20 average. Would that be correct?

21
22 MR D'AMATO: Yes, that's exactly right. Probably in
23 section 67, the chart that illustrates the transition
24 grants over time gives evidence to support that claim, in
25 that, as you can see, when we started the journey, we
26 identified a large component, being the green, reflecting
27 the transition grants in the metro LHDs, versus the dark
28 blue, which was the transition grants originally identified
29 in rural and regional LHDs.

30
31 Over time, and particularly in a relatively quick
32 turnaround, if you want, over three years, you can see that
33 the green amount reduced significantly, and that was
34 obviously because of volume; because of data also, in terms
35 of in introducing ABF from day one there were probably
36 significant data improvements that contributed to this, and
37 ultimately, you know, the ability of districts to start
38 benchmarking their costs and identifying opportunities to
39 deliver that care at the more efficient cost.

40
41 MR ONLEY: But it also recognised, too, that we had
42 acknowledged the cost structure in those rural ones, and
43 you see the RSC component has increased in its place, and
44 there is a difference between the RSC and the transitional
45 cost price. One, you had to drive efficiencies through the
46 growth; the RSC was a recognition that your cost structure
47 is higher and there's no penalty, so --

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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

1 paediatric adjustments, for instance, 81 million, and you
2 can see in the last two columns how these have been
3 allocated to the different groups of LHDs.
4

5 So, for instance, in that particular case, the
6 paediatric adjustment, we have reflected that of the
7 81 million, 10 million is allocated to the rural LHD. That
8 will be Hunter New England, because this adjustment is only
9 allocated to recognised paediatric services, and the
10 71 million, as you would expect, is all going to the kids'
11 network.
12

13 Then if you go further down, you can see there's
14 a remote area adjustment, and you wouldn't be surprised
15 that out of the 64 million, 54 million is actually
16 allocated in the budget of the rural LHDs, and so on. Just
17 to give you a sense of how, once we unpack the formula that
18 you can see below, it is reflected in the budget allocation
19 of the districts.
20

21 MR MUSTON: Putting the rural LHDs to one side for
22 a moment, you tell us in paragraph 31 of the statement that
23 you have made an application to IHACPA for some adjustments
24 to be added to the weightings to take into account the fact
25 that treating patients from a culturally and linguistically
26 diverse community was, as it were, more expensive.
27

28 MR D'AMATO: Yes. So the IHACPA process allows
29 jurisdictions to provide feedback throughout their
30 consultation period, which normally happens around
31 December/January, where states and territories have 45 days
32 to submit requests for additional adjustments or additional
33 elements that might not be captured in the national
34 efficient price determination or the national efficient
35 cost determination.
36

37 In the past, we have escalated the CALD as
38 a particular adjustment because of the feedback we received
39 from the districts. So in particular, in some of our
40 regions - namely, Western Sydney, South Western Sydney -
41 there have been suggestions that this is a significant
42 impact on the cost of delivering care.
43

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

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

3
4 The challenges for this particular group of patients
5 are that often they might use interpreters; there is an
6 assumption that some might stay longer, in terms of length
7 of stay, but some of the evidence actually has been showing
8 the opposite, in that they don't tend to stay longer than
9 the average length of stay, because at times there is an
10 assumption that they might not understand the staff and
11 they don't understand the workforce, so they prefer going
12 home and being treated by family.

13
14 So ultimately, the evidence that we were able to
15 provide wasn't conclusive enough at the national level to
16 convince IHACPA to introduce this particular adjustment.

17
18 MR MUSTON: Can I ask in relation to that, was the
19 evidence that you were able to gather conclusive enough at
20 a state level to at least persuade you, within the state,
21 that the cost of delivering care to the CALD community,
22 even though it might be difficult to identify precisely
23 which patients are within the CALD community and which are
24 not, having regard to the sorts of questions you might need
25 to ask to work that out, was higher than delivering care to
26 people who were not within that community?

27
28 MR D'AMATO: We did the work a while ago.

29
30 MR ONLEY: Look, I think on the CALD stuff, we have looked
31 at that several times. As Alfa said, getting the actual
32 data is problematic.

33
34 MR MUSTON: Can I ask why that is, why getting the data is
35 problematic?

36
37 MS SMITH: I'm happy to take that, if you like. So we
38 definitely have strong data at a population level, so we
39 know from the census data, for example, in different parts
40 of the state, the number of people born overseas, those who
41 use a language other than English, et cetera. But in our
42 hospitals data, which is what we are required to submit to
43 IHACPA to provide the evidence, it isn't as strong, as in
44 particularly the proportion of people that speak a language
45 other than English, it's not an item that nationally is
46 well collected. So having a really strong evidence base
47 that identifies all of the patients in that category is

1 difficult.

2

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

7

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

11

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

15

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

19

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

26

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

34

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

40

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

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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

1 efficient, and at that point there was a call made to pay
2 everyone at the same price. That meant that we had to take
3 money out of other hospitals to give it to these hospitals,
4 and as a result, everyone's budget blew up. That's because
5 the hospital that was efficient realised that to get more
6 money, they just had to do more activity, and the hospitals
7 that were inefficient couldn't achieve the efficiencies
8 overnight and, as a result, kept being inefficient.
9

10 So as a result of that particular lesson, experiment,
11 when we stepped into the ministry we introduced this
12 concept of transitioning, so over time, and we've seen that
13 in the average cost, that the convergence has certainly
14 been as a result of an effort to maintain a system that's
15 safe and operating and, if you want, moderate some of these
16 risks. So that's one aspect that I think we need to
17 reflect on, and it worked for us in this case.
18

19 MR MUSTON: Does that also apply in relation to, say,
20 service change more generally, if you want to disinvest in
21 a particular service and invest in a new one, so you take
22 the view that the community doesn't really need something
23 that's always been done as much as it needs another service
24 which is not currently being provided, but obviously you
25 can't turn around overnight and say, "We're going to cancel
26 this one and start up the new one", because that (a) might
27 come up against some of the "lower case p" political
28 challenges that have been alluded to; and (b), from
29 a workforce point of view, you've got human beings who are
30 delivering a particular form of care and not another one
31 and there's a period of transition that you need to go
32 through in order to change the shape of your workforce to
33 change the services you are delivering?
34

35 MS SMITH: If I pick up on your example before the break
36 of knee surgery versus paediatric services in the
37 community, you can't turn an orthopaedic surgeon into
38 a speech pathologist, for example, overnight, so it would
39 be a transition if you were to disinvest in one and start
40 another.
41

42 MR MUSTON: Does that mean you effectively need some
43 headroom, in terms of your funding, in order to scale one
44 of them down while you are building the other one up?
45

46 MS SMITH: Absolutely.
47

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

6
7 MS SMITH: Not to mention that that could take 20 years.

8
9 MR MUSTON: Yes. But that probably gets us to an
10 important point: service planning, and funding decisions
11 which support good service planning, needs to be done
12 ideally on, say, a five- or 10-year horizon, does it not?

13
14 (All witnesses nod)

15
16 MR DALY: Yes.

17
18 MR MUSTON: It's dynamic and needs to be reassessed, if
19 not constantly, year on year to work out whether changes in
20 technology have meant that maybe we didn't think that we'd
21 need - well, we thought we'd need some cardiothoracic
22 surgeons but now technology has changed and we think,
23 instead, we need cath labs, and we can roll them out, but
24 subject to those sorts of changes, it needs to be something
25 which is being thought about system-wide, but also within
26 each local health district across a 10-year or longer
27 horizon?

28
29 MR DALY: Yes, and that is something that the secretary
30 and the ministry executive have identified, and we've
31 started work on it with some new role configurations across
32 a number of branches in the ministry.

