Report of the NSW Health Council

A Better Health System for NSW

03/2000

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March 2000

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25 February 2000

The Hon Craig Knowles, MP
Minister for Health
Level 33
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

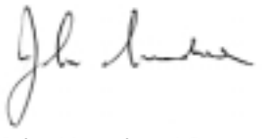
Dear Minister

It is with pleasure that I submit to you the report of the NSW Health Council.

I believe we have put forward an achievable, exciting and lasting set of recommendations which will improve the quality of health care for the people of NSW. I also believe that we have laid the foundations for a more responsive and adaptable health system as we move into the 21st Century. The changes we have recommended will significantly enhance the role of consumers, the community and clinicians.

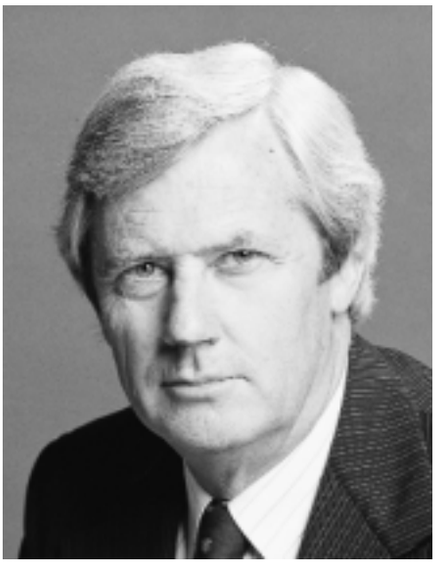
I would like to express my appreciation to the Council, to the Resource Group headed by Jennifer Westacott who assisted the Council and to the many people who gave so willingly of their time to assist us to prepare our report.

I commend to you our report and wish you well with its implementation.



John Menadue, AO
Chairman

Chairman's Message



Hospitals or Health?

In the course of our work I often speculated that we should have been called the Hospital Council. So much of our work and so much of the 'health debate' is really about hospitals and sickness, rather than health. The desire of many clinicians and managers to shift resources and provide more care in the community with an increased emphasis on both early intervention and keeping people well, gets lost in the clamour for more beds and more expensive facilities in hospitals.

About 12% of the population is admitted to hospital in any one year. Yet public hospitals absorb approximately 57% of the total State Government health expenditure. By international standards, there is not a strong case for more hospital beds. In 1997/98 the New South Wales rate for overnight hospital admissions was 157 for 1,000 population. In Canada it was 105, in the US 116, and in the UK about 130.

We know that preventive measures – better diet, more exercise, anti-smoking and anti-drink driving and immunisation campaigns – can produce dramatic reductions in sickness. But preventive measures do not deliver immediate health dividends and they don't have the same high profile champions that hospital services do.

Services should be based primarily around where patients and consumers live. The autonomy and dignity of each patient is best served by providing services wherever possible outside a hospital. So a shift to community multi-disciplinary health teams is a major issue still ahead of us. In our report we have not had time to sketch out how this might be achieved. Clearly, it is necessary to improve linkages between GP services in the community which are funded by the Commonwealth, and hospital services which are managed by the State.

Even more important in my view and what I regard as the key issue for the long term, is informing consumers and involving the community in their health care. Under day-to-day pressures, it is possible to lose sight of the big picture. Every organisation and every system needs to be firmly and consistently called back to its primary purpose. In this case, it is the health of people. If our recommendations in this regard such as the 24-hour Health Call Centre, the Electronic Health Record and participatory structures are implemented and driven with enthusiasm, the health of the community will prosper. Informed patients and an informed community are the best judges of the priorities for their own health system.

Behind all that we have described and recommended in this report, there is a major problem in an ever-growing demand for health services. The more facilities that are provided, the more they will be utilised. Doctor and patient pressures will not abate. It is similar in transport. The more money is spent on roads, the more cars are attracted onto them and Governments are then under pressure to build more roads.

We seem to want more of almost everything, including more and better health. We are inclined to believe there is a cure for almost everything, even inconveniences. With these high expectations, we don't discuss whether we are prepared to pay more taxes for better health, and tax is the most equitable and efficient way to raise money for health. At the end of the day the money has to come from somewhere. In New South Wales about 24% of the State budget is spent on health. Are we prepared to pay more taxes to spend more on health or would we prefer to cut back on education or other Government programs? Because health resources are limited, they have to be rationed. That is what waiting lists and waiting times in Emergency Departments are about. But instead of publicly debating the resources available for health and how priorities should be allocated within those resources, the current debate is about the symptoms, the closure of beds and even whether hot breakfasts in hospitals are going to be cut. How can we decide, for example, the merits of spending public money on the last few days of a patient's life rather than on babies, children and mothers? We need an informed and serious public discussion about health directions and priorities.

That is why we highlighted honesty as an important value and principle, particularly honesty about the resources available and what it is reasonable to expect from the highly professional staff within the system. We need to be open and honest with each other about what we are prepared to pay for our health services and how we want the money spent: on community and preventive care or acute care in hospitals?

My final comment goes to implementation. Much of what we have recommended is based on what we have seen working in the State's health care system. I want to put on record my and the Council's recognition of the many innovations in health care delivered by dedicated managers and clinicians in Area Health Services and the NSW Department of Health. The challenge is to ensure that excellence and innovation are not confined to one hospital, or one Area Health Service. There must be widespread implementation so that everyone in New South Wales shares the benefits of advances in technology, improvements to clinical practice, improved efficiency and better communication.

This will require the highest levels of leadership and commitment by clinicians, by local managers, by Area Health Services and by the Department of Health.

Health systems around the world have different strengths and weaknesses. I believe in NSW we do very well by world standards. But we have a lot of hard work and hard decisions ahead. I believe this report helps us along the road.

Thank you to my colleagues on the Council who gave so much of their expertise and time to assist with this report.

John Menadue, AO
Chairman

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TERMS OF REFERENCE

1. To deliver a plan to the NSW Minister for Health that provides effective strategies
   to improve the delivery of quality health services, better manage costs, and improve the health outcomes of people in metropolitan, regional and rural NSW.
2. The strategies in the plan will address the following objectives:
   - to improve the health of the people of NSW and ensure that patients and the community are the objectives of change
   - to ensure quality of care
   - to provide accessible and equitable health services across NSW
   - to increase the effectiveness and efficiency of the clinical services, Area Health Services, the NSW Department of Health, and the private and non-government sectors
   - to reform the Commonwealth-State relationship to deliver better systems, funding structures and arrangements
   - to better manage costs by fostering productivity and best practice, and clearly defining performance indicators
   - to enhance management and information systems in order to ensure the adoption of clinical and industry best practice
   - to determine the training needs of the future health workforce
3. The NSW Health Council will have regard to the following documents and issues:
   - Strategic Directions for Health 1998-03 – Better Health, Good Health Care
   - community awareness and understanding of health service provision issues and health service delivery trends
   - Australian Health Care Agreement
   - the role of the public, private and non-government sectors
   - best practice case studies
   - the location of health services
   - partnerships for comprehensive service delivery
   - information technology strategies for better delivery of administrative efficiencies, telemedicine, information sharing and cross-agency collaboration
   - appropriate frameworks for education, training and research
4. In developing the plan the NSW Health Council will further consider:
   - the need to ensure a flexible, effective, quality health system which responds to community needs, population growth, ageing and changes in clinical practice and technology
   - the need to ensure that the unique and diverse health needs of rural and remote communities are recognised
   - the available research findings on health policy, service delivery and health financing

MEMBERS OF THE NSW HEALTH COUNCIL

Mr John Menadue (Chairman)
Mr Menadue has held a range of positions including Secretary, Department of Prime Minister and Cabinet Office, Ambassador to Japan and Chief Executive Officer of Qantas.

Mrs Gabrielle Kibble (Deputy Chairman)
Mrs Kibble is the Chairman of Sydney Water.

Professor Stephen Leeder
Professor Leeder is Dean of the Faculty of Medicine and Professor of Public Health and Community Medicine at the University of Sydney.

Professor Margaret McMillan
Professor McMillan is Dean and Professor of the Faculty of Nursing at the University of Newcastle.

Professor Ian Webster
Professor Webster is Professor of Public Health in the School of Community Medicine at the University of NSW and Director of Population Health, South Western Sydney Area Health Service.

Associate Professor Brian McCaughan
Associate Professor McCaughan is Clinical Associate Professor of Surgery in the Faculty of Medicine at the University of Sydney and President of the NSW Medical Board.

Associate Professor Jane Hall
Associate Professor Hall is the founding Director of the Centre for Health Economic Research and Evaluation (CHERE) and Associate Professor in the Department of Public Health and Community Medicine at the University of Sydney.

Dr Barry Catchlove
At the time of conducting our review, Dr Catchlove is Executive Director with Mayne Nickless Limited.

Dr Heather Dalgety
At the time of conducting our reviews, Dr Dalgety was Deputy President of the NSW Rural Doctors Association.

Mr Paul Gross
Mr Gross is Chairman of the Board for Health Group Strategies Pty Ltd in Australia, France and Japan.

Ms Kate Quirke
Ms Quirke is Executive Director of Product Strategy and Marketing in the Asia-Pacific for iSOFT.

Mr Michael Reid
Mr Reid is Director-General of the NSW Department of Health.

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Linda Sorrell
Tim Wills

Executive Summary

OVERVIEW

Conduct of the review

The NSW Minister for Health ('the Minister'), The Hon Craig Knowles, MP, established the NSW Health Council ('the Council') in July 1999. The Council was required to undertake a review of the State's health care system[1] in accordance with the terms of reference set out in this report. Listed in the Appendices are the names of individuals and organisations from whom we received submissions and with whom we met.

When Council commenced this review, the State's health care system was under considerable pressure. This was particularly the case in areas such as access to Emergency Departments, access to Intensive Care services and waiting times for public hospital admissions.

Council believed that the most appropriate way to approach its task was to begin with an examination of the factors that were contributing to this pressure.

We met with a range of clinicians, health managers, consumers and stakeholders in order to hear from the people who were dealing with these challenges on a daily basis. We sought their views about what needed to be improved, what was working well and what they considered to be the practical and lasting changes that would relieve the pressure on health workers and improve access for consumers.

The State's health care system performs very well and generally provides excellent, accessible and affordable health care to the people of NSW.

Findings

Specifically we found that:

- The State's health care system performs very well and generally provides excellent, accessible and affordable health care to the people of NSW.
- The system is feeling the pressure of increased patient demand and rising costs.
- These pressures are not confined to NSW or Australia, but are common to many other health systems.
- The annual process of setting and allocating budgets limits the ability of clinicians and managers to plan their staffing and resource levels to meet peaks in demand.
- Clinicians and managers highlighted the need to understand the importance of linking various parts of the health system in the delivery of patient care. In their view, hospitals, specialists, general practitioners (GPs), community health teams, mental health teams and allied health workers all need to be linked together to provide continuity in patient care. They urged us to focus on these links in order to deliver lasting improvements to health services. For example, pressures on Emergency Departments are often caused by blockages in another part of the hospital, such as lack of access to a bed in a ward or access to an operating theatre.

The system is feeling the pressure of increased patient demand and rising costs.

- There is an emerging need to provide more coordinated care to people with chronic and complex health conditions such as heart and lung disease and cancer. Many of these people have multiple hospital admissions each year, and frequent urgent admissions through the Emergency Department.
- There are many innovative approaches to tackling the challenges facing Emergency Departments, Intensive Care Units and hospital waiting lists, and the treatment of conditions like diabetes, cancer, asthma and HIV/AIDS.
- More incentives are needed to promote widespread implementation of innovations in health care across NSW. These could include funds to support particular service improvements in addition to any overall growth funds in the health budget. This would allow new ideas to be tested without having to take funds away from other services.
- Clinicians must be more involved in setting and monitoring standards of clinical practice. This will provide a way of evaluating new approaches to providing care and will help ensure that the highest standards of quality are maintained.
- Consumers need more access to information about the nature of local services and easy access to advice and support about particular health problems, treatments and the performance of health care providers.
- There is a need to examine the role and distribution of health services in both metropolitan and rural NSW so that services meet the different needs of communities. This will require better planning, including greater community involvement.

More incentives are needed to promote widespread implementation of innovations in health care across NSW.

Focus of the review

In response to these findings we have focussed on the following key issues. We believe our recommendations provide practical solutions to current pressure points and will have positive, flow-on effects to other areas.