33
34 The genesis for it - sorry to go back to the past -
35 was a very clear, in fact, direction from government, from
36 the minister at the time, as part of the devolution to the
37 LHDs, to disinvest, to support local service planning,
38 which initially I'm sure occurred, because the appropriate
39 branches of the ministry were dissolved and some of that
40 skill set went into the LHDs, but over the last decade,
41 since that devolution in 2010, I think there's been a fair
42 degree of disinvestment in those planning resources, such
43 that there's not the strength that there used to be
44 centrally, and it's patchy, to be kind, across the LHDs,
45 so --

46
47 THE COMMISSIONER: This is the "missing middle", is it,

1 that Mr Minns was talking about when he gave evidence,
2 in terms of what you are talking about in terms
3 of planning --
4

5 MR DALY: I'm sorry, I'm not familiar with what Phil said,
6 but it's sounding like it.
7

8 THE COMMISSIONER: I think it is, yes.
9

10 MR MUSTON: It's a regular target for efficiency drivers,
11 isn't it, that middle management?
12

13 MR DALY: You can disinvest in management but you can't
14 disinvest in service. That's a lot tougher.
15

16 MR MUSTON: Just to make sure we've understood correctly,
17 the discussions that are happening at the moment, driven by
18 the secretary, are, what, a rebuilding of that capability
19 within the ministry?
20

21 MR DALY: Strengthening it, yes. It's there to the extent
22 of where it informs some of our capital programs. Is it
23 there to the extent of providing evidence-based guidance to
24 each of those LHD service plans on national, international
25 or professional best practice? It's not strong enough for
26 that, and for a chief executive to deliver a clinical
27 service plan that may or may not inform a capital
28 redevelopment, there inevitably will be changes in profiles
29 that can often be very difficult to be accepted by some
30 professional groups, hence the need for the evidence base
31 to demonstrate the efficacy of preference in a service
32 profile for that particular population group, and whilst
33 there is that there, to a component to inform our capital
34 developments, I think as an executive - and certainly the
35 secretary doesn't believe it's strong enough to inform
36 better clinical service planning, so that's a journey we're
37 just starting on at the moment.
38

39 MR MUSTON: It goes beyond capital planning, though,
40 doesn't it?
41

42 MR DALY: Oh, yes.
43

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

1 because we've always done it?"

2

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

7

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

10

11 MR DALY: I'm sorry I used that.

12

13 MS SMITH: At least the kidneys.

14

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

16

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

24

25 MR DALY: Do you want to answer?

26

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

29

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

35

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

45

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

1
2 MR MUSTON: A strong role of the ministry which is being
3 restrengthened now, you tell us, through the direction of
4 the secretary. What about at the LHD level? Do they
5 require resourcing to enable that sort of capacity to be
6 built within the LHD to enable them to resist the forces
7 that might be operating within various facilities and
8 various departments that have, for good or bad, the
9 practical effect of shaping the way our services look and
10 are delivered?

11
12 MR DALY: This is an opinion, and Alfa, who oversees the
13 capital program, might have a more empirical answer to you,
14 but I think I used the word "patchy" quite intentionally,
15 because I think where there has been a strong capital
16 program within an LHD in recent times, by necessity, they
17 may have needed to maintain a stronger planning presence
18 than those LHDs that may not have had a very strong and/or
19 active capital program and hence disinvestment probably
20 occurred.

21
22 MR MUSTON: Does anyone have anything they want to add to
23 that?

24
25 MR D'AMATO: No, apart from the fact that I agree with the
26 comment. It is patchy and it is certainly, you know, more
27 the result of the - whether it is the capital program,
28 whether it is the CE or there is an historical capacity and
29 capability that they retain at the district level, because
30 ultimately when we were in area health services there was
31 one group, and when we split then the groups, you know,
32 ended up in one part and - you know, so at times from - and
33 again, like, my experience, some of the more experienced
34 ones ended up in one part of the district.

35
36 MR MUSTON: The connection between potential planning
37 capacity within the districts and a capital project
38 suggests the two are closely connected across the board,
39 but the planning capacity that might exist within the
40 districts which have a new build happening, is that service
41 planning which is being done LHD-wide or system-wide or is
42 it more targeted to, "What are we going to do with the, as
43 a result of escalations, increasingly small pool of money
44 that we have to build this large hospital?"

45
46 MR CARR: My general - working in Central Coast more
47 recently, I think there's one or two people there doing

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

5
6 MR MUSTON: So it's limited resource for them and limited
7 funding resources to be making these transitional decisions
8 about disinvesting and changing the shape of the health
9 system to better meet the evolving needs of a particular
10 community, in any event, even if it was part that was well
11 resourced; would that be right?

12
13 MR CARR: Yes, that's a bigger, higher-level piece of
14 work.

15
16 MR MUSTON: But ultimately you could have all of the
17 planning resources, the best service planning resources in
18 the world, but unless you actually have the funds available
19 to give effect to that planning, it's - it looks good on
20 paper; is that so?

21
22 MR D'AMATO: Just on a general comment, I think there are
23 also opportunities to focus more on the strategic planning
24 side of things, not just the capital planning, because
25 I think at the moment it is relatively fragmented, and
26 I agree with the comments being made, but there is an
27 opportunity in better integrating these strategic plans
28 that could help us going forward.

29
30 MR MUSTON: So, for example, and not wanting to put up
31 a hypothetical example that shocks the people of the south
32 coast, but, for example, there might be particular services
33 which could adequately be delivered to people within the
34 southern LHD, or at least the eastern half of the southern
35 LHD, through, say, Wollongong, which would enable Southern
36 NSW LHD to disinvest in an expensive and inefficient form
37 of care and perhaps redirect those moneys into other areas,
38 but that sort of system-wide planning, where precisely
39 what's being offered at different LHDs in the way in which
40 you might have, whether you call them centres of excellence
41 or just centres where particular procedures are done in a
42 more efficient way, that's not happening, I gather, at the
43 moment?

44
45 MS SMITH: I think ideally we want a balance between those
46 that have local knowledge of the community and the services
47 that are delivered and then those that have oversight of

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

5
6 MR MUSTON: You say "ideally". Do I gather from the word
7 "ideally" that we're not there yet?

8
9 MS SMITH: I think that would be a reasonable assumption,
10 yes.

11
12 MR MUSTON: Which bit is missing?

13
14 MS SMITH: I think, as Matthew has alluded to, the
15 secretary has given the direction that that's where we need
16 to be, but we're not there yet.

17
18 MR MUSTON: I'm about to move to another topic,
19 Commissioner, if that's a convenient time.

20
21 THE COMMISSIONER: It certainly is. We will adjourn until
22 2 o'clock. Adjourn until then.

23
24 **LUNCHEON ADJOURNMENT**

25
26 THE COMMISSIONER: Yes, when you are ready.

27
28 MR MUSTON: So if I can move on to another aspect of the
29 funding model, which is the block funding of smaller
30 hospitals, that's something, as we understand it, that
31 flows through the ABF system from the Commonwealth. So to
32 the extent that the Commonwealth is funding or has
33 identified a hospital with a particular level of activity
34 as a block funded hospital, the state funds it via that
35 mechanism; is that right?

36
37 MR D'AMATO: Yes, that's correct.

38
39 MR MUSTON: In terms of the size of the block of funds
40 which are allocated to the hospital, is that a state-based
41 block or a Commonwealth-identified block?

42
43 MR D'AMATO: If I may, in our statement, when you look at
44 the service agreement for Murrumbidgee, it identifies an
45 item for small hospitals.

46
47 MR MUSTON: That's paragraph 26 on page 6.