- We wanted to ensure that **access to health services** and the **quality of patient care** will continue to improve. Our recommendations therefore address the following key areas:
  - improving service delivery in the areas of critical care (Emergency Departments and Intensive Care Units) and planned and acute hospital admissions
  - enhancing services to rural communities
  - changes to the way care is provided to people with chronic and complex conditions like heart disease and cancer
  - improving patient information systems so that there are better links between health care providers
  - strengthening efforts to recruit and retain a skilled nursing workforce
  - improving the planning of metropolitan health services

- We devoted considerable attention to improving **funding** arrangements for the State's health care system. This includes recommendations about overall funding levels, the importance of funding certainty and improving the way individual services are funded to support the implementation of recommended clinical practice.
- We identified ways that **clinicians** can be encouraged to take a greater **leadership** role in setting and monitoring standards of clinical practice.
- We examined ways of increasing the involvement of individual **consumers** and **communities** in decision-making.
- We believe there are opportunities for greater cooperation with the **private** and **non-government** sectors in the planning and delivery of health care, and have identified some areas where further work is needed to foster that cooperation.
- Finally, we examined ways in which **planning, accountability** and **governance** arrangements could be improved throughout NSW Health[1] to support the implementation of our recommendations. This will need to be supported by a two-year change management and implementation plan led by the NSW Department of Health ('the Department').

VALUES AND PRINCIPLES

We believe that the following set of values and principles are fundamental to an effective and sustainable health system, and must guide the implementation of this report.

The role of a health system

We believe that the fundamental role of a health system is to improve the health of the population and to provide care to sick and injured people.

Equity

We believe that everyone in NSW should have equitable access to quality health care for comparable need, regardless of where they live, regardless of where they enter the health system and irrespective of whether funds are provided by the State or Commonwealth Government.

The right to information and choice

We believe that consumers of health care have a right to information and choice about the services and treatments available to them, and a right to information about the success of medical interventions and the performance of all health care providers in hospitals and medical practices.

Value for money

We believe that the community is entitled to expect that resources will be used efficiently, and will be prioritised to the areas of greatest need.

We believe that consumers of health care have a right to information and choice about the services and treatments available to them, and a right to information about the success of medical interventions and the performance of all health care providers in hospitals and medical practices.

We believe that a commitment to honesty is crucial – honesty about what medical intervention can achieve, honesty about the resources available and honesty about the expectations placed on managers and clinicians.

Rewarding excellence

The fundamental strength of any health system is the people who work in it. Innovation and excellence must be valued and rewarded.

Personal responsibility

Individuals must be assisted to take more responsibility for their own health, through better information and more active involvement in decision-making about their health care.

Social responsibility

The responsibility for a successful health system rests more widely than with health providers and managers alone. We acknowledge the need to address the social, economic and environmental factors which lead to poor health.

Honesty

We believe that a commitment to honesty is crucial – honesty about what medical intervention can achieve, honesty about the resources available and honesty about the expectations placed on managers and clinicians.

Compassion and dignity

We share a strong belief that health care must preserve and enhance autonomy and dignity, and be delivered with compassion and sensitivity.

DIRECTIONS FOR CHANGE

Improving service delivery

Based on the many excellent examples which exist in NSW, Australia and around the world, we recommend that service delivery should be improved in the following three areas:

- the management, funding and coordination of critical care (Emergency Departments and Intensive Care Units)
- the management of planned and acute hospital admissions
- the coordination of care of people with chronic and complex conditions, such as cancer and heart disease

Critical care

In December 1999 the NSW Government announced the provision of $45 million additional funding over three years to relieve pressure on Emergency Departments and Intensive Care Units ($15 million over three years to Intensive Care Units and $30 million over three years to Emergency Departments). We recommend that these funds should be linked to the following improvements to service delivery:

- **Intensive Care Units**
  We conclude that with the growing complexity of medical intervention there is a need to increase access to intensive care services. We have outlined changes which need to occur in the coordination, funding and quality of Intensive Care Unit services. We recommend that additional funds be tied to changes in those areas.
- **Emergency Departments**
  This report highlights some of the problems facing Emergency Departments – including a 7.2% growth in demand between 1997/98 and 1998/99,[2] and pressure on Emergency Departments caused by demands on other parts of hospitals, such as operating theatres and Intensive Care Units. We have also highlighted the difficulties associated with patients who have frequent and urgent admissions to Emergency Departments – such as people with mental health conditions or drug and alcohol problems, and elderly people with respiratory problems or heart disease.

  We are concerned about the growing use of Emergency Departments as alternatives to GPs. This is especially true in rural communities, where access to a GP is limited or where doctors do not bulk-bill.

We recommend that NSW Health develop a three-year emergency care plan to ensure the widespread implementation of initiatives which will improve the relationship between each Emergency Department and the rest of the hospital.

The three-year emergency care plan should ensure that the additional $30 million over three years provided by the NSW Government is directed to finding sustainable solutions by drawing on the innovative approaches already operating in many hospitals in NSW. These solutions should extend beyond Emergency Departments.

The three-year emergency care plan should also consider the role and distribution of Emergency Departments, particularly in metropolitan Sydney.

Planned and acute hospital admissions

Hospital admissions account for 57% of all NSW Government expenditure on health care.[3] Hospital resources should therefore be effectively utilised, admissions should be appropriate and hospital care should be better linked with other parts of the health system, so there is continuity of care and an emphasis on improving health outcomes.

Drawing from the successful implementation of initiatives under way in many NSW hospitals as part of the National Demonstration Hospitals Program, we have examined how hospital resources could be better utilised. Improved utilisation of hospital resources will assist with waiting list management and in reducing cancellations of elective surgery.

Hospital admissions account for 57% of all NSW Government expenditure on health care.[3] Hospital resources should therefore be effectively utilised, admissions should be appropriate and hospital care should be better linked with other parts of the health system, so there is continuity of care and an emphasis on improving health outcomes.

We have recommended a number of changes to clinical practice in public hospitals, including:

- The majority of elective patients should be admitted on the day of their treatment or surgery.
- Day-only admissions should increase.
- Clinical pathways should be more widely used in all NSW public hospitals.
- A common discharge summary should be developed, and the Commonwealth and State Governments should work together to increase computerised links between GPs and hospitals so that discharge information can be transferred quickly and easily.
- Clinical case management should be more widely used in all NSW public hospitals for patients having very complex treatment.

Priority Health Care programs for people with chronic and complex health conditions

Our primary objective is to improve quality of life for people with these conditions, their families and carers.

There is a compelling case for both Commonwealth and State Governments to improve the coordination and quality of health care to people with chronic and complex conditions. Many of these people have as many as three or more hospital admissions per year, of which as many as 30% are unplanned, urgent admissions through Emergency Departments.[4]

We recommend an enhanced, State-wide approach to the provision of health care to people with chronic and complex conditions, through three Priority Health Care programs. These will focus on early intervention, more care in the community and strategies to minimise crisis situations and unplanned hospital admissions. We have identified three key areas in addition to existing programs for mental health, Aboriginal and Torres Strait Islander health and drug and alcohol services: cardiovascular conditions, respiratory conditions and cancer. Our primary objective is to improve quality of life for people with these conditions, their families and carers.

The Priority Health Care programs will include:

- individual care plans delivered by teams of health workers such as GPs, community nurses, allied health workers and services such as Home and Community Care
- new patient information systems which give a complete picture of an individual's health and treatment history, so that vital information about diagnosis and treatment is easily accessible and the onus is removed from individuals to coordinate their own care and retain and recall complex medical information

The NSW Government has agreed to provide $45 million over three years to the Priority Health Care programs. We recommend that these funds should be applied to improving information technology systems, supporting the introduction of individual care plans (which in some cases might involve increasing the availability of clinical case managers in the community and in hospitals), training clinicians and supporting public education and health promotion activities.

Recruiting and retaining a skilled nursing workforce

A valued, respected and sustainable nursing workforce is essential to the future success of the State's health care system and to the quality of health services. Our report highlights the current shortage of nurses, particularly in midwifery and mental health. We are also aware of the number of registered nurses (up to 40,000) who are not pursuing an active nursing role, and the implications of this shortage for patient care.[5] We believe that urgent action is needed to target those nurses who are registered but who are working in other professions or leaving the workforce. We recommend that NSW Health continue with its research to identify the key triggers which would encourage nurses to return to the workforce, and that the outcomes of this research be supported and funded. We also recommend that the Commonwealth Government be encouraged to increase the number of training opportunities for nurses in NSW.

Using information technology to optimise the delivery of patient care

We recommend significant changes to patient information systems in the State's health care system over the next three to five years. We believe that the health systems in both NSW and Australia have been slow to follow the lead of other industries, where information technology systems have become a core feature of responsive service delivery.

We recommend the following changes:

- That NSW Health and the Commonwealth Government work together to develop an Electronic Health Record for every individual in NSW.
- That as a first step towards developing Electronic Health Records, NSW Health take action to improve the links between patient information systems within hospitals (such as transferring information from an Emergency Department to the wider hospital), between hospitals and community health teams and between hospitals and GPs.
- That NSW Health establish a Unique Patient Identifier for every individual in NSW, so that health care providers can identify with certainty the particular patient they are dealing with, irrespective of where the patient has entered the health system.
- That telemedicine be fast-tracked and the telecommunications system upgraded, so that clinicians can exchange diagnostic information and provide immediate care and advice regardless of where a patient is located.

All these initiatives will require an agreed plan between NSW Health and the Commonwealth.

We recommend that the NSW Government lead the way in ensuring that the highest standards of security and confidentiality are met, in order to protect the individual's right to control both the type of information recorded in their Electronic Health Record, and the type of information which may be exchanged between providers.

We believe that the health systems in both NSW and Australia have been slow to follow the lead of other industries, where information technology systems have become a core feature of responsive service delivery.

We recommend that the NSW Government lead the way in ensuring that the highest standards of security and confidentiality are met, in order to protect the individual's right to control both the type of information recorded in their Electronic Health Record, and the type of information which may be exchanged between providers.

We recommend the need for greater networking of health services throughout metropolitan Sydney. We emphasise that it is neither safe nor cost-effective to provide all health services from every location.

We believe that improving services to rural communities is vital to the success of the State's health care system. Our recommendations seek to improve the certainty and predicability of services to rural communities.

Improving the planning of metropolitan health services

This report highlights the need to improve planning and decision-making about the future role and distribution of Sydney's health services.

We recommend that the Department immediately establish a Metropolitan Planning Taskforce to develop a plan for the whole of Sydney's population. This will identify both those services which need to be provided locally, and the current gaps in the distribution of those services across metropolitan Sydney. The Metropolitan Planning Taskforce will oversee the implementation of clinical service plans for metropolitan Sydney. The priority will be:

- Intensive Care Units
- Trauma
- Emergency Departments
- Neurosurgery
- Interventional cardiology/cardiac surgery
- Renal transplantation
- Paediatrics
- Obstetrics
- Long-stay mental health services

We also recommend the need for greater networking of health services throughout metropolitan Sydney. We emphasise that it is neither safe nor cost-effective to provide all health services from every location. There are many excellent examples of Area Health Services creating specialised roles for each of their hospitals, thereby improving the quality of patient care and avoiding costly duplication of resources. It will be essential to continue to network hospitals, both within Area Health Services and across NSW – that is, some hospitals will provide specialty services for the entire State.

Finally, we recommend that there should be much greater networking of metropolitan and rural health services, to ensure that everyone in NSW has equity of access to affordable and appropriate care. The availability of telemedicine and advanced telecommunications provides new and innovative ways of providing care, supporting greater networking of both metropolitan and rural health services.

Improving services to rural communities

We believe that improving services to rural communities is vital to the success of the State's health care system.

Our recommendations seek to improve the certainty and predicability of services to rural communities. We are conscious of the important role played by health services in contributing to the overall well-being of a community, for example by providing employment opportunities.

We recommend the following improvements:

- That new funding arrangements be introduced for rural communities – both to improve funding certainty, and in recognition of the higher costs of providing services in remote locations.
- That the Commonwealth and State Governments work together to ensure that all rural communities receive their fair share of health dollars. We note that in some cases, lack of access to a GP means that communities are not able to access potential Commonwealth-funded health expenditure.
- That the Commonwealth and State Governments take immediate action to improve accommodation options for elderly people living in hospitals due to the lack of Commonwealth-funded nursing home or hostel accommodation.
- That key clinical services in rural referral hospitals – in areas such as acute psychiatric services, oncology, orthopaedics and renal services – should be upgraded, so that travel to receive appropriate care is reduced. Decisions about specific services will obviously be a matter for individual Area Health Services.
- Formal networks between rural and metropolitan Area Health Services.
- That the installation of telemedicine be fast-tracked to an increased number of sites, and the telecommunications network improved.
- That NSW Health expand initiatives to attract and retain a skilled workforce, including an expansion of scholarship programs for nurses and allied health workers and an expansion of rural clinical schools.
- That NSW Health strengthen the role of smaller local hospitals by co-locating as many services as possible – including GPs, ambulance services, community health workers and mental health workers.
- We recommend that improvements to rural health services be overseen by an implementation group made up of both independent and NSW Health representatives, in order to bring together the recommendations contained in this report with those of the Ministerial Advisory Committee on Health Services in Smaller Towns.

That NSW Health expand initiatives to attract and retain a skilled workforce, including an expansion of scholarship programs for nurses and allied health workers and an expansion of rural clinical schools.

Additional funds, more equitable funding and improving value for money

We examined approaches to funding health care in other parts of Australia and elsewhere, and conclude that there are aspects of the NSW approach which can be improved. In order to give better support to patient care and achieve the best value for money in expenditure on health care, we recommend the following improvements:

Three-year budgets and growth

Early in our review, we considered whether the level of funding was adequate to meet the demands on the State's health care system. We observed that the annual approach to funding such a complex system was both inflexible and ineffective.

The methods according to which individual services are funded can provide powerful incentives to implement recommended clinical practices.

During the course of our review we held discussions with the Minister about funding options, and made the following recommendations:

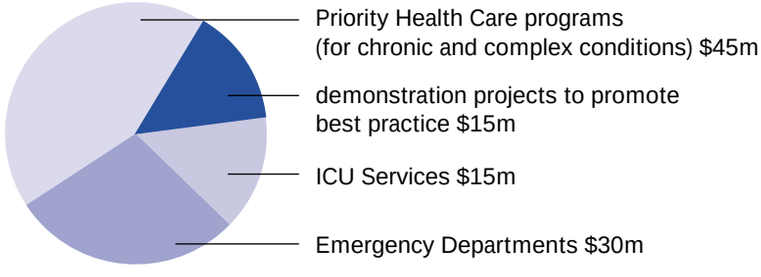
- that the NSW Government should agree to three-year budgets for NSW Health
- that additional funds should be provided in response to increased demand and costs
- that in addition to growth, funds should be provided to support the service improvements we recommend in areas such as chronic and complex conditions, Emergency Departments and Intensive Care services

At the time of preparing our final report the Minister advised that the NSW Government had agreed to these recommendations – that is, to a three-year rolling budget for NSW Health plus additional funding to respond to growth in demand. The Minister advised that the NSW Government would provide additional recurrent funds (that is, additional to growth funding) totalling $105 million over three years to support the service improvements we had recommended, as set out in Figure 1.

The Council strongly believes that the drawdown of these additional funds should be linked both to performance and to the implementation of our recommendations.

Figure 1

NSW Health Council Funding for Service Improvements
$105m over 3 years



Responding to growth and more equitable funding arrangements

We make a number of recommendations about how resources should be distributed to improve the effectiveness of health care.

First, we recommend that NSW Health develop an agreed growth formula, in order to guide NSW Government allocations to health beyond the agreed three-year budget.

Secondly, we recommend that NSW Health retain the system of population funding.

Thirdly, we recommend that expenditure of growth funds be prioritised to assist those Area Health Services whose funding has not kept pace either with the growth in their populations and/or with changes to the characteristics of their populations. This must be done in the context of robust planning in rural and metropolitan communities, as outlined in this report.

More effective and efficient funding of specific services

We conclude that the methods according to which individual services are funded can provide powerful incentives to implement recommended clinical practices. We believe that the community is entitled to expect that expenditure on health services is efficient, that care is appropriate and that there is effective monitoring and analysis of variations in costs, admission rates and waiting times between providers.

Episode funding for all planned and acute hospital admissions

We recommend that NSW Health introduce an episode funding system for all planned and acute hospital admissions other than those in Emergency Departments, those in Intensive Care Units, admissions to local rural hospitals and admissions to hospital of people with mental health conditions.

While an episode funding approach is already in use in some NSW hospitals, most hospitals are funded by way of fixed grants which are determined historically. Historic funding takes insufficient account of a hospital's real performance, whether the number of admissions is appropriate or whether the cost of treatment is consistent between similar hospitals.

All Area Health Services will be required to fund the planned and acute activity component of a hospital's budget using an episode funding approach.

This component of a hospital's budget will be based on the following: the price for each category of treatment (following clinical advice which reflects recommended clinical practice) and the planned volume of patient activity which reflects the needs of the population.

We believe there are a number of advantages to an episode funding approach, as set out below.

Cost variation

An episode funding approach allows managers and clinicians to analyse variations in cost of an episode of care. We are concerned that a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function, with no discernible difference in quality of care or severity of condition.

Appropriateness

This report highlights the need for more appropriate medical interventions. Episode funding should mean that clinicians and managers can compare admission rates and length of stay for certain conditions, analyse variations and assess the appropriateness of care. Again, we question why a woman living in one Area Health Service is twice as likely to undergo a hysterectomy than women living in other Areas.

We are concerned that a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function, with no discernible difference in quality of care or severity of condition.

We question why a woman living in one Area Health Service is twice as likely to undergo a hysterectomy than women living in other Areas.

Quality

The episode payment to the hospital must make provision for pre-admission planning, and for after care such as a comprehensive discharge plan or follow-up by a community nurse. There must be a financial incentive to get the right care at the right time at the right cost.[6]

Difference in the proposed approach for NSW

We believe episode funding is important in order for NSW Health to be able to monitor and minimise variations in cost, admission rates and length of stay. The approach we recommend has three characteristics specifically designed to differentiate it from the experience of other States:

- This method of funding must be seen in the context of a population funding approach. Area Health Services will retain the right to move funds between services such as hospitals and community health teams, in order to achieve the best outcomes for their community.
- It must be complemented by a focus on measuring health outcomes. NSW Health should improve its capacity to monitor the success of medical intervention, and this will require better monitoring of unplanned admissions, particularly admissions through Emergency Departments.
- We are recommending the introduction of episode funding in the context of increased funding and budget certainty, and not as a means of cutting costs.

Improving funding certainty to Intensive Care Units and Emergency Departments

We recommend changes to funding arrangements for Intensive Care Unit services and Emergency Departments to improve the predictability of their funding.

We recommend that Area Health Services should provide both Intensive Care Units and Emergency Departments with an annual grant allocation which reflects the staffing and equipment required to meet peaks in demand.

Funding to community, mental health and primary health services, research and population health

We recommend that the existing methods of providing annual grants to these services continue. However, to improve funding arrangements for these services we recommend two areas for change:

- That NSW Health introduce more consistent classifications about the types of services funded under activities such as population health, community health, mental health, research and public health.
- That there be clear performance agreements for these services, specifying the standard of service to be provided, clearly stipulating the priorities for service provision and clearly identifying required service outputs.

Cooperation between the private and other non-government sectors

Our work on improving funding arrangements highlights the need for NSW Health to identify opportunities for greater cooperation between public, private and other non-government health care providers. This is essential both to achieve value for money in health care expenditure and to foster diversity and innovation in the delivery of patient care. We recognise the achievements of the many private and other non-government providers throughout the State's health care system, and recommend:

- That Area Health Services be required to involve other sectors in Area Health Service planning. We acknowledge that this is already the case in many Area Health Services. This report highlights a number of areas where greater collaboration in planning and priority setting are important. These include involving the Divisions of General Practice in dealing with peaks in demand in Emergency Departments, and looking for opportunities to contract with the private and other non-government sectors to provide new services as part of the allocation of growth funds.
- Greater involvement by other sectors in capital investment, in order to optimise the use of existing capital infrastructure (including hospitals and community health centres) and to generate funding for new capital projects.
- That Area Health Services continue to work together to identify opportunities for greater efficiency in the management of contracts such as cleaning, catering and corporate transactions. These should identify further opportunities for other sectors to become involved in the delivery of these services.

We believe that NSW Health must take a number of actions to foster greater involvement by private and other non-government sectors:

- As recommended above, more specific performance agreements should be established with all health service providers. These should specify service standards, outputs and budgets. This will allow an Area Health Service to compare the performance of all public, private and non-government providers.
- NSW Health should move to a common set of measurable performance indicators which relate to health outcomes, quality and financial performance. Again, these would allow for greater comparison of the performance of all providers.
- Greater transparency of costs should be achieved, together with full costing of clinical and non-clinical services. This will allow for market-testing and benchmarking of different providers.
- The Department should strengthen its capabilities to assist Area Health Services to manage contracts with other providers.

We recognise the achievements of the many private and other non-government providers throughout the State's health care system.

Promoting clinical leadership and accountability

The involvement of leading clinicians in setting and monitoring standards of clinical practice will be vital to the success of our recommendations. This will also ensure that the system remains responsive to both changes in clinical practice and advances in technology.

The involvement of leading clinicians in setting and monitoring standards of clinical practice will be vital to the success of our recommendations.

We believe that there must be a change in the relationship between clinicians and managers in order to create an open, consumer focussed, accountable and financially responsible culture for NSW Health.

We recommend a number of changes:

- That permanent Clinical Implementation Groups be established to sponsor clinical involvement in setting and monitoring standards of clinical practice.
- That a Clinical Council made up of the Chairs of the Clinical Implementation Groups and other leading clinicians be formed to advise on State-wide strategy and clinical priorities.
- That NSW Health establish a website to provide information relating to the performance of providers.

Informed consumers and involved communities

We believe that our recommendations will require an increased capacity both to engage and involve communities in planning at a local and State-wide level. We also believe that individuals are entitled to better information about local services and treatment options.

We recommend that:

- NSW Health establish a 24-hour telephone information and advice centre, referred to in this report as the Health Call Centre. This will provide information about the availability of local services, and access to a registered nurse for advice about health problems.
- NSW Health establish an Internet site where consumers and clinicians can access information on reviews of evidence of the effectiveness of treatments.
- That local community participation structures be enhanced. This includes the appointment of dedicated staff in each Area Health Service, to assist community organisations to participate in planning the role and distribution of health services.
- That a new, State-wide consumer forum be established to provide input into State-wide policy development and resource allocation.

Planning and governance: achieving greater accountability

We have examined the planning, accountability and corporate governance arrangements of NSW Health with a view to identifying areas where improvements are necessary to support the implementation of our recommendations. We have put forward some medium-term priorities for greater devolution of decision-making to Area Health Services and their Boards. We believe this will make administrative arrangements more effective in the long term.

This report does not recommend structural changes such as reducing the numbers of Area Health Services. We believe that this would be potentially disruptive and destabilising during a period of significant reform, and that the resources of NSW Health will be better applied to the implementation of changes to clinical practice, improving services to rural communities, upgrading information technology systems and involving consumers and clinicians in decision-making. This will have a direct and immediate impact in improving health care to consumers, and should take priority in the short- and medium-term.

We recommend a strengthening of the Department's strategic and funding roles, as well as its capabilities to perform these roles.

Short-term priorities to support Council's recommendations

We believe there are a number of areas where the current accountability and governance arrangements should be improved to support our recommendations, including:

- A strengthening of the Department's strategic and funding roles, as well as its capabilities to perform these roles. We recommend that the strategy for NSW Health should be updated to reflect the changes we propose and to take account of the NSW Government's new budget and funding arrangements.
- Improvements to planning and accountability arrangements, so the overall strategy for NSW Health is more clearly linked with Area Health Plans and budget allocations.
- Simplifying Area Health Service performance agreements for Boards and Chief Executive Officers and linking them more closely to the Area Health Plan.
- Improving the purchasing role of Area Health Services by requiring that they enter into formal performance agreements with providers such as hospitals and community health teams, based on expected outputs and performance targets.
- Improving efficiency by implementing immediate changes to the purchasing of corporate services and the sharing of corporate activities between Area Health Services.
- In the short term, greater authority for Area Health Service Boards to develop and monitor local strategy. We also recommend that the skill mix of Area Health Service Boards should reflect the scale and complexity of the services they provide – including clinical input, business, finance, legal and facilities management. Community-based representation is also essential.

In the medium term we believe that NSW Health must further devolve decision-making to Area Health Services and their Boards. This is essential in order for the State's health care system to reflect the diversity of needs across the communities of NSW.

Medium-term priorities

In the medium term we believe that NSW Health must further devolve decision-making to Area Health Services and their Boards. This is essential in order for the State's health care system to reflect the diversity of needs across the communities of NSW.

A move to greater devolution of decision-making can only occur when there is a well articulated, measurable strategy for the State's health care system and a strong performance management environment which ties Area Health Plans with the broader strategy for NSW Health.