1
2 MR D'AMATO: Thank you. That's the allocation. That
3 particular allocation sits above the line in that, above
4 the state-only block, so that component is actually in
5 scope for Commonwealth. The total allocation in this case
6 for Murrumbidgee is 265.8 million. Murrumbidgee has around
7 28 small hospitals, amongst the whole group of hospitals.
8 In fact, the majority of those small hospitals are within
9 five LHDs. So we have 108 small hospitals across the
10 state. That includes also the regional ones and the
11 regional predominantly are Hunter New England, 25;
12 Southern, six; Murrumbidgee, 28; Western New South Wales,
13 32; and Far West, six.

14
15 The overall allocation is, at the state level, in
16 expense, gross expense, around 757 million, and we have
17 conducted an analysis as a result of a recommendation from
18 the regional inquiry in regards to the funding allocated to
19 the small hospitals, and that review identified that there
20 were significant diseconomies of scale that weren't quite
21 well accommodated within the current funding model and
22 therefore --

23
24 MR MUSTON: Just pausing there, the block of funds which
25 had been identified for, say, the hospital in Batlow -
26 which, if my memory serves me correctly, was a block funded
27 hospital - was identified as, through this process, not
28 quite being enough to actually operate that hospital and
29 deliver the services being delivered through that hospital?

30
31 MR ONLEY: I can't remember whether Batlow is an MPS or a
32 small hospital. I think --

33
34 MR MUSTON: I think it is an MPS, now that you say that.

35
36 MR ONLEY: So MPSs didn't fit into the small hospital
37 category that Alfa was talking about. The numbers that are
38 on the statement here, they're funded - the same as they're
39 funded on the state price, small hospitals are funded on
40 the New South Wales funding small hospital model.

41
42 MR MUSTON: Is the New South Wales figure lower than the
43 Commonwealth figure --

44
45 MR ONLEY: No, it actually --

46
47 MR MUSTON: -- much like the national efficient

1 price versus the state efficient price?

2

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

12

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

17

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

20

21 MR ONLEY: Correct.

22

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

24

25 MR ONLEY: Correct, yes.

26

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

32

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

41

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

47

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

5
6 The variable component doesn't necessarily line up
7 exactly with the New South Wales state price or state
8 efficient price, but it's close to it, so that there's not
9 enough variation to create a disincentive.

10
11 MR MUSTON: The decision about which hospitals are block
12 funded and which are ABF, is that driven by the state or
13 the Commonwealth?

14
15 MR ONLEY: We follow the Commonwealth modelling.

16
17 MR D'AMATO: That's been set by IHACPA, and a number of
18 years ago we argued that the definition back then had to be
19 changed, but we were unsuccessful with the argument. We
20 argued that the definition should apply only to admitted
21 activity rather than all activity, only because of the
22 volatility of some of the non-admitted and community
23 health, in particular in the regions, but we didn't win the
24 argument. So as a result, the threshold is 3,500 NWAUs
25 across all activity labels, whether it is subacute, mental
26 health or ED.

27
28 MR MUSTON: We have heard evidence in our travels around
29 the regions to the effect that there are hospitals that sit
30 above that threshold but are, nevertheless, relatively
31 small hospitals, for example, Cooma Hospital, which it is
32 said is not well met by or well funded through the ABF
33 model because of the nature of the services that are needed
34 to be provided there because, of issues such as the
35 geography and the demographic of the population, but the
36 cost of providing those services on relatively small scales
37 is not properly reimbursed through ABF.

38
39 MR D'AMATO: Can I just make a comment in regards to
40 Cooma. So as we discussed before, we have local
41 adjustments, and local adjustments have been put in place
42 exactly for places like Cooma, because there are two
43 different dimensions to be mindful of. One is the
44 Commonwealth revenue, and effectively, when we do our
45 analysis, in interrogating whether hospitals should be
46 block or ABF, we take into account in terms of revenue are
47 we better off where it is? And the answer at this stage in

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

3
4 MR MUSTON: Just pausing there, when you say "better off",
5 better off in what sense?

6
7 MR D'AMATO: Revenue, as in the Commonwealth contribution,
8 because the Commonwealth contribution is guided. Where
9 there is ABF, there is a volume times price, times
10 Commonwealth contribution rate to determine what is the
11 revenue they will receive, otherwise there's a different
12 formula for a block-funded hospital.

13
14 MR MUSTON: So from the perspective of the state, taking
15 a hospital like Cooma, for example, keeping it in the ABF
16 space rather than block funded means, system-wide, the
17 state gets more money from the Commonwealth than it would
18 if it were to convert it into a block funded facility?

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

21
22 MR MUSTON: From the perspective of Cooma Hospital,
23 though, or Southern NSW LHD, how does it work for them?

24
25 MR D'AMATO: Effectively because we are taking into
26 account recognised structural cost, we're taking into
27 account these economies of scale that may apply, that is
28 accommodated from the expense side of this equation, so
29 jumping to a conclusion whether the hospital should be in
30 ABF or block, I think we should just unpack a little bit
31 more of that equation to take into account these different
32 dimensions.

33
34 I believe that, obviously, this is something that we
35 review regularly, based on the feedback we get from the
36 districts and again, going back to what Neville mentioned
37 before, we did create an environment where the small
38 hospitals are better connected in terms of funding and
39 activity with the ABF hospitals, through the process of the
40 purchasing they have in place, where they purchase
41 everything, whether it is delivered from a small hospital
42 or an ABF hospital.

43
44 So I think we try our best to accommodate and balance,
45 the risks, but I think that, at times, we probably just
46 need to recognise that these assessments need to be taken
47 into account from the revenue, state perspective, versus

1 the expense.

2

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

10

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

14

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

20

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

26

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

33

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

42

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

1
2 MR MUSTON: While stretched, the workforce is apparently
3 there, but from a funding point of view, what they say is
4 when you take the amount of activity which is claimable for
5 107 deliveries and you add that to the state efficient
6 price as adjusted, or multiply that by the state efficient
7 price as adjusted, it doesn't come close to meeting the
8 costs of running a 24/7 maternity facility.
9

10 MR D'AMATO: I would argue that that wouldn't necessarily
11 be the correct formula either. In fact, if they were then
12 able to then add recognised structural cost, which is on
13 top of the state efficient price and all the block funding
14 that we provide as part of their budget, might be a better
15 assessment.
16

17 The other side of this is, ultimately, as we
18 discussed, and Professor Duckett has mentioned, it's all
19 about averages. At times there will be winners and at
20 times there will be losers. This particular case, I think,
21 is perhaps more complex than just simply saying it is an
22 average, but I think we need to acknowledge that we try our
23 best to balance the whole risk, and we can always do
24 better, but it's not something we're ignoring at the
25 aggregate - at the district level. That's the reason why
26 we adjusted for the medical workforce this year and we
27 provided some additional funding for the block funded
28 hospitals. With that particular district, we've been
29 monitoring their performance, financial performance, for
30 a number of years.
31

32 MR ONLEY: I think it's important too that the ministry
33 funds the districts, the districts fund the facilities. So
34 whilst we might provide a level of funding to the district,
35 I don't know what, then, the district provides to the
36 facility, and we have had instances where it may not be the
37 same.
38

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

1
2 MR ONLEY: The general process has been that subsequent to
3 the budget going out they get a workbook which details,
4 from their costing information right through to the
5 allocation process to the facilities, how we have allocated
6 the budget, and then there's provision in all of that for
7 them to reallocate as they need to. That goes to the
8 finance people. What they tell the CEs --

9
10 MR MUSTON: So to use that example, the example we've just
11 been talking about, as part of the overall budget delivery
12 process, there would be a handbook which is provided that
13 says, "This is the amount of dollars that we have provided
14 to you on account of the anticipated costs of running Cooma
15 Hospital"?