IMPLEMENTATION

Change management strategy

Our recommendations will require a concerted and comprehensive approach to implementation. We therefore propose the following:

- That a coordinating group with independent representatives (reporting to the Minister) should be established to oversee and assist with implementation and change management. We believe that this group should be made up of representatives from the structures we have recommended to guide specific reforms – including the Clinical Council, the Metropolitan Planning Taskforce, the State-wide Consumer and Community Forum and the Rural Services Steering Committee. The group responsible for overseeing implementation and change management should also include central agencies such as the Cabinet Office and the Treasury, and a person or group to foster private and non-government cooperation.

  The coordinating group would have three primary functions. First, it would establish and monitor a detailed implementation plan. Secondly, it would advance some of the issues we have identified as needing further work – such as private/non-government cooperation, population health, mental health and Aboriginal and Torres Strait Islander health. Thirdly, it would subject the outcomes of our recommendations to continuous appraisal and review.

- This report identifies a number of key recommendations whose implementation is essential – both to the achievement of other objectives and to the overall effectiveness of the State's health care system. We believe these recommendations should be included in all executive level performance agreements.
- The majority of reforms should be completed in two years.

Commonwealth-State reform

We make a number of suggestions about ways to improve Commonwealth-State relationships in health care. Our suggestions for change concentrate on the need to improve the links between GPs, hospitals and community health teams, and opportunities to improve the effectiveness of funding arrangements. We are primarily concerned about the lack of parity in funding contributions between the Commonwealth and State Governments. We note that while State-funded contributions increased by 5.3% per year in real terms between 1991/92 and 1998/99, Commonwealth contributions increased by only 3.9% per year over the same period.[7] We conclude that a national review of health funding arrangements is necessary, and must be a key priority in the implementation of this report.

Demonstration projects

This report opens with a discussion about the need for a more informed and balanced debate about health care in Australia, and the need to address increasing demand. We argue that a successful health system cannot be measured by the number of hospital beds alone. Instead, both the State and Commonwealth health care systems need to strike a balance between early intervention, early detection, community education, lifestyle, providing more care in the community and tackling the links between disadvantage and poor health outcomes. To start this process of longer term reform, we recommend the establishment of two demonstration projects.

In the same way that we recommend that early implementation of the Unique Patient Identifier and Electronic Health Record should be focussed on the most vulnerable (that is, people with chronic and complex conditions), we also believe there could be substantial benefits in fast-tracking implementation for an entire population. This will harness the benefits of our recommendations more quickly.

The two demonstration projects – one of which must focus on a rural community – will fast-track the implementation of all our recommendations, together with a greater involvement of consumers and other human services agencies.

These projects should be characterised as follows:

- a concerted effort to link health care providers with information technology and telemedicine
- with each patient's consent, the use of Unique Patient Identifiers to assist in providing continuity of care to patients
- sponsoring teams of clinicians to implement the Priority Health Care programs, with an emphasis on community education and health promotion
- fast-tracking the implementation of our recommendations to improve clinical practice in areas such as same-day admission and clinical pathways
- linking human services agencies in the development of a single plan for each community
- developing budgets which reflect the totality of Commonwealth Government, State Government and non-government investment in health care, so that a community can see the full range of health care resources
- establishing a single community consultation forum to provide advice to a range of Government agencies on needs for health care, education, housing and employment

The Government has provided $15 million over three years for these projects, which we propose should be overseen by the coordinating group responsible for overall implementation.

We feel strongly that additional funding should be closely tied to the program we have outlined.

This report must be seen within the context of the continuous improvement of health services. Reform must not stop when the implementation of our recommendations is completed.

CONCLUSION

We have put forward a practical and achievable set of reforms that will deliver affordable and effective health care. We feel strongly that additional funding should be closely tied to the program we have outlined.

This report must be seen within the context of the continuous improvement of health services. Reform must not stop when the implementation of our recommendations is completed. Advances in technology, improvements to clinical practice and the changing nature of consumer expectations will require a process of ongoing change and adaptation. We believe that in areas such as funding arrangements and the involvement of consumers and clinicians, we have laid a strong foundation which will ensure that the State's health care system remains responsive and appropriate to the needs of the community as we move into the 21st century.

1 The term **State's health care system** is used to describe all health services/organisations within the State, including the public, private and non-government sectors. The term **NSW Health** is used to describe the public health system in NSW. This includes the NSW Department of Health, the 17 Area Health Services and the three State-wide services, namely the Ambulance Service of NSW, Corrections Health Service and the New Children's Hospital. The term **the Department** refers to the NSW Department of Health.

2 NSW Health Annual Reports, 1997/98 and 1998/99, NSW Department of Health.

3 NSW Health Unaudited Annual Returns, 1998/99.

4 Analysis undertaken by NSW Department of Health, Structural and Funding Policy Branch, 1999.

5 Information received from the Chief Nursing Officer, NSW Department of Health, 1999.

6 We acknowledge the value of the work carried out by the NSW Ministerial Advisory Committee on Quality in Health Care, The State Continuous Improvement Steering Committee, 'A Framework for Managing the Quality of Health Services in New South Wales', February 1999.

7 ABS Australian Government Financial Estimates, Cat No. 5501.0 and Commonwealth and State Government Budget Papers, 1990/00.

1 Context for Change

OBJECTIVES

Our recommendations to the Minister seek to achieve six major objectives.

Access and quality

Strategies to improve access to health services and the quality of patient care.

Funding

Strategies to create more equitable, efficient and effective funding systems which increase the value for money of expenditure on health care.

Clinical leadership

Strategies to increase the involvement of clinicians (doctors, nurses and all other health workers) in determining health care priorities and in setting and monitoring the standards of clinical practice.

Consumer and community empowerment

Strategies to empower individuals and communities in decision-making about health care.

Corporate governance, planning and accountability arrangements

Strategies to improve planning, administrative and accountability arrangements to ensure the effectiveness and efficiency of decision-making.

Health improvement

Strategies to foster a stronger focus on the promotion and maintenance of good health.

ISSUES EXAMINED

To achieve our objectives we undertook six pieces of work. The resultant Working Papers were used to guide our recommendations and are available publicly.

Specifically we examined:

- options for improving **the delivery and organisation of health services** in the areas of critical care (Intensive Care Units (ICUs) and Emergency Departments), the management of planned and acute hospital admissions, and the care of people with chronic and complex health conditions, such as cardiovascular disease, respiratory illness and cancer (Working Paper 1)
- the need for **better planning and decision-making about the role and location of metropolitan health services** (Working Paper 2)
- options for enhancing **services to rural communities** (Working Paper 3)
- options for improving **information technology systems** to support patient care and more informed decision-making by health managers (Working Paper 4)
- options for improving **funding levels** and **funding systems** in order to increase access to services and the effectiveness of care (Working Paper 5)
- options for further engagement of **consumers and communities** in decisions about their own health care and the planning of health services (Working Paper 6)

In examining all six areas and finalising our recommendations, we recognised the role and contribution of the private and non-government sectors within the NSW health system.

We also examined how planning, accountability and governance arrangements could be improved to support the implementation of our recommendations.

The Working Papers were prepared with the assistance of reference groups made up of clinicians, managers and consumer representatives. Membership of the reference groups are listed in the working papers. The proposals put forward in the Working Papers have informed our recommendations.

FOCUS

We have focussed our review on improvements to clinical care. We are conscious that we have not been able to deal comprehensively with all of the areas which make up a successful health system. Examples include public health, population health, dental health, drug and alcohol services, mental health, Aboriginal and Torres Strait Islander health and training and research. Work must continue in these areas as part of the implementation of our report.

It is important to acknowledge that some of these matters such as drug and alcohol services, mental health and Aboriginal and Torres Strait Islander health are already the subject of a concerted State-wide effort. We also believe that many of the changes we are putting forward will directly benefit these and other parts of the wider health system. For example, many patients with mental health and drug and alcohol conditions who frequently have urgent admissions via the Emergency Department will benefit from the recommendations we have made to improve emergency care, such as better management in the community to avoid crisis situations and urgent admissions. Similarly, the recommendations we have put forward relating to improving the provision of health care to people with chronic and complex health conditions will assist many Aboriginal and Torres Strait Islander people who are vulnerable to conditions like heart disease and diabetes.

CONTEXT

Our recommendations have been influenced by a number of factors, which can be summarised as:

- the NSW Government's decision to increase **funding** to NSW Health and provide funding certainty – this decision was taken during the life of the NSW Health Council
- the importance of recognising and building on the existing **strengths** and **achievements** of NSW Health
- the challenge of achieving lasting improvements to health care in the context of increasing and potentially unlimited **demand**
- the recognition that a review of any State health system can only deal with part of the picture and that some changes will need **Commonwealth, State** and private sector cooperation

1

More dollars for health and funding certainty

An important feature of our work has been an ongoing dialogue with the Minister and senior NSW Government officials about our findings and recommendations. During the course of our review we met with many clinicians and Area Health Service managers. They explained the pressures they were facing in meeting growing demand in a climate of budget uncertainty, annual budget reviews and a lack of predictable growth funds. We were also aware of the problems facing some Area Health Services whose funding did not reflect the growth in their populations.

In our discussions with the Minister and our work on funding options we recommended several changes to funding levels with the condition that they should be tied to achievable reforms of the health system. First, we recommended the need for budget certainty and three-year budgets. Secondly, we outlined the need for real growth funds and a predictable growth formula to meet future demand. Thirdly, we highlighted the urgent need to address the problems of some Area Health Services whose funding had not kept pace with the growth in population. Finally, we outlined the need for stability of funding in specific areas of the State, such as isolated rural health services.

At the time of finalising our recommendations the Minister advised that the NSW Government had given approval to growth funding over three years, three-year budgets and recurrent funds in addition to growth funds to support the service improvements we have recommended.

A total of $105 million ($35 million per annum for three years) will be provided to support reforms in the following areas:

$15 million	for additional ICU beds and a network of ICUs
$30 million	to help tackle the pressure in Emergency Departments and to deal with blockages between Emergency Departments and the rest of the hospital
$45 million	to provide incentives for widespread implementation of better approaches to health care for people with chronic and complex conditions like cardiovascular disease, respiratory illness and cancer – these will be called Priority Health Care programs and will focus on a State-wide approach to early detection and the provision of health care plans for individuals and their carers (see Chapter 2)
$15 million	for demonstration projects in two selected Area Health Services, to fast-track service improvements such as the introduction of new technology and changes to clinical practice
$105 million	

Building on achievements

By international standards NSW Health performs very well. The dedication, commitment and professionalism of those who work within it are key features in this success. We were conscious of the need to build on and sustain its existing strengths, including:

- the principles of universal entitlement and access
- the focus on tertiary education and research
- the adoption and use of new and advanced technologies
- a growing awareness of the importance of health promotion and the prevention of illness

There is compelling evidence that NSW Health has achieved a great deal, in terms of:

- **productivity**
  NSW Health has achieved an average productivity gain of 2.3% per annum since 1990/91.[8]
- **number of people assisted**
  Over recent years the number of people being assisted in NSW Health has steadily increased. For example, in 1998/99 there were 2.4% more public patients admitted than in the previous year. Similarly, for non-inpatient services – including Emergency Department attendances and community health services – there was a 2% increase compared to the previous year.[9]
- **changes to the way health care is provided**
  In recent years there have been significant changes to the way that health care is provided. For example, whereas 15 years ago people with diabetes were routinely hospitalised for stabilisation of blood sugar, this is now the exception rather than the rule.
- **mortality rates and health status**
  There have been significant improvements in the health status of the general population. For example, since 1985 life expectancy at birth has increased by 4.4 years for males and by 3.2 years for females. Deaths due to cardiovascular disease have steadily declined since the late 1960s. Since 1989 the mortality rate for stroke has declined by an average of 3.7% per year for males and 3.6% per year for females.[10]
- **successful efforts at prevention and health promotion**
  Together with the rest of Australia, NSW has made significant gains in some areas of prevention and health promotion. Since 1977 smoking rates in NSW have declined by around one third. Between 1991 and 1998 HIV/AIDS transmission rates declined by 53%.[11] The NSW Breast Screening Program carries out over 270,000 screens per annum.[12]

- **capital investment**
  NSW Health has been steadily improving its capital infrastructure. This includes both existing and new services. Many of the changes to the design and function of services will support new approaches to providing health services which we have outlined in our report.

  Since 1995/96, a total of $2.3 billion has been allocated to improving facilities. Some examples include:

  - **The New Children's Hospital**
    $314 million was allocated to a state-of-the-art, 350-bed paediatric hospital.
  - **Illawarra Area Health Service Strategy**
    $73 million was allocated to upgrading Wollongong Hospital to teaching hospital status and creating a new multipurpose complex – Hickman House.
  - **Lithgow Hospital**
    $26 million was allocated to provide a comprehensive local service made up of inpatient beds, a co-located medical centre and a rehabilitation unit.
  - **Coffs Harbour Services**
    $80 million was allocated to constructing a new service made up of the public hospital, community health, mental health and a new ambulance service on the one site. It is worth noting that our work on improving rural health services (Chapter 3) recommends that this approach of co-locating services is ideal for rural communities.[13]

Implications

We recognise that there have been significant achievements in the provision and advancement of health care. However, these achievements pose challenges for the way we organise and fund ongoing delivery of service. Increased life expectancy continues to provide challenges to the health system, and less intrusive treatments will require innovative thinking about the most successful way to deliver health care.

The medical reforms of 25 years ago were principally about equity of access of all to the health system. With increased demand and increased cost we must now focus on how the health system can better deliver care. If we fail to meet this challenge, the system will come under more pressure and equity of access will be at risk.

The challenge of growing demand

We have produced this report at a time of ongoing growth in the demand for publicly funded health services. This demand is being driven by advances in treatment and the growth of technology. This is evidenced by the following:

- There has been a steady growth in hospital admissions. (Over the period 1992/93 to 1998/99 there was an average growth per year in overall admissions of 4.5% and an average growth per year in public patients of 8.1%.[14])
- In the period 1997/98 – 1998/99 there was a 7.2% increase in demand on Emergency Departments.[15]
- The cost per patient has increased by 2.7% per annum (from 1994/95) which is influenced by wages, goods and services, medical supplies and pharmaceuticals.[16]
- The complexity of demand is also increasing with the proportion of the population aged over 65 estimated to rise from 12% to 18% by 2021.[17]

Increasing demand has been parallelled by a decline in private insurance from 55% of the population at the start of Medicare in 1984 to about 30% at present.[18]

It is against this backdrop of increased demand and increased cost that our recommendations for change need to be understood. In this report we put forward a package of initiatives which we believe will improve access and quality to health care. However, we believe that the success of our reforms, and also the success of the health system to date, will be eroded unless Commonwealth and State Governments and clinicians lead a community debate about the need for realistic expectations about what a health system can deliver, and the need to ensure that health care is appropriate.

Meeting this challenge will require sustained and thoughtful community education. It will require a focus on lifestyle, on diet and on individuals taking more responsibility for their own health. It will require Governments and communities to tackle the problems of disadvantage that lead to sickness.

Finally, meeting this challenge will require a more informed and balanced debate about what makes up a good health system. We believe that a successful health system is characterised by a far wider range of factors than the numbers of hospital beds. This will require a shift in expenditure to providing more care in the community, and an increased emphasis on both early intervention and keeping people well.

Unless there is widespread recognition of the need to deal with increasing demand, the cost of health services may well extend beyond the capacity of Governments and the community to pay for it.

Commonwealth-State cooperation

There has been considerable public debate about the respective responsibilities of the State and Commonwealth Governments.

We have suggested a number of ways that Commonwealth-State relationships could be improved. These will go some way to improving coordination and the effectiveness of expenditure. These include:

- the need for a national health policy (This should deal with the respective roles and responsibilities of the State and Commonwealth Governments, desired health outcomes and the most effective ways of delivering patient care.)
- the need for greater parity in funding allocations to respond to growth (We note that over the last 10 years, State contributions have risen at a greater rate than Commonwealth contributions. In the period 1991/92 to 1998/99, the NSW Government has increased its recurrent expenditure by 5.3% per year in real terms. This compares with an increase of 3.9% per year in Commonwealth recurrent funding for the same period.[19]
- the urgent need for an agreed Commonwealth and State approach to improving health information technology and to linking general practice to other parts of the health system
- the need to address the lack of progress – particularly in rural areas – in providing appropriate care for aged people who are living in hospital beds due to the shortage of suitable nursing home or hostel accommodation
- the need to resolve the issue of lack of flow-on funding for award increases to NSW Health staff employed under Commonwealth-funded programs where the Commonwealth has not provided additional funding to the States to compensate for wage increases – for example HIV/AIDS programs and Home Nursing Services
- the need for clarity about the role of private health insurance, and how to maximise the benefits of insurance for consumers
- the need to improve links between GPs and other parts of the health system, such as hospitals and community health teams, and to provide greater financial incentives for GP after hours services
- the need for the Commonwealth and the State to ensure that their level of funding is adequate to meet the health needs of communities (In our work on rural health services, we express our concern that funds for medical and pharmaceutical benefits currently do not reflect population needs but the location of health providers. Where there is a shortage of providers some communities are not able to take up their fair share of potential Commonwealth expenditure for their health needs.)

The Council supports the call for further work at the national level to improve the effectiveness of Commonwealth and State arrangements in the delivery of health care. We believe this should be commenced quickly, to support and enhance the changes we have put forward at the State level to improve the quality and effectiveness of health care for the people of NSW.

CONCLUSION

The provision of additional funds by the NSW Government is a great step forward – on condition that they are tied to reform. The changes we put forward in this report are intended to achieve that reform. We believe that our recommendations are practical, that they build on the successes of the existing system, that they will relieve pressure on doctors and nurses and all other health workers and that they will create a 21st century health system designed around the needs of individuals and communities.

8 Analysis undertaken by NSW Department of Health, Structural and Funding Policy Branch, 1999.

9 NSW Health Annual Report 1998/99, NSW Department of Health and data from Evaluation and Monitoring Branch 1999.

10 Health of the People of NSW, Report of the Chief Health Officer, 1999. NSW Department of Health (in press).

11 ibid.

12 Breastscreen NSW, 1999.

13 Advice from NSW Health, State-wide Services Development Branch.

14 NSW Health – Inpatient Statistics On-line Collection, 1999.

15 NSW Health Annual Reports, 1997/98 and 1998/99, NSW Department of Health.

16 Analysis undertaken by NSW Department of Health, Structural and Funding Policy Branch, 1999.

17 NSW Health Annual Report, 1998/99.

18 Private Health Insurance Administration Council, December, 1999.

19 ABS Australian Government Financial Estimates, Cat No. 5501.0 and Commonwealth and State Government Budget Papers, 1990/00.

2 Improving Service Delivery

OBJECTIVES

Improved access to health services and improved quality of patient care.

FINDINGS AND OBSERVATIONS

Access to health care services and the quality of patient care are influenced by a number of factors, including:

- whether the level of overall funding provided to the health system is adequate
- whether the processes of providing care are well organised – including the roles and responsibilities of various providers, communication systems and the interaction between various providers
- the availability of a skilled workforce
- how well resources (such as hospital beds and technology) are utilised to provide appropriate care
- whether the distribution of health services meets the needs of particular communities
- the extent to which administrative systems, work practices, training and even the design of hospitals are adapted to respond to changes in the way care is provided

This chapter deals with improvements to service delivery and the processes of providing health care. Our key finding is that there is a link between the way services are organised and the accessibility and quality of health care.

Additional funding will go some way to improving the effectiveness of the system. However, unless services are properly organised and properly planned, then the Government and the community will not realise the full benefits of these additional funds.

From our discussions with clinicians, managers and consumers we make a number of observations about the need to improve service delivery.

- There are many examples of innovation in clinical practice which if applied more widely across NSW Health would improve both the system's cost-effectiveness and its capacity to respond to demand. We believe that the implementation of recommended clinical practice should not be left to the discretion of 17 Area Health Services. More incentives are needed to promote the widespread implementation of innovations.
- We are concerned that the current shortage of skilled nurses in the State's health system is impacting on the quality and cost of health services.
- We believe that urgent improvements are needed to patient information systems in order to improve links between health care providers (such as hospitals, GPs and community health teams) in the delivery of patient care.
- We conclude that improvements to service could be better supported by improving the planning and distribution of services (see Chapter 3).
- Finally, we believe that funding incentives could be more closely linked to supporting recommended clinical practice (see Chapter 4).

DIRECTIONS FOR CHANGE

We propose the following improvements to service delivery:

- improving the management, funding and coordination of critical care (Emergency Departments, emergency services and ICUs)
- improving the management of planned and acute hospital admissions
- providing better coordinated care to people with chronic and complex conditions such as cardiovascular disease, respiratory illness and cancer
- developing further strategies to attract and retain a skilled nursing workforce in NSW
- overhauling patient information systems and the development of an Electronic Health Record

We selected the above service improvements because we believed they would respond to the most pressing and urgent issues facing the State's health system and would have positive and lasting flow-on effects.

Recommendations:
Intensive Care Units

1. That the Department should urgently implement a strategy for the improved management of Intensive Care Units and the allocation of the additional funds announced by the NSW Government in December 1999.
2. That this strategy should be concentrated on improving the coordination and networking of Intensive Care Unit services and the implementation of a new method of funding.
3. That these improvements to Intensive Care Unit services and the distribution of the additional funds should be overseen by a group of clinicians and health service managers, including doctors and nurses from a number of facilities.
4. That this group should advise on the impact of the additional funds, and undertake a further investigation into the anticipated demand for Intensive Care Unit facilities over the next five years.

Improving service delivery in critical care

Intensive Care Units

There is a need to address current shortfalls in the numbers of tertiary referral ICU beds[20] and to plan properly for future patient demand. In simple terms, the type of surgery and treatment being performed in hospitals is now more complex than 20 years ago, and thus requires increased capacity within ICU services. The increased availability of ICU services and improved planning about their location and availability will improve access in other areas. For example, the number of ICU beds affects the amount of elective surgery that can be performed, and the speed with which critically ill patients can be moved from the Emergency Department.

In December 1999 the NSW Government announced that it would allocate an additional $15 million over three years to ICU services. We propose that these additional funds should be tied to changes in the coordination, quality and funding of ICU services, as follows:

- ICU beds across metropolitan Sydney must be better networked so that at any given time it is possible to assess where beds are available.
- There must be more consistent standards for classifying an ICU service and about the appropriateness of ICU admissions. These standards should relate to workforce availability, clinical skills and the volume of patient activity needed to maintain those skills.
- ICUs must be funded in a way that reflects their high fixed costs and the need to be available at all times to the most critically ill.

Emergency Departments and hospital emergency services

Improving the operation of Emergency Departments and their connection to the broader hospital is important to the ongoing accessibility and quality of health services. We reviewed a significant body of work from both NSW and other States, which demonstrates that the problems being experienced within Emergency Departments are often caused by demands on other parts of the hospital. These can include demand for operating theatres, demand for ICU beds and demand for beds in wards. Such blockages mean that patients may be forced to remain in the Emergency Department, or that ambulances are required to bypass a hospital.

Our discussions with clinicians and managers from Emergency Departments and other parts of hospitals have highlighted some key issues that need to be addressed. Emergency Departments have experienced a significant increase in demand: in the period 1997/98 – 1998/99 the increase was 7.2%.[21]

Some of that demand is attributable to repeat demand from patients with recurring conditions like a mental illness, or elderly patients with respiratory problems. We believe that there needs to be better management of these patients in the community to help them avoid crisis situations that require urgent admissions through the Emergency Department.

For some people, Emergency Departments have become a substitute for GP services. It is arguable that a number of these patients, particularly in rural communities, are using the Emergency Department because they cannot access a GP after-hours, or because there is no bulk-billing in some communities. This has prompted some Area Health Services to co-locate GPs in Emergency Departments, or to set up GP after-hours services.

There are currently no formal guidelines between the State and Commonwealth Governments for funding GP after-hours services, and there has been no real evaluation of respective Commonwealth and State responsibilities for the provision of emergency care.

We acknowledge that there is no single solution to the surge in demand on Emergency Departments. We have received a number of suggestions about ways to relieve the pressure on Emergency Departments, including:

- increased use of senior medical staff, with greater authority to admit and discharge patients from public hospitals
- bed management strategies for the entire hospital to ensure that patients can be moved from the Emergency Department to wards or operating theatres, requiring more flexible discharge and admission practices
- 24-hour availability of senior clinical staff, to undertake more comprehensive assessment of people presenting to the Emergency Department
- more use of short-stay wards, to provide care to people who need treatment but do not need to be admitted to hospital

Recommendations:
Emergency Departments and hospital emergency services

5. That the Department develop a three-year emergency care plan which incorporates:
   - projected demand and likely pressure points
   - work on the future roles and numbers of Emergency Departments in metropolitan Sydney
   - the allocation of the $30 million over three years (and other growth funds) to promote initiatives which improve the flow of patients between Emergency Departments and the hospital, and Emergency Departments and the community
6. That a new funding system for Emergency Departments be introduced from 1 July 2000.
7. That the three-year plan be led by a group of clinicians and senior managers who provide advice on the distribution of additional funds and on long-term planning about the role and distribution of Emergency Departments.
8. That the Department and the Commonwealth Government negotiate an agreed set of guidelines for the funding of GP after-hours services and/or the co-location of GPs in emergency rooms, to clarify objectives and funding responsibilities.
9. That the Department (and in particular the Centre for Mental Health) should fund the provision of specialist mental health nurses to assist with the management of mental health clients in Emergency Departments. Priority should be given to those Area Health Services with a high presentation rate of mental health clients in Emergency Departments, including rural communities.