16
17 MR ONLEY: It's not a handbook, it's a series - it is one
18 spreadsheet with a whole series of workbooks in it, which
19 goes through the RSC calculation, the cost price adjustment
20 calculations, the allocation splits from the costing and
21 savings into the budget format that we've got here, for
22 example, so they can trace back.

23
24 MR MUSTON: Do you find, as part of that process, you get
25 feedback from the districts whereby they say, "You've
26 identified X dollars that we've managed to trace back
27 through was referable to this facility. Our costing
28 suggests that the facility costs 1.5X. Why the disparity"?

29
30 MR ONLEY: We're using their costings, so it shouldn't be
31 different.

32
33 MR MUSTON: But while accepting that that maybe should be
34 the case, do you get that feedback from them, or is there
35 that level of engagement with the districts where they have
36 managed to trace back through the figures and identify
37 figures referable to facilities and particular cost centres
38 and raise with you the potential disparity between what
39 they perceive to be the real costs and those which have
40 been allocated?

41
42 MR ONLEY: I think each year there's been one-on-one
43 discussions with all the districts to finance about the
44 workings and how it works, and obviously feedback, but the
45 budget to that extent is indicative for them, that they're
46 able to reallocate the total bucket that they've got
47 available there, and the workbook provides for them to make

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

3
4 MR D'AMATO: It probably is fair to say that we have had
5 some challenges over the last few years, particularly
6 because at each time of these iterations we need to then
7 back out all the one-off funding, particularly one-off
8 funding related to COVID, and it wasn't an easy task.

9
10 Again, going back to before COVID, this exercise was
11 very - it's all been transparent, but it was much easier to
12 be interpreted by the local districts. I think that
13 tracing back through the costs and the cost data in the
14 submission was much easier because we didn't have to,
15 again, remove all these one-offs, whether it was for PPE or
16 whether it was for additional testing, COVID testing and
17 the like, and it creates some significant challenges.

18
19 However, from this year, now, again, we're stepping
20 into this new post-COVID environment, I met with every CE
21 and at times with the chair, the board chairs, to step them
22 through their budget schedule and all of the additional
23 funding that we are allocating to the budget this year, and
24 to recognise that, at times, there are challenges in
25 comparing, if you want, last year's financial results to
26 the new budget, precisely because a number of the results
27 included one-off funding or the results of one-off
28 initiatives that had to be backed out.

29
30 MR MUSTON: In relation to the one-off initiatives, the
31 next aspect of the funding that we've heard something about
32 is program specific funding.

33
34 MR D'AMATO: Mmm.

35
36 MR MUSTON: Could you explain where that fits into the
37 equation?

38
39 MR D'AMATO: There's a number of program specific
40 funding - Brighter Beginnings or First 2000 Days is a good
41 example, or palliative care, mental health, drug and
42 alcohol. All are associated to either new NPPs that
43 required establishment costs up-front, in which case then
44 we'd provide this funding into the budget but outside the
45 actual NWAU, with an expectation that, with time, these
46 will form part of the base and through the NWAU.

1 Normally, these are monitored throughout the normal
2 process that we put in place, depending on the subject.
3 The ice inquiry, for instance, the outcome of the special
4 inquiry into the drug ice, was an initiative that is
5 governed by Dr Chant. So, for instance, under her unit,
6 there is a drug and alcohol unit, and they're normally
7 instructed where to send the funding in their service
8 agreement or - as well as outside the service agreement.
9

10 What I mean by "outside the service agreement" is
11 simply because at times these initiatives are approved
12 through the budget cycle, and at times these are very late
13 decisions, so the unit or the policy area are not in a
14 position to allocate the budget in the service agreement,
15 because they had to then develop an implementation plan, so
16 we'll do subsequent adjustments to the budget to take into
17 account that at that point the branch has decided where to
18 send money, just to give you some examples.
19

20 MR MUSTON: What's the usual time frame for some of these
21 program specific funding streams? They're not forever
22 funding, I assume?
23

24 MR D'AMATO: Well, no, that's a good point. I think at
25 times they are four-year, so they go over the forwards.
26 Then it becomes a concept of, as identified through the
27 process of the four-year with treasury, then determining
28 whether these should be continued or stopped - or
29 increased, at times, when there is evidence that supports
30 the actual expansion of these services.
31

32 MR MUSTON: It's been suggested to us sometimes that the
33 period of time that the funding is in place for is often
34 not enough to actually work out, in an evidence-based way,
35 whether it is something that should or shouldn't be
36 continued, which leads, almost inevitably, to a conclusion
37 that the evidence does not support the continuation of the
38 funding. That might be a cynical view. Do you have
39 a comment on that?
40

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

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

4
5 MR MUSTON: These are some of the items which have been
6 referred to us by the LHD CEs, as "soft funding" - that is,
7 funding that sort of exists and might come back, but it's
8 not sufficiently certain to enable you to employ the people
9 that you need, for example, on a long-term basis, to
10 provide that service.

11
12 MR D'AMATO: Look, I'm aware of some the challenges. I do
13 think that some of these need to be taken into
14 consideration on what is available overall, and some of the
15 evidence, as we discussed this morning, should be provided
16 back into the roadshow process, the purchasing environment,
17 so we can then take into account whether some of this
18 activity is actually delivered and will continue to be
19 delivered through the activity targets and therefore
20 purchased, or is outside. At times some of this is also
21 outside because it might be clinical research or the like,
22 which has a different funding source altogether.

23
24 MR MUSTON: Some of the project specific funding or tying
25 funding to a particular project enables funding to be used
26 to distribute resources in a way that achieves particular
27 priorities or strategies of NSW Health.

28
29 MR D'AMATO: That's correct.

30
31 MR MUSTON: Are there other ways in which the funding
32 structures are used to achieve priorities or advance
33 strategies of NSW Health?

34
35 MR D'AMATO: I think the main vehicles for us to
36 distribute funding are either through the purchasing,
37 therefore, through activity targets, or specific
38 initiatives. Specific initiatives are normally guided by
39 policy areas, they instruct us where to send the money and
40 how long for, and they are responsible for the evaluation
41 of those programs as well.

42
43 MR MUSTON: In relation to the purchasing, is there a way
44 in which the purchasing of activity is used to further
45 particular strategies or achieve key priorities within the
46 health sector?
47

1 MR PORTELLI: I mean, yes. The inclusion of some of the
2 NPPs themselves can get included into the service agreement
3 as well, so if they are related to activity that will
4 achieve that strategic outcome, then we include them into
5 the service agreement.
6

7 We again rely on the districts and their clinical
8 services planning and the service agreement structure
9 itself around the districts aligning to the strategic
10 priorities of an organisation, so our future health
11 strategy, the regional health strategy where relevant, and
12 through that linkage, it's up to the districts, with that
13 general discretionary pool, to, you know, allocate
14 resources according to what they think are the strategic
15 priorities in line with those guides.
16

17 We have in the past also used the purchasing framework
18 to push some other statewide programs that weren't done
19 through NPPs. So the "Leading Better Value Care" program
20 that Sharon spoke to before, is a good example of where we
21 have used that structure in order to further the objective.
22

23 MS SMITH: Another example would be the deferred care
24 package where there was specific funding provided to the
25 state to deal with the backlog of elective surgery
26 post-COVID. That was time-limited, and the money and the
27 expected activity formed part of the activity targets for
28 that particular year in which it was relevant.
29

30 MR MUSTON: To the extent that, at least in the post-COVID
31 environment, I think you've told us that budgetary
32 constraints are such that there is very little headroom to
33 make changes to the system or adjust the array of services
34 that are being offered as opposed to just dealing with the
35 fire hose of business as usual, there isn't a huge amount
36 of scope, is there, to use funding decisions around at
37 least the purchasing of activity to steer the health
38 service in any particular direction?
39

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

1 scenarios on what that envelope looks like.

2
3 You know, like I said previously, pre-COVID, the bulk
4 of the money that we would allocate through the purchasing
5 framework would have been known and communicated to the
6 system in February, giving districts and networks months to
7 plan for that and giving us a little bit of further time as
8 well to look through any requests that come through.

9
10 MR MUSTON: Other than in terms of the adjusters that are
11 brought to bear in identifying what portion of growth is to
12 be allocated from one LHD as opposed to another, what ways
13 are the size and health needs of the population resident
14 within a particular local health district being taken into
15 account in deciding how much activity, say, to purchase
16 from that district?

17
18 MS SMITH: It forms the bulk of those kinds of growth
19 decisions, because the size, the age distribution and the
20 underlying drivers of health consumption that might exist
21 within that community, as we said, in the past have been
22 the main drivers of allocation. So, you know, the
23 remainder, the new initiatives or other factors, are really
24 on top of that, but that's been the core of what we've
25 actually distributed.

26
27 MR MUSTON: That's the growth. Maybe I was not clear
28 enough in my question. So those are factors you're taking
29 into account in deciding how much a particular district's
30 budget should grow by. To what extent are those factors -
31 that is to say, size and health needs of the population
32 resident within the area of the local health district -
33 being taken into account in deciding what the base figure
34 should be?

35
36 MS SMITH: So every year when we look at that equity
37 component of the model, so we are looking at the whole base
38 at that point, and that does drive the adjustment, the
39 equity adjustment, that I spoke about earlier, between the
40 districts and networks. So if a district overall is
41 delivering or the residents are consuming less health
42 services than we would anticipate, then they will be
43 allocated more growth. So there's a reassessment of that
44 base every single year.

45
46 Now, to be honest, the amount that we've had available
47 to allocate on an equity basis has been relatively small,

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

5
6 But taking time is not always a bad thing, because
7 districts can't scale up really quickly, they need to
8 identify workforce in order to scale up. So it's a bit of
9 a balance between identifying that they need more activity
10 in their model and giving them the amount of time that they
11 might require to scale up to the level that we would want
12 them to be at.

13
14 MR MUSTON: Just in terms of the period of time over which
15 that equity might be introduced, on the current funding
16 trajectory, what sort of time scale are we talking about?
17 Is it a few years or --

18
19 MS SMITH: Yes.

20
21 MR MUSTON: -- decades?

22
23 MS SMITH: No. So the model works by dividing whatever
24 that quantum is by eight and then spreading that over the
25 eight years, even though it's recalculated every year. So
26 it might go up and down depending on what has happened in
27 that district in the previous 12 months.

28
29 For example, if they've had a new build open and they
30 have returned a lot of people that might have been seeking
31 health services outside of their district to their
32 district, then we might see that gap close quickly, but in
33 other cases, we might see it close very, very slowly.

34
35 MR MUSTON: What about the extent to which health services
36 are provided to patients from outside the LHD? How are
37 those sort of cross-boundary issues dealt with at the
38 moment?

39
40 MS SMITH: The activity is counted at the site that it is
41 delivered. So a really good example would be Royal Prince
42 Alfred Hospital, as one of our large hospitals in Sydney.
43 About 30 per cent of the unplanned activity that occurs at
44 Prince Alfred Hospital is actually residents of other local
45 health districts.

46
47 Now, that's not just because they have specialised

1 services there, it's also because a lot of people drive
2 past Royal Prince Alfred, or people that have accidents or
3 illnesses in the city are often taken to Royal Prince
4 Alfred, whereas other hospitals might have, you know, 2, 3,
5 4 per cent of their activity from residents from other
6 parts of the organisation or other parts of the state.

7
8 So that's in their base activity because they've
9 always delivered that activity for residents outside of
10 their local health district.

11
12 MR MUSTON: And so if we enhanced our planning
13 capabilities a little bit and we potentially had a more
14 strategic system-wide distribution of work across the
15 network to make sure it was being delivered as efficiently
16 and equitably as was practicable, then adjustments would
17 need to be made, and could be made, to the underlying
18 funding models to enable the place at which care was being
19 sought to be the place at which funding was delivered?

20
21 MS SMITH: We already do that to a large extent with
22 statewide services, so for example, ICU, level 6 ICU
23 services are networked across the state. So we take that
24 out and fund that separately. It's not just part of the
25 normal activity and growth model, it's funded first.

26
27 So there is an element of that. It doesn't mean we
28 couldn't consider further services as part of that
29 approach, and by doing that, we would make sure that if
30 there was a networked approach, if that's what is being
31 suggested, then the funding would go to the site that is
32 actually delivering that service on behalf of others.

33
34 MR MUSTON: Can I raise another topic, which is the
35 supplementation of budgets. If I've understood the
36 evidence that we've gathered so far, LHDs get given
37 a particular envelope of money within their service level
38 agreements.

39
40 MR D'AMATO: That's correct.

41
42 MR CARR: Initial budget.

43
44 MR MUSTON: Initial budget. Throughout the year, as
45 events arise, that budget is supplemented with a further
46 injection of capital, depending on - or not capital,
47 a further injection of funds --

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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

1 to encourage the districts to deliver what they need to
2 deliver. I think it is just a game of trying to find the
3 right balance.
4

5 Then there are other items that might be issued
6 throughout the year because of one-off initiatives that
7 might be, you know, approved - a good example - well,
8 actually this one, it was approved throughout the year,
9 wages, policy, been approved by government throughout the
10 year, then we adjust throughout the year, just to give you
11 some examples.
12

13 MR CARR: Depreciation, high-cost drugs are big amounts of
14 that. Like in '18 just to give you an example, '18/19 we
15 allocated about 1.28 billion, or about 6 per cent of the
16 initial budget. In COVID, that went up to 12 to
17 18 per cent, and last year it was about 8 per cent, or
18 a bit over 2 billion. This year, up to year to
19 date, October, we've allocated about 400 million, or about
20 1 per cent, so we've tried to really bring that amount of
21 budget forward into that service agreement, so to give them
22 greater certainty, it's one of our financial strategies for
23 this year.
24

25 MR MUSTON: For the non-accountants amongst us, why is it
26 that the depreciation can only be allocated by way of
27 a supplementation? Is it something that's not known
28 until --
29

30 MR D'AMATO: It is only the variances. We're talking
31 about the increases. So there is an initial budget
32 including depreciation, but because the final, if you want,
33 calculation of what is the new value of the assets, it
34 normally is recognising books in the system by October,
35 then the variances, whether it is up or down, are adjusted
36 after the service agreement. So it is not the entire
37 depreciation budget; we are only talking about variances,
38 again, so that no-one needs to absorb these into
39 their financial performance.
40

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

1
2 MR MUSTON: So that's depreciation. To the extent we're
3 talking about policy proposals and the like, it would seem
4 ideal if the system operated in a way that meant decisions
5 around all of those sorts of things were made in advance of
6 the allocation of the budget, such that a chief executive
7 of a local health district knew, subject to some variation,
8 what the bulk of their funding was going to be for the
9 year, so decision-making could be informed by that
10 certainty around the funding?

11
12 MR D'AMATO: I totally agree. I think that's certainly
13 what we lack at the moment. Look, after four or five years
14 of COVID where it was very challenging, it was very
15 volatile, what we really need to focus on, and that's what
16 we're trying to achieve this year with our financial
17 strategies, is providing as much certainty as possible to
18 the districts so they can plan. And at the end of the day,
19 that concept should be applied by treasury to us so we can
20 know a little bit earlier in the cycle what we can then set
21 aside for population and ageing, and potentially also for
22 prevention, as part of this what they call 4 per cent.