- better coordination of operating theatres – and where volume necessitates, more theatre time provided to emergency cases
- where appropriate, the location of mental health nurses to assess and plan appropriate discharge care of patients presenting with a mental health condition
- more effective case management of people who are frequently admitted to hospital via the Emergency Department, who could avoid admissions if their care were better coordinated in the community
- providing more incentives for GPs to provide after-hours services, and in some cases to provide those services adjacent to a major Emergency Department

We propose that the NSW Government's allocation of an additional $30 million over three years to Emergency Departments should be targeted to ensure that these kinds of initiatives are more widely implemented throughout all public hospitals. It is critical that managers and clinicians should be given an opportunity to find the best solution for their hospital. Expenditure should focus on strategies to improve the flow of patients, either into other parts of the hospital or (where appropriate) back into the community with proper referral to their GP or community health team.

In addition to sponsoring local initiatives, there are three State-wide actions which should be undertaken to address the problems in Emergency Departments:

- We recommend that a new funding arrangement should be introduced for Emergency Departments. This would be similar to that proposed for ICUs, where only a small percentage of funding is based on the volume of patients treated. The majority of funds would be provided on a fixed basis, in recognition of the high fixed costs of Emergency Departments and the fact that they must have adequate staff available at all times to assist those who are critically ill.
- We recommend that the Department should facilitate the development and implementation of a three-year emergency access plan. This will support existing strategies as recommended by the Access Block Working Party,[22] and the strategies implemented by Area Health Services to respond to increased demand in winter.
- The three-year emergency plan should consider the most appropriate distribution and role of Emergency Departments now and in the future, particularly across metropolitan Sydney. An agreed plan for the role and distribution of Emergency Departments will ensure that the right level of services is available to meet the needs of the local population, and that the correct level of infrastructure is available to support the Emergency Department – such as ICU beds, operating theatres and the availability of key specialists.

The provision of three-year funding, coupled with $30 million over three years, will enable clinicians and managers to develop a long-term plan in order to find permanent solutions to the problems of access to emergency care. Again, the emphasis is on those strategies that will better link Emergency Departments to the wider hospital and to the community.

As with ICUs, we recommend the need for a broad range of clinicians to be involved in the development of the three-year plan. They should also provide advice about the distribution of the $30 million over three years, and about the priorities for distribution of Emergency Departments throughout metropolitan Sydney.

This group should involve representatives from Emergency Departments, operating theatres, ICUs, hospital management and community health representatives.

Improving the management of planned and acute public hospital admissions

We believe that better access to public hospitals and better quality of care can be achieved through improved utilisation of hospital beds, rather than through increased numbers of hospital beds. We have carefully examined the results of the ongoing National Demonstration Hospitals Program (NDHP),[23] in which some NSW hospitals have been successfully introducing the type of changes we recommend.

Some of the key successes of hospitals participating in the NDHP include:

- cancellation of surgery on the day of admission decreased by 50%
- unplanned, unbooked readmissions within a month of surgery reduced by 26%
- 61% of participating hospitals showed overall efficiency gains, and the program has generally been associated with efficiency gains of $90 million to $110 million annually[24]

We believe that NSW Health should move to system-wide implementation of some of the features of the NDHP, as set out below. This will have significant benefits to NSW Health in improving the utilisation of beds and the quality of patient care. This will in turn have significant flow-on effects in reducing cancellations for elective surgery and improving access to public hospitals.

Admission on day of treatment/surgery

Improved utilisation of hospital beds and access to hospital care will be facilitated by the requirement that patients be admitted on the day of their treatment. This now operates in many NSW hospitals. At present 60.3%[25] of NSW hospitals admit patients on the day of their treatment, with some hospitals performing well in excess of this figure.

Recommendations:
Improving the management of planned and acute public hospital admissions

10. That the clinical practice targets for admission on day of treatment/surgery and day-only admissions we proposed be introduced from 1 July 2000.
11. That the Department should lead the way in identifying priority conditions and treatments, and that there be an expanded use of clinical case managers and clinical pathways in all NSW hospitals.
12. That NSW Health work with the Divisions of General Practice and the Commonwealth Government to develop a standard (preferably electronic) discharge summary for NSW public hospitals.
13. That together with senior managers, expert leading clinicians should oversee the setting of clinical practice standards, as well as strategies to provide assistance and advice to other hospitals in reaching those targets.

Based on the results of the NDHP and the performance of many NSW hospitals, we believe that the majority of patients being admitted for electively should be admitted on the day of their planned treatment, and that a target of 80% can be achieved.[26] We recognise that the implementation of this target relates to a number of interdependencies, including the use of pre-admission clinics and better communication between GPs and specialists in order to arrange tests prior to admission. We are also mindful that there will need to be some flexibility with this target, and that in each case the ultimate discretion must remain with the clinician. For example, some elderly people or people living in remote locations may not be able to be admitted on the day of their surgery or treatment. We recommend a sensitive implementation of this change, and that providers be given assistance to reorganise their administrative arrangements.

Day-only admissions

Across the world there has been a growth in the number of procedures and treatments that can be provided on a day-only basis. This is a direct result of advances in clinical practice (including the use of minimally invasive procedures), improved medical technology and the increasing trend toward ambulatory care.

We recommend the implementation of the Department's target of 60%[27] for all surgery, on a same day basis, be met by 1 July 2001. However for individual procedures (including some medical) we believe there is considerable room for improvement and we recommend that the Department set specific targets for these procedures. We acknowledge that a move to day-only admissions will have substantial implications for work practices, information technology and (importantly) the role and design of many hospitals, such as increasing the availability of procedure rooms and operating theatres.

Our work on metropolitan and rural health services (see Chapter 3) makes a strong case for the need to take account of these changes to clinical practice in planning the role and distribution of services.

Appropriate health care

We recommend that there must be a continuous focus on delivering appropriate health care. We are concerned about significant variations between Area Health Services in the type of treatment being provided and in admission rates to hospital. For example, for one procedure alone – tonsillectomy and adenoidectomy – children living in some Areas are twice as likely to undergo the procedure as children living in some other Areas (324 per 100,000 children compared with 169 per 100,000).[28] While obviously each individual case is different and variations always arise, we believe that it is vital that clinicians and managers examine the appropriateness of admissions. We further examine this issue in Chapter 6, where we recommend greater clinical leadership and accountability for the appropriateness of health care.

Clinical pathways

The widespread use of clinical pathways is an important strategy for improving the overall utilisation of hospital beds. A clinical pathway is developed by expert clinicians in order to define on average how long a person should be in hospital, when they should be discharged and the various health milestones they need to reach in the course of their treatment. While each individual case is different and complications can and will occur, we believe the widespread use of clinical pathways will have the following benefits:

- assisting in more timely discharge – that is, if it has been pre-agreed that a person should be in hospital for say three days based on meeting certain milestones, then the authority to discharge can be devolved to a wider range of clinicians
- facilitating better overall bed management by ensuring more predicability in the admission and discharge planning of patients
- giving patients and their families certainty about when they will be discharged, to enable them to organise their after-care and home situation

Case management

The NDHP illustrates the value of dedicated clinical case managers, particularly for patients having complex treatment. We have visited hospitals in NSW and other States and seen the benefits of having a single contact point to coordinate pre-admission activities such as tests, and discharge activities such as organising a visit by a community nurse. We believe that the increased use of clinical case managers will benefit people with chronic and complex conditions. We recommend that NSW Health should promote the expansion of these types of positions in all NSW public hospitals.

Discharge planning

Structured discharge planning is important in order to improve the quality of patient care. We note that discharge planners[29] are common in many hospitals. We recommend that the number of discharge planners should be expanded in all NSW hospitals, particularly for patients having complex treatments. We are concerned that there is no strategy for a uniform, computerised approach to a discharge summary from hospitals to GPs, and from GPs or hospitals to community health or mental health teams. This must be addressed, with cooperation at both the State and Commonwealth levels.

Private sector and non-government sector involvement

We have met with private sector and non-government providers of health care, who highlight the need for structured planning between the public, private and non-government sectors. At a time when some public hospitals have limited capacity and are under pressure, some private facilities have an occupancy rate of only 72%. This compares with an average occupancy rate of 84.7% in public hospitals.[30] There should be a serious effort to involve other sectors in health service planning in order to encourage more flexible use of all health resources.

That is, a private or non-government hospital may be able to assist with peaks in demand, or to provide a particular service as part of a wider network of public, private and non-government services.

Recommendations:
Improving health care for people with chronic and complex health conditions

14. That State-wide Priority Health Care programs be developed for cardiovascular disease, respiratory illness and cancer.
15. That the Department establish an advisory group of leading clinicians and managers, to determine:
    - which specific conditions will be targeted within the broader categories, and a priority timetable for the programs
    - priorities for the expenditure of incentive funds of $45 million over three years to achieve specific goals
    - which local structures need to be put in place to ensure programs achieve changes to local practice
16. That negotiations commence with the Commonwealth Government to ensure that GPs are involved in these programs.
17. That work commence immediately on the feasibility of developing a separate funding stream for chronic and complex conditions, and in the interim implementing the following:
    - separate reporting of hospital admissions
    - monitoring the frequency and length of admissions, particularly those through the Emergency Department

Improving service delivery for people with chronic and complex health conditions

The case for change

We recommend that NSW Health must improve the provision of health care to people with chronic and complex health conditions.

We believe that there must be a concerted effort to improve early detection, early intervention and the provision of a continuity of care between general practice, hospitals and community health providers. We also believe that it is important to reduce the numbers of urgent admissions through Emergency Departments experienced by people with these conditions.

As the population ages and the number of people in NSW with chronic and complex conditions increases, there is a need for early intervention and to improve the management and coordination of their health care. The case for developing new approaches is compelling:

- We analysed six conditions (congestive heart failure, renal failure, diabetes, chronic obstructive airways disease, stroke and HIV/AIDS) and identified that people with these conditions (11% of all people treated in hospitals) accounted for $1.2 billion of public and private hospital services.
- People with these six conditions rely heavily on the public hospital system, with 85% of their admissions being to public hospitals.
- Around 30% of admissions for people with these six conditions are through Emergency Departments.[31]

If we take heart failure as a more specific example and provide more detailed analysis, the case for change is even more compelling:

- In NSW 23,000 people are admitted to hospital with heart failure each year.
- This accounts for 58,000 hospital admissions.
- 30,000 of these admissions are urgent, through Emergency Departments.
- 4,000 people with heart failure are admitted four or more times in a year.[32]

The provision of health care for people with chronic and complex conditions is often more complicated than for other people in the community. This is not only because they have more frequent and unplanned hospital admissions (including urgent admissions through Emergency Departments), but because they need to interact with a number of health care providers and health services and other Government services at any given time. This includes GPs, specialists, community health workers, mental health workers, allied health and Home and Community Care. Patients are often required to coordinate their own care, putting them at risk of receiving different advice from different providers.

The particular needs of people with chronic and complex conditions present a challenge to the way health care is organised, requiring health care providers to communicate with each other, to work as a team and to avoid duplicating tests and procedures. It also requires better information technology so both the individual and their health care providers have access to accurate and timely information about their health and treatment history.

Improving health care for people with chronic and complex conditions is a fundamental issue of social justice. Individuals with these health conditions are often unable to work, have to meet additional expenses associated with their illness, suffer with chronic pain, and require a great deal of support from their carers and families.

Due to major advances in health care and changing demographics, the proportion of the population aged over 65 is estimated to rise from 12% to 18% by 2021.[33] Consequently, the demand for health care for people living with chronic and complex conditions is increasing in NSW.

In establishing new ways of providing care – such as the use of improved information technology, and providing more care in the community – there is a strong case for giving priority to those who are highly vulnerable and who depend most on the health system to improve their quality of life.

Priority Health Care programs

Our objectives in trying to tackle this complex issue are:

- to improve quality of life of people with chronic and complex conditions
- to improve the quality of life of their carers and families
- to prevent crisis situations and urgent admissions to hospitals

We recommend that NSW Health introduce new approaches to providing care to people with chronic and complex conditions as part of three additional State-wide Priority Health Care programs, namely cardiovascular disease (including the risk factors of diabetes and stroke), respiratory illness and cancer. These would be additional to the existing focus on mental health, drug and alcohol services and Aboriginal and Torres Strait Islander health.