23
24 MR ONLEY: The initial elements of what you've just
25 discussed, they're all in that Murrumbidgee schedule, so
26 you can see the initial amounts there.

27
28 MR CARR: And the state budget is handed down, what,
29 first or second week of June, so there's a little bit of
30 time, and I think probably that's informed also by, I
31 guess, the Commonwealth budget earlier on in April/May,
32 yes. So there is a bit of a flow-on there, I think.

33
34 MR MUSTON: Can I ask, Mr D'Amato and Mr Carr and
35 Mr Onley, that you go to paragraphs 81 and 82, the last two
36 paragraphs of your statement. You've put forward the
37 potential need for a rethinking of the funding model so as
38 to produce something that's more of a blended funding
39 model, retaining some of the benefits of ABF but
40 recognising the importance and role of population equity,
41 the need for greater investment in prevention, et cetera.
42 What do you have in mind as a structure that you think
43 might be a good transition from the existing structure?

44
45 MR D'AMATO: So, first of all, we've started a bit of
46 a consultation internally with a number of CEs in respect
47 to what our thinking is. The thinking at the moment is

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

11
12 I guess the thinking at the moment is that the
13 operational side, you know, obviously combined with the
14 purchasing approach, could focus on operational KPIs,
15 versus the other part of the service agreement could focus
16 on outcome KPIs, something that would take a little bit
17 longer to monitor, and ideally can kind of provide us with
18 that blended approach and a bit of a balanced approach, in
19 that, from my point of view, having a good pipeline of
20 investment in the prevention could actually see benefits in
21 the other side of the service agreement, so they can
22 complement each other.

23
24 At the moment I feel everything is relatively skewed
25 to the acute settings, because that's the biggest component
26 of a budget, so not necessarily decoupling the two but
27 creating a strong link through certainty. That's one of
28 the concepts that we are exploring at the moment.

29
30 MR MUSTON: Do those of you involved in the purchasing
31 side of it have a view about how that might work?

32
33 MR D'AMATO: They're involved with the design of this,
34 too.

35
36 MS SMITH: We are completely supportive.

37
38 MR PORTELLI: I concur.

39
40 MR MUSTON: Could I ask Mr Daly, and your colleagues who
41 have subscribed to your statement, to go to paragraph 44
42 and following. I think we have probably largely covered
43 this off, but the discretion that is referred to in
44 paragraph 44 is dependent upon a degree of financial
45 headroom.

46
47 MR PORTELLI: Correct. That would be what I referred to

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

3
4 MR MUSTON: Have I understood your evidence correctly
5 that, at least in the post-COVID environment or the
6 immediate environment that we are in, that untied pool of
7 money that might be used for those discretionary purposes
8 is not, in reality, available to the LHDs?

9
10 MR PORTELLI: Certainly not in the proportions that have
11 been in the past, and it's linked to the statement by my
12 finance colleagues in paragraph 54 - there is a chart that
13 illustrates that reduction.

14
15 MR MUSTON: Perhaps I might invite your finance colleagues
16 to just explain exactly what that chart is telling us in
17 paragraph 54.

18
19 MR PORTELLI: I'm happy to. Yes, so it's basically the
20 white chart - so the light blue bar is detailing the total
21 sum of the activity purchased through the purchasing
22 process; the red shows you the quantum attributed to new
23 builds, so of the light blue, the red is new builds; the
24 dark blue talks about the population ageing and equity
25 funding that was contributed - that was, again, part of the
26 light blue there, and as you can see, that dark blue was
27 a pretty substantial portion, '18/19 it was well over
28 350 million, about just over 350 in '19/20, and then it
29 decreased substantially as the years went on.

30
31 This is not the total funding allocation to the
32 districts and networks, you know, my colleagues have spoken
33 about other avenues, but certainly in terms of that
34 discretionary pool of untied funds where the districts can
35 again respond to their local needs, bring to life the
36 clinical services plan, that number has substantially
37 reduced.

38
39 MR MUSTON: Has it reduced to a level where - an amount of
40 money which is provided for that purpose is, obviously,
41 always going to be useful, but there comes a point where
42 it's so small that it isn't actually enough to really
43 achieve any significant change or benefit. Where are we at
44 the moment?

45
46 MR PORTELLI: It's hard to say. Like my colleague Alfa
47 has clearly shown, there are other bits of funding that

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

7
8 I don't think another year of this will be
9 a sustainable way forward. I think we've got to a level
10 now that we know we will need to continue the way that we
11 have in the past. However, yes, it is difficult to know
12 exactly, right now, given all the other bits and pieces
13 flowing through, what the wash-up is of the last four
14 years.

15
16 MR D'AMATO: I think going back to Joe's comments, the
17 trend that you can see before COVID, in the last year,
18 '18/19, we were looking at around 450 million-plus set
19 aside to purchase activity. Now, since then, this amount
20 has dropped significantly and I believe this is
21 unsustainable. And that's what we're seeing across the
22 system, in that what we issue, effectively, is not
23 sufficient to meet the needs, and what we see is activity
24 above targets, so there is going to be a bit of a challenge
25 for us to live within this envelope.

26
27 MR MUSTON: And when we talk about activity there, just
28 for clarity, we're talking about both the Commonwealth
29 recognised activity and that activity which hasn't been
30 identified by IHACPA but is recognised by the state for the
31 purpose of funding decisions with its LHDs?

32
33 MR D'AMATO: Yes.

34
35 MS SMITH: Correct.

36
37 MR MUSTON: A number of LHDs, we are told, are above their
38 budgets and often by a significant margin, which has
39 resulted in a suite of efficiency regimes that have been
40 rolled out across the LHDs. Could I just ask which part or
41 branch of the ministry is responsible for delivering those
42 efficiency reports and preparing the efficiency reports?

43
44 MR PORTELLI: My branch.

45
46 MR MUSTON: What's the process that your branch goes
47 through in order to identify the particular efficiencies

1 which are to be harvested from the LHDs?

2

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

8

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

13

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

29

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

40

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

45

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

1
2 MR DALY: There's a number of performance improvement
3 teams in my mobs, most of them are under Joe. One very
4 busy one, obviously, is in relation to emergency
5 departments, patient flow to improve back-of-house flow to
6 support EDs; there's an improvement team around planned
7 surgery, how to manage planned surgery wait lists, theatre
8 lists; and there's also an efficiency improvement support
9 team, the EIST.

10
11 That's a team that has a lot of operational
12 experience, because it's the operations managers in
13 hospitals that drive expenditure, and they provide an
14 oversight and a consulting service, if you like, to the
15 EIP - to the LHDs in relation to their EIPs.

16
17 They do, on occasion, go in and do in-depth reviews,
18 sometimes at the chief executive's request, sometimes at
19 Alfa's request, sometimes at the secretary's request, if
20 she has concerns.

21
22 They also provide a lot of benchmarking data because
23 they've got a whole-of-system view and can provide evidence
24 around relative inputs for the outputs compared to other
25 like-size LHDs and hospitals. So they do a lot of work
26 around that.

27
28 MR MUSTON: We've been provided with a number of
29 documents, produced by I think that team, that have
30 identified areas of saving or potential areas of
31 efficiency. I might take you to a table that summarises it
32 in a moment if that is helpful, but one of the common
33 themes is FTE realignment, whereby it is said that FTE has
34 increased at a rate which outstrips the level of activity.
35 That's said to be demonstrative of a lack of efficiency.

36
37 Whilst one can see at least the superficial appeal of
38 that, what's the science that goes into working out
39 whether, in a particular case, an increase in FTE which
40 outstrips an increase in activity actually is reflective of
41 inefficiency or, rather, reflective of just the way in
42 which health care needs to be delivered in a particular
43 setting?

44
45 MR DALY: Well, it has been a not uncommon feature of
46 a number of LHDs, as I think you were pointing out, and in
47 an ABM environment, if you have a mismatch between your

1 inputs and your outputs, you don't have to be really bright
2 to work out that you are going to have a financial problem.
3

4 I think, in part, a major contributor has been a
5 hangover from COVID, which, whilst the price was adjusted
6 to pick up on additional costs around protective equipment,
7 infection control, additional cleaning, all of that was
8 added into the price to compensate, as we do these reviews,
9 here we are now really two years into BAU post-COVID - if
10 we will ever get to a BAU post-COVID - where we are still
11 discovering there are FTEs on that have not come off and
12 they were put on on time-limited funding for the COVID
13 period and for the COVID outcomes, but there has also been
14 a growth beyond, beyond their outputs, to deliver the
15 outputs which otherwise were being delivered pre-COVID. So
16 it has been a common feature.
17

18 MR PORTELLI: It's probably worth flagging that those
19 recommendations were not really - they have gone in based
20 on the benchmarking, based on data that the districts
21 themselves may not have had, that the executive or the
22 managers of the hospitals may not know; it's basically
23 trawling through the data and saying, "Here are some areas
24 where you might consider looking at whether or not these
25 parts of the business are running efficiently." It is
26 absolutely not saying, "You need to take steps in this
27 area"; it is saying, "You might want to consider this."
28 But often, as Matthew said, if you over budget and it is
29 not matched by, you know, activity, it's not matched by
30 anything else other than just being over budget, there is
31 a question about efficiency compared to the rest of the
32 state.
33

34 MR MUSTON: Is there not a possibility, though, that
35 a system which, with a finite budgetary envelope, continues
36 to deliver care perhaps at greater cost and across a wider
37 range of areas as we can do more by way of interventions,
38 results in the existing workforce and the existing level of
39 care that is being provided being spread ever more thinly
40 within that budgetary envelope, such that you get to
41 a point where the workforce is stretched to breaking point?
42

43 MR DALY: If the outputs were - if the delta of the
44 outputs to the inputs were not as large as what they are in
45 too many cases, I would agree with you, but that's not the
46 case.
47

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

13
14 MR DALY: I accept the human factor of the premise of your
15 second comment. I've got no evidence that pre-COVID was
16 unsustainable, having worked in this system for 30 years,
17 so I don't see any evidence to that effect.

18
19 MR MUSTON: Well, the evidence that we've received in our
20 hearings across the state suggests that the workforce -
21 that there are serious pressures in terms of the workforce
22 and the burden that is placed upon them across the
23 facilities. I mean, questions might arise as to what is or
24 isn't sustainable, but what's sustainable for them,
25 I guess - well, when it becomes unsustainable for them,
26 they will stop working, and that is a problem for the
27 state.

28
29 MR DALY: Mmm.

30
31 MR MUSTON: How do we work out what is a reasonable level
32 of efficiency and what is actually spreading things too
33 thinly in terms of the extent to which we are resourcing
34 the health sector to deliver a range of and a particular
35 amount of activity? As the authors of the efficiency
36 reports, you must have some answer to that.

37
38 MR PORTELLI: Yeah, look, you're talking about a concept
39 that's very large and it would be very difficult to sort of
40 quantify. A lot of the initiatives that the team look at
41 go back to what the awards say, you know, for particular
42 classes of staff. They look at the award ratios: are they
43 in line with what the award says? In many cases, things
44 are being done above the award and, you know, it's just
45 about bringing it back into line.

46
47 A lot of the FTE reductions aren't actually headcount

1 reductions, they are just better managing your service so
2 you reduce your overtime, and there are triggers in the
3 award to incentivise managers not to overburden their
4 staff. So it's not necessarily about reducing the
5 headcount; often the strategies are about better processes
6 and better management of the existing resource that you
7 have, which has the opposite effect of what you are sort of
8 describing, about reducing the burnout of staff.
9

10 So it just depends on the case in point about what the
11 benchmarking says, about how the protocols are. Health is
12 extremely protocol driven and so, over time, protocols and
13 practices can creep in that go above and beyond what was
14 previously done and it's just, again, about providing an
15 opportunity of a statewide team that looks across the
16 different, you know, hospital sites and goes, "Well,
17 actually, I've seen this work really well here. Have you
18 considered looking at it?" And it's about, you know, then
19 teaming them up with other sites as well where they can go
20 "Well, they can do it; why can't we?"
21

22 MR MUSTON: Sometimes doing that work and identifying
23 areas where hard efficiencies can actually be secured
24 requires a little bit of financial headroom in order to
25 actually do the work required to achieve that outcome,
26 would that be right?
27

28 MR PORTELLI: I would agree with that.
29

30 MR MUSTON: As part of this process, is there a flying
31 squad that comes in from the ministry to contribute to the
32 FTE which is available on the ground in LHDs so as to
33 achieve some of these objectives?
34

35 MR PORTELLI: There is a new team that has been spun up
36 that looks at health roster efficiency and using the tools
37 we have available to better use those tools to deliver
38 better outcomes for our staff. Where the particular
39 functionalities aren't being used properly, the team comes
40 in and helps train staff to do that. So that would be one
41 example, yes.
42

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

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

5
6 MR PORTELLI: I mean, LHDs do have a few teams in their
7 existing structures, so they've got performance units, they
8 have got people and culture teams, they've got nursing
9 teams at the district level. So this, theoretically, could
10 be appended to their existing workloads and actually should
11 form part of their normal workloads. I know in my time at
12 the district, we had these programs that we had to look
13 into in my team and support them. Again, we've been doing
14 this for over a decade. These aren't new programs. You
15 know, I think this should just be folded into business as
16 usual. As any kind of efficient healthcare system that
17 tries to deliver high-quality care, these are constant
18 mechanisms, and again, this is part of an evolution not
19 revolution kind of formula, it is how we constantly keep
20 our system efficient.

21
22 MR MUSTON: Is it not challenging for LHDs to do that,
23 though, when they are operating in an extremely
24 economically tight environment?

25
26 MR PORTELLI: I think everything is difficult in an
27 economically tight environment, but yes.

28
29 MR D'AMATO: I just want to add some examples where we
30 actually invested to make these changes on the ground,
31 whether that is procurement, procurement reform, where we
32 identified some challenges or some risks that could
33 actually be not only identified through additional
34 resources but actually free up further resources in regards
35 to contract management, for instance. So we provide the
36 funding to the districts to invest and improve their
37 capabilities around the contract management.

38
39 We're doing something similar in regards to
40 decommissioning of ICT platforms. Again, it is a very
41 challenging process, locally, but the investment is worth
42 it, given the return on decommissioning some of these, from
43 the cybersecurity risks as well as the ongoing costs of
44 maintaining certain systems that we don't use anymore. So
45 this is just to give you some examples. We always consider
46 whether there is a good opportunity to invest in the
47 districts to then achieve further efficiencies or savings.