We have not identified the specific conditions that fall within these broad categories of cardiovascular disease, respiratory illness and cancer. The selection of specific conditions will be a matter for a group of leading expert clinicians and managers, which we recommend should oversee the implementation of these programs.

The Government has provided $45 million over three years to fund initiatives under these programs.

We recognise that the implementation of a State-wide approach will be complex and that change must take place at both a State-wide and a local level. We don’t want to prescribe a formula. We want to stimulate debate and provide incentives for change.

We suggest there are three elements to implementing these programs in NSW. First, there is a need to deal with State-wide issues relating to efficiencies in information systems and cross-Government issues. Secondly, it is important to sponsor local projects and assist providers to change clinical practice at the point of care, at the same time involving patients in controlling their condition and reducing their risk factors. Thirdly, there is the more long-term need to investigate whether there are better ways of funding the care of people with these conditions.

State-wide issues

The following key issues need to be resolved at a State level:

- There needs to be agreement about desired **health outcomes** for specific conditions, and **performance indicators** identified that would assist in measuring these outcomes.
- New **clinical practice** guidelines – informed by research into current successes and innovations in clinical care – need to be agreed.
- **Consumers** must be involved in identifying the services they need.
- New **information systems** must be developed to facilitate the easy transfer of information about an individual's health history and diagnostic information - between GPs, other health workers and hospitals.
- **Cross-Government** issues need to be resolved. There is no point having a focus on health care only. It is important that services like Home and Community Care and Housing are included in the establishment and implementation of the programs, to ensure that the full range of necessary support is in place for individuals and their families.
- **GPs** must be fully involved in planning and delivery at both the State and local levels. The Commonwealth's decision to fund GPs to coordinate care is an important step.[34] This funding and the expanded role of GPs now need to be incorporated into the design of the Priority Health Care programs, particularly at the local level.
- A strong focus on **training** and support for local providers will be important.
- Finally, this can only be driven by **clinical leadership**. Clinicians with proven success in innovation must drive and lead this process alongside senior health managers, many of whom have supported clinical innovations in these areas.

Local projects

We recommend that the primary focus of activity should be at the local level. This should involve the use of individualised health care plans which focus on early detection, comprehensive assessment, prevention and lifestyle, and which define and link the activities of a number of health workers around the needs of the individual. These health care plans are usually medium-term, and patients are involved in their preparation.

We recommend that the $45 million allocation over three years should be targeted mainly to support local projects. These would not be pilot projects. They would be directed to encouraging and financially supporting different local approaches to providing care. Consortia of clinicians across Area Health Service boundaries, across the acute, primary and community sectors and across public, private and non-government sectors should be invited to submit plans for projects consistent with the State-wide direction.

New funding arrangements

We believe that over the next three to five years there should be a serious examination of how funding arrangements should be organised in order to support greater continuity of health care and early intervention. The most important priority is to ensure that the quality of health care improves, along with health outcomes. To a large extent this will drive what types of funding incentives will deliver the best care.

Over time it should be possible to develop a separate funding stream for the Priority Health Care programs. This would involve providing funding to cover the full range of an individual's needs – ranging from visits to their GP, their admissions to hospitals, and services provided by community health, allied health and Home and Community Care. The intention of this type of approach to funding should be to focus on the individual receiving the care, rather than on the institutions providing it.

Any approach of this kind will need to be carefully staged. At present information systems within the State's health care system are simply not well enough developed to separate the full cost of an individual's care over, say, a 12-month period.

As stated, the top priority is to improve the quality of clinical care, including access by clinicians to better data on past treatments and diagnosis. However, a number of questions or issues need to be resolved about ways to improve funding methods in order to support the provision of better quality health care and improved health outcomes. These include:

- how to assess the total costs of the care needs of each patient
- how to provide financial incentives so that the right care is provided at the right time to achieve better health outcomes (for example, it may be better to invest health funds in preventive activities, such as diet and exercise programs, to maintain someone's health)
- how to use funding to encourage links between various health care providers and foster a team approach to providing care during an episode of illness

We recommend that as the first and most sensible step, NSW should identify hospital admissions for patients who fall within the Priority Health Care programs so that there is a capacity to monitor factors such as length of stay and the frequency of admissions, particularly in the Emergency Department.

Recommendations:
Nursing workforce

18. That NSW Health continue and expedite its research into the triggers that would encourage registered nurses not actively employed in the State's health care system to return to the workforce.
19. That the outcome of that research be supported with specific initiatives to increase the numbers of registered nurses working in NSW Health.
20. That the Commonwealth and State Governments work together to reduce the cost of nursing education and increase the availability of places in post-graduate specialities.

Attracting and retaining a skilled nursing workforce

Currently there is a shortage of nurses in Australia, as is the case worldwide. It will be essential to address the shortage of nurses in NSW in order to improve service delivery. Many of our recommendations – including to expand the numbers of clinical case managers, to provide more care in the community to people with chronic and complex conditions, to expand ICU services and to increase access to Emergency Departments – will depend on an adequate and stable skilled nursing workforce.

The following information makes a compelling case for action by both the Commonwealth and State Governments:[35]

- NSW Health is currently actively recruiting 1,000 full-time equivalent nursing positions.
- There are significant shortages in areas such as mental health, community health, midwifery, critical care, aged care, emergency care, and cardiothoracic services.
- NSW Health is currently using 2,215 casual staff, of which 400 are from commercial nursing agencies. This adds to cost and does not facilitate a team approach to the provision of care.
- There are an estimated 40,000 registered nurses in NSW who are not working as nurses in the State's health care system.
- These shortages are affecting both rural and metropolitan services.[36]

We are conscious that in the long term the capacity to attract and retain a skilled nursing workforce will depend on changing the culture of the State's health care system. Nurses, like all other health workers, must be valued and respected and there must be realistic expectations about their workloads. This will require changes in the relationships between clinicians (doctors, nurses and other health workers) and between clinicians and administrators.

A number of strategies have already attempted to address this problem. We recommend further action, based on the following considerations:

- We support the proposed research which is to be undertaken by the Department into why registered nurses are not pursuing nursing careers, and what triggers would return them to the workforce.
- We believe that the outcomes of that research must be followed up by State and Commonwealth support for initiatives to encourage nurses to return to NSW Health, including funding where appropriate. These initiatives might include training and development, expanded opportunities for progression within clinical career structures, and access to accommodation in remote locations.
- Finally, Commonwealth Government support is required in NSW to assist with increasing the affordability of all educational programs and increasing the availability of places in post-graduate specialities.

Improving information technology systems to support service delivery

Issues and challenges

We recommend that the Information Management Technology and Telecommunications (IMT&T) strategy for NSW Health should be reviewed to support improved service delivery. We conclude that there is substantial evidence internationally that information technology systems (particularly patient information systems) can be powerful tools to support clinicians to provide care, and to provide consumers with both access to more information and more control over their own health records.

We conclude that both NSW Health and the State's health system have fallen behind many other industries where information technology has revolutionised responsive and effective client service. This is evidenced by the comparatively low rate of investment in information technology in NSW Health, where expenditure is less than 1% of the budget.[37]

There are a number of challenges that will need to be overcome for NSW Health to take full advantage of innovative approaches to information technology in delivering more effective and quality patient care:

- As with many other health systems and many industries, there are a number of legacy systems which have been developed over many years but which are incompatible, do not allow for the transfer of information between providers, and/or do not provide a complete record of a patient's history.
- There are inconsistent standards for coding and classifying patient information and clinical information, and inconsistent standards about privacy and confidentiality.
- There are variations in work practices that impede the introduction of more uniform systems.
- The community has legitimate privacy and confidentiality concerns about the increasing use of computerised information, and these will need to be carefully addressed.
- Information technology is often not seen as a core part of clinical practice, and there will need to be substantial training of clinicians and managers to ensure that there is widespread acceptance of technology as a tool to assist in the care of patients.

We recognise that building a modern information technology platform for a system as large as NSW Health will be a complex task and may need considerable investment. However, we strongly believe that the benefits to consumers, and to the overall effectiveness of the system in the short- and medium-term, will justify that investment.

We strongly advocate the need for a clear and unifying, up-to-date strategy with a strong focus on supporting clinical care.

Recommendations:
Improving information technology systems to support service delivery

21. That the Department should cooperate closely with Area Health Services and the Commonwealth Government to revise its IMT&T strategy to set out a State-wide strategy to develop an Electronic Health Record for every individual in NSW. This strategy should detail:
    - what the record will cover – for example, tests, diagnostic information, treatment history and pharmaceutical information
    - an agreement with the Commonwealth Government about timing, implementation and the inclusion of Commonwealth-funded sources
    - how privacy and security issues will be resolved
    - how clinicians and consumers will be involved in developing the strategy
22. That as part of its work in developing an Electronic Health Record, NSW Health should undertake the following:
    - the introduction of a Unique Patient Identifier, starting with two Area Health Services and the Priority Health Care programs
    - improvements to patient management systems to link services such as hospitals, community health and general practice
    - the immediate mandating of data standards, security standards and the development of classification systems
23. That the IMT&T strategy should set a timeframe for staging an Electronic Health Record for the Priority Health Care programs, and for two Area Health Services. This should include relevant evaluation criteria to assess their impact in improving the quality of care.
24. That the Department work together with the Office for Information Technology to produce a telecommunications strategy designed to support improvements to patient information systems and the expanded use of telemedicine, as outlined in Chapter 3.

Impacts of the current system on patient care

The information technology challenges that confront NSW Health have direct implications for the quality and responsiveness of patient care.

Unless rectified urgently, they will stifle and limit the important changes we recommend throughout this report. These include linking all health care providers in caring for individuals, linking metropolitan and rural health services and providing information via call centres and on the Internet.

The current system has the following limitations:

- There is no single record that contains a person's health history – including illnesses they have had, information about treatments or surgery they have undergone, and any adverse reactions to drugs. This record should also include risk factors such as obesity, family history of disease, smoking and allergies. Although GPs are increasingly computerised, such information is confined to each individual practice.
- There are no computerised links to network GPs, hospitals and community and mental health teams. This limits a clinician's capacity to communicate, for example GPs cannot transfer test results before a patient visits a specialist or is admitted to hospital. As a result, tests may be repeated, and the patient may have to attend a pre-admission clinic or be admitted to hospital before the day of their surgery or treatment.
- Information cannot be transferred between hospitals. Although each hospital has a patient administration system, its data capture is confined to that hospital. In some cases information cannot be transferred between different parts of a hospital, for example from the Emergency Department to a ward or to the ICU.
- Computerised discharge information cannot be transferred from a hospital to a GP or a community nurse. GPs often remain unaware that their patient has been in hospital, and do not necessarily receive any formal information from the hospital, which would give them reliable information about the treatment their patients received.
- There is no single identifier which allows health providers to identify with certainty the identity of the particular individual to whom they are providing services. Again, this hinders the ability to link a number of health providers in the provision of care.
- Consumers have little or no access to records, either in hospitals or through their GPs. Also, there is currently no mandatory requirement for a GP to release a patient's health record when that patient exercises their right to change providers, or when the GP moves on. This is particularly important in rural communities, where the turnover of GPs tends to be higher than in metropolitan communities.
- There is presently no way to link the cost of Medicare and pharmaceutical payments and the costs of State-administered health services such as hospital admissions and community health visits.

One result of these limitations is that the only continuous record of information is the patients themselves. This becomes a high-risk and high-cost strategy when a patient is unconscious in an Emergency Department, is confused or disoriented or simply overloaded with different information from different providers.

We emphasise that difficulties with implementing major advances in health information technology are not confined to NSW Health. However, various health systems around the world do offer examples of outstanding success, which should be examined.

The need for an Electronic Health Record

We recommend that the IMT&T strategy for NSW Health should be revised to accelerate the planning and introduction of a secure Electronic Health Record for every individual in NSW.

An Electronic Health Record is a single, complete patient record of all health care information which relates to an individual. It records all information about treatments that an individual has received – including hospital admissions – and diagnostic information such as test results.

We recognise from the outset that this recommendation will raise legitimate community concerns about privacy and confidentiality. The NSW and Commonwealth Governments and NSW Health must lead the way in developing and implementing the strongest privacy legislation and the strongest security and confidentiality standards.

We believe that the benefits that will flow from the introduction of the Electronic Health Record – including dramatic improvements in the quality of health care and improvements to the effectiveness of the health system – will more than justify the introduction of this record in NSW. However, we emphasise that a careful and staged approach is essential.