1

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

7

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

25

26 MR DALY: Health has been training its own workforce for
27 100 years, and where increased new graduates were coming
28 on, the ministry has always been supportive - in fact,
29 through the chief nurse directly funding additional nurse
30 educators, as an example. But if the new graduate/new
31 trainee numbers are not increasing again, commensurate
32 with, take an educator of any ilk, then you've got to
33 question why that's the case. And, you know, to Joe's
34 point before, some of the practice is not about getting rid
35 of FTE, it's about, in some cases, complying with the
36 award, of which we don't have a choice, we're obligated to
37 comply with the award - the relevant union knocks on your
38 door if you are below the hours per day that are prescribed
39 on a ward, but no-one knocks on your door to say that you
40 are 25 per cent above the hours on that ward. And
41 similarly, just practices that had to be adopted during
42 COVID, such as the use of nurse specials - you know, early
43 in COVID, appropriately, the system responded by
44 specialising those COVID-infected patients, often on
45 a one-to-one basis, but, you know, as our understanding of
46 COVID, the management of COVID, and then as those
47 admissions have dramatically reduced, we should be going

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

10
11 So it was all about - and this was with the full
12 support of nursing executives and infection control
13 experts - going back to practices that were pre-COVID, now
14 that we're over, but COVID changed a whole lot of
15 practices, some for good and should be for good, but
16 others, there is no rationale for it.

17
18 MR MUSTON: Could I just come to two other parts of the
19 health service that are the subject of funding decisions.
20 The first is the ambulance service. We've been given some
21 evidence to the effect that the ambulance service is block
22 funded and has historically been block funded.

23
24 MR PORTELLI: That's correct. From a purchasing
25 perspective, we don't purchase activity from NSW Ambulance.
26 I understand, as we go through the discussions, there's
27 often an NPP around that looks to increase the number of
28 FTE within the ambulance service over - you know, a certain
29 number per year for a four-year period, and that usually
30 gives the bulk of their increase in funding, unless there
31 are other specific items that are negotiated with finance.

32
33 MR D'AMATO: Yes, normally the process for ambulance is
34 slightly different to the rest of the system in regards to
35 the activities we've purchased, and more recently, the
36 activities we've purchased have all been related to
37 decisions of government to either invest in additional
38 paramedics, whether in the metro region or in other areas;
39 additional stations - so the previous government announced
40 a number of additional stations; or wages increases. So
41 that's pretty much the bulk of it.

42
43 Obviously there are, at times, other more technical
44 considerations, in particular around the telecommunication
45 and other infrastructure that ambulance uses that the rest
46 of the system are slightly different in their approach,
47 that's all.

1
2 MR MUSTON: The block of funding provided to ambulance, or
3 the base of the block funding provided to ambulance, we're
4 told, has not historically been adjusted for growth?

5
6 MR D'AMATO: The block amount has always been adjusted for
7 cost escalation. The growth allocation was more related,
8 again, to the components related to more paramedics, and
9 effectively that is one of the key cost drivers in the
10 ambulance service.

11
12 I think now probably five or six years ago there was
13 an agreement to increase the number of paramedics through
14 a program called "SWEP", and basically over the four years,
15 we added more paramedics. When that concluded, then there
16 was another program started, and that's the one we are
17 going through at the moment.

18
19 So I'm not necessarily agreeing with the fact that the
20 base has not been adjusted. We could always do more, don't
21 get me wrong, but I think there has been recognition from
22 the government of the ambulance service and the importance
23 of ambulance services, and that's why they decided to
24 invest not only in more paramedics but also more
25 infrastructure to provide better services.

26
27 MR MUSTON: In relation to another block funded service,
28 justice health --

29
30 MR D'AMATO: Yes.

31
32 MR MUSTON: -- at some point in the past, a base was
33 identified as the cost of delivering health care within the
34 prison sector. Does anyone here know what that was based
35 on or what sort of medical service or medical care
36 delivered to prisoners was seen as an appropriate level of
37 care at the time that the base was arrived at?

38
39 MR D'AMATO: Look, I can't confirm, but I just want to
40 note that justice health, unlike ambulance services, is
41 also partly funded by the Commonwealth in respect of the
42 forensic mental health that is in scope for the NHRA,
43 whereas the service provided in prisons is actually state
44 only, funded by the state.

45
46 In regards to the base, it's a bit difficult. From
47 memory - I can't remember what it was, which area health

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

3

4 MR ONLEY: No.

5

6 MR MUSTON: When one looks to justice health, you
7 potentially have, by reason of your captive audience, as it
8 were, quite a nice bubble that you could use to identify,
9 in a fairly careful way, what are the health needs of this
10 particular small population; what are the services that we
11 should be providing to meet those health needs. One can do
12 a cost benefit analysis of all of those services and form
13 a view about the extent to which we as a public health
14 system should be meeting those health needs and then allow
15 funding to be informed by that process. Has that happened?
16

17 MR D'AMATO: Normally, the process happens through
18 different branches within the ministry. So the mental
19 health branch may at times allocate additional funding to
20 justice, and the drug and alcohol service might be also
21 investing in justice health. So these are the main drivers
22 for increases in the budget, apart from a number of years
23 ago where there was an uplifting to the base budget as
24 a result of additional beds - whether there was an
25 infrastructure development - that's when we adjusted the
26 budget.
27

28 MR MUSTON: We're told in evidence that there is a process
29 of changing the KPIs in the service level agreement that
30 justice health has with a view to not just identifying
31 targets for the delivery of service that meet a small part
32 of the need but, rather, identifying the need and the
33 extent to which it's unmet within the prison population so
34 as to perhaps create greater focus.
35

36 MR DALY: That's exactly right. I'd asked the chief
37 executive well over a year ago, because I chair their
38 performance management, and the KPIs are predominantly
39 green, which is a good thing, but then it does question
40 about are we challenging ourselves sufficiently and pushing
41 ourselves to maximise the input for that client base, and
42 she agreed - we're now in furious agreement. I've yet to
43 hear back from her as to what the new KPIs should be that
44 will stretch corrections health, and they are wanting to be
45 stretched.
46

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

1 probably currently feel a bit stretched - in order to
2 stretch in a positive way, they would need a funding
3 envelope to enable them to do it, presumably?
4

5 MR DALY: She has not raised that with me.
6

7 MR MUSTON: It has not been raised with you that the
8 funding envelope made available to justice health is not
9 sufficient to meet the health needs of the prison
10 population?
11

12 MR DALY: Not in any performance meeting I've had in the
13 last two years.
14

15 MR D'AMATO: One comment I need to make, their performance
16 in respect to the financial performance has been very good,
17 they have been on budget over a number of years, and
18 I appreciate that that doesn't mean that they have met all
19 the unmet needs, but financially they are performing very
20 well compared to the rest of the system.
21

22 MR MUSTON: Financial performance might reveal good
23 management and an effective way of doing the very best you
24 can with an existing budgetary envelope and not trying to
25 do more.
26

27 MR D'AMATO: I totally acknowledge that. As I say, just
28 looking at one KPI alone doesn't mean that we have good
29 visibility on what isn't met.
30

31 MR MUSTON: Coming back to an earlier question which
32 I suppose flows from that, has any attempt been made to
33 identify the extent of the health needs of the prison
34 population, the cost of meeting those health needs and then
35 making budgetary decisions informed by that, rather than
36 continuing to give the excellent financial managers at
37 justice health the same amount of money to keep doing, in
38 an excellent way, what they have been doing?
39

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

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

3

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

15

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

24

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

29

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

35

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

44

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

47

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

2

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

4

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

18

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

29

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

32

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

43

44 Mr Chiu, do you have any questions?

45

46 MR CHIU: No questions, Commissioner.

47

1 THE COMMISSIONER: All right. Thank you.

2

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

6

7 <THE WITNESS WITHDREW

8

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

10

11 MR MUSTON: I think the ACCHO roundtables next Wednesday.

12

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

14

15 MR MUSTON: Okay.

16

17 THE COMMISSIONER: We will adjourn until next Wednesday at
18 10 o'clock for the first ACCHO roundtable. Thank you.

19

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

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