Features of an Electronic Health Record

The Electronic Health Record will have the following features:

- It will be accessible to the individual consumer and their providers, regardless of location and with appropriate attention to privacy and security safeguards.[38]
- The individual will need to give consent about the type of information made available, and the transfer of information between providers.
- The record will contain clinical records, advice, specialist referrals, pharmacy details, diagnostic tests and results.
- The Electronic Health Record will be able to provide GPs, specialists, public and private hospitals, community health centres, and other health providers with access to relevant information about an individual's medical history with the patient's consent.
- It will facilitate the use of computerised discharge summaries.
- It will be linked to clinical protocols and clinical pathways and assist the health care provider in clinical decision-making.

- An information system based on the Electronic Health Record will allow the collection of data (with careful regard to security and privacy) that can be used to measure the quality and performance of health care provision, and to assist the consumer in making informed health choices.

The use of an Electronic Health Record is now widely regarded as a high priority in health care reforms in countries such as Scandinavia, the United Kingdom, Canada and the USA.

Benefits of an Electronic Health Record

The introduction of an Electronic Health Record will have a number of benefits to both patients and health care providers:

- A clinician will have all the relevant information before them to diagnose a patient and provide treatment or organise a referral to another clinician.
- When patients are referred to another clinician relevant information can be transferred electronically if the patient consents. This will include test results and possible risk factors such as history of adverse reactions to certain drugs.
- The onus will no longer be on the patient to retain and recall vital and often complex diagnostic information and advice.
- When a person's doctor arranges tests, the results can be transferred electronically to other relevant providers, thus avoiding the inconvenience and cost of having tests repeated.

We believe that to maximise the benefits of the Electronic Health Record, NSW Health consider the introduction of a Health Smart Card for individual consumers. The Health Smart Card would not contain all the information held in the Electronic Health Record, but would act as a pointer to how information could be accessed and identify the type of information that is held.

The Health Smart Card would belong to the consumer. Its value will be in improving an individual's knowledge and control over information contained in the Electronic Health Record.

We recommend NSW Health investigate the use of a Health Smart Card as a means of increasing consumer control over information and that consumer groups should be involved in its development and implementation.

A staged approach to introducing the Electronic Health Record

The move towards introducing an Electronic Health Record must be staged, the subject of open and informed community debate, tested via a number of demonstration projects and subjected to rigorous security and confidentiality standards.

We have identified a number of steps in this process and we recommend a staged approach to the introduction of the Electronic Health Record, as follows:

- The IMT&T strategy should be revised to include the staged introduction of an Electronic Health Record, allowing for the involvement of consumers, clinicians and relevant privacy bodies.

- The strategy should identify the types of information to be recorded, and specify privacy and confidentiality standards.
- This strategy should establish a timetable for a number of steps which are essential to introduce an Electronic Health Record. These include a Unique Patient Identifier, improving links between patient management systems, mandating standards and improving clinical care systems.
- The introduction of the Electronic Health Record should commence with and be evaluated through a number of demonstration projects, including health conditions which fall within the Priority Health Care programs and selected Area Health Services.

A Unique Patient Identifier

The ability to establish with certainty the identity of an individual who is seeking treatment and to link their identity with existing treatment records is essential, both to implementing the changes we recommend to clinical practice and to supporting greater continuity and quality of health care.

Without a Unique Patient Identifier it is difficult to coordinate a person's interaction with a number of health care providers, especially over time and between locations.

Currently there is no uniform Unique Patient Identifier system for NSW Health. Nor are there mandated requirements or strategies to link patient identification systems between the Commonwealth- and State-funded services.

The Unique Patient Identifier needs to link all activities that an individual can access in an Area Health Service, including inpatient and outpatient activity in a hospital, and community and allied health services.

We propose that the most sensible starting point for this initiative is to develop the Unique Patient Identifier for the three Priority Health Care programs we recommend, and in at least two Area Health Services as part of the demonstration projects recommended in Chapter 8.

A staged approach to the introduction of the Unique Patient Identifier would have the advantage of initially confining its use to a smaller group of people. It is probably of most value to people who regularly access multiple providers, such as people with chronic and complex health conditions. Careful consultation with both consumer organisations and clinicians will be essential.

The Commonwealth Government and the Health Insurance Commission must also be closely involved, as there is little point in a Unique Patient Identifier being confined
to State-administered services unless the number can be used when accessing GP services.

Clearly, the strategy for implementing a Unique Patient Identifier for the Priority Health Care programs and for two Area Health Services must be complemented by the development of a strategy for the entire State.

Upgrading patient management systems

The Department must update its IMT&T strategy to introduce immediate changes to patient management systems, to allow:

- fast-tracking a capacity to transfer information used for clinical care between Emergency Departments and the wider hospital
- accelerating moves to link patient information and discharge information between hospitals and community health providers
- developing the capability to identify individual patients within the Priority Health Care programs through the use of a Unique Patient Identifier
- fast-tracking the ability to transfer information between hospitals within Area Health Services and between Area Health Services
- urgent action to provide computerised discharge information to GPs, and a strategy to establish a computerised link between GPs and Area Health Services

Mandating standards for patient management systems

In order to introduce the Electronic Health Record, the Unique Patient Identifier and improve the links between existing patient management systems, it will be necessary to define and mandate core standards and practices.

Technical infrastructure and application systems will only be effective if they are accompanied by information system reform in the areas of privacy, standards, classification systems, and work practices.

All parts of the State's health system must adopt consistent data standards, terminology and classifications. Unless they do, information held by different service providers cannot be shared and exchanged.

The failure to adopt and implement uniform standards corrupts the quality of the data, producing unacceptable risks to the consumer where information is to be used for clinical care.

For electronic systems to exchange data, clinical information must be coded in a common language. Until this common language is defined, accurate electronic communication between service providers and the use of technology to support decisions is not possible.

We recommend that the Department mandate standards for data, privacy and security and work practices, to be used in all patient management systems in NSW Health.

Clinical care systems

In order to diagnose a patient's condition and to develop treatment plans to bring about the best possible outcome for the patient, clinicians require information which is both timely and of high quality.

Such information is fundamental to the delivery of best practice clinical pathways.

Where feasible, the Patient Management Systems should be extended to include results and the entry of orders. This would encompass the ordering of pathology tests, radiology examinations and consultations, and the potential to dispense drugs on-line.

We recommend that when revising the IMT&T strategy clinical care information systems are identified, in consultation with clinicians, and an implementation timetable is established and costed. We also recommend that these clinical care information systems are integrated with existing or proposed systems, and have the capability to deliver information for clinical decision-making to all health care providers at the point of care.

Demonstration projects for the Electronic Health Record

We recommend that within two years NSW must be in a position to introduce an Electronic Health Record. Again, this should commence with the Priority Health Care programs
to allow for proper evaluation and negotiation of relevant privacy issues. Its introduction must be on a voluntary basis for patients. We also recommend that it should be introduced in two Area Health Services as part of demonstration projects (see Chapter 8).

Improving the telecommunications network

The availability of a quality telecommunications infrastructure linking all parts of the State's health system is critical to achieving an integrated health information system. Such an infrastructure and consequently such integration are most conspicuously absent in rural areas. We note with considerable concern that there is no agreed telecommunications strategy to address this problem. This will need to be developed for a number of Government departments to avoid wastage and mismatches between Government agencies.

Implications for funding

As stated, while we recognise that there may be additional capital costs associated with improving patient information systems, we advocate that these must be weighed against the substantial savings and improvements to patient care that can be realised. These savings and improvements include a reduction in the duplication of tests between GPs, specialists and hospitals and the capacity to support early intervention in patient care, thereby reducing urgent admissions (sometimes through the Emergency Department) to hospitals.

Achievable benefits – Improving service delivery

Critical care

- Improved coordination of Intensive Care Unit services will reduce Intensive Care Unit transfers between hospitals.
- The increased availability of Intensive Care Unit services will improve access in other areas such as surgery, and reduce blockages to access in Emergency Departments.
- A three-year emergency care plan will provide a long-term strategy to access problems in Emergency Departments.
- Expanded GP after-hours services will reduce the pressure on Emergency Departments.

Planned and acute hospital admissions

- The better utilisation of hospital beds will mean better access for all patients, reductions in waiting times and an increased capacity for the system.

Chronic and complex health conditions

- Health outcomes for patients with these conditions will improve, as will their quality of life.
- Urgent admissions through the Emergency Department will be reduced.
- There will be a new focus on maintaining good health, through early intervention and the provision of more care in the community.

Recruiting and retaining a skilled nursing workforce

- The capacity to attract and retain a skilled nursing workforce will support improvements to service delivery, and reduce the high extra costs currently incurred in the employment of casual and agency staff.

Improving patient information systems

- The State's health system will gain the capacity to revolutionise health care and link health care providers.
- There will be a vastly improved capacity for early intervention and the coordination of care.
- Consumers will have better access to information about their health care, and greater control over security and privacy issues.
- The duplication of tests will be reduced.
- GPs, hospitals and community health providers will be better able to work towards delivering a seamless health care service.

20 Defined by NSW Health as Level 6 Role Delineation, and the Faculty of Intensive Care as Level 3.

21 NSW Health Annual Reports, 1997/98 and 1998/99, NSW Department of Health.

22 The Access Block Working Party was convened by the Minister to advise on delays in transferring patients from Emergency Departments to ward beds, and to identify practical solutions to address these problems.

23 The National Demonstration Hospitals Program is a national initiative to improve care in hospitals, commenced in July 1995. Stage 1 was completed in June 1997, Stage 2 in July 1998, and Stage 3 will run through until March 2001. Participating NSW hospitals are St George, Prince of Wales, Liverpool Health Service and John Hunter Hospital.

24 Australian Resource Centre for Hospital Innovations, National Demonstration Hospitals Program Phase I Review, 1997.

25 Day of surgery performance for booked admissions in NSW, December 1999.

26 These procedures include endoscopy and cardiac catheterisation.

27 Same Day Surgical and Endoscopic Procedures Policy, NSW Health, 1999, p14.

28 Analysis undertaken by the Health Services Research Group, University of Newcastle, 1999.

29 A discharge planner organises discharge activities, such as referral to the community health team, transfer of information to the GP, and assessment of post acute care needs.

30 NSW Health Annual Report, 1998/99.

31 Analysis undertaken by NSW Department of Health, Structural and Funding Policy Branch, 1999.

32 Analysis undertaken by NSW Department of Health, Structural and Funding Policy Branch, 1999.

33 NSW Health Annual Report, 1998/99.

34 In November 1999 the Commonwealth commenced the payment for the three new Medicare Benefits Schedule items that will enhance Primary Care. These items cover annual voluntary health assessments for all people 75 years of age and over, case conferencing and care planning. Spending for the new MBS items will total around $110 million over four years. (Source: Peter Davidson, Manager of General Practice Program, Health Services Development Branch, Commonwealth Department of Health and Aged Care.)

35 Information supplied by the Chief Nursing Officer, NSW Department of Health 1999.

36 Information supplied by the Chief Nursing Officer, NSW Department of Health 1999.

37 Information supplied by Information & Assets Services – NSW Department of Health.

38 For example, a diabetes patient with a clinical case manager will be able to update their record daily with their blood sugar readings.

3 Enhancing Health Services to Metropolitan and Rural Communities

OBJECTIVE

Improved access to health services and improved quality of patient care.

INTRODUCTION

As at June 1999 the population of New South Wales was 6,411,680 people, of whom 4,783,334 lived in metropolitan Sydney including Newcastle, Wollongong and the Central Coast.[39] The distribution of the population has changed, with significant growth in areas such as South Western Sydney, the Central Coast, the Mid North Coast and Northern Rivers. There have been some areas that have shown a significant decline, the most noticeable being the Far West. In addition, the population is ageing: the proportion of the population aged 65 years and over was 12% in 1997, and by the year 2021 is expected to rise to 18%.[40]

These demographic changes have significant implications for health services, as do the changes to clinical practice outlined in Chapter 2. Advances in technology and telemedicine also offer opportunities for innovations in the delivery of patient care, especially greater networking of services.

Our recommendations for improvements to service delivery (see Chapter 2) require improved planning and decision-making about the role and distribution of health services in both metropolitan Sydney and rural NSW. This planning must involve extensive consultation with communities if services are to reflect local needs and priorities.

We are concerned that at the time of conducting our review there was no agreed plan within NSW Health about the future of Sydney's health services, and no long-term strategy to improve services to rural communities.

Planning of this nature has been hampered by a lack of certainty about future budget allocations. With the provision of growth funds and three-year budgets, there is now an opportunity to redefine the role and distribution of health services in metropolitan and rural communities to reflect changes to clinical practice, changes in community expectations and advances in telecommunications and information technology.

In this chapter we set out the key principles which should drive planning and decision-making, and key milestones which need to be achieved. We emphasise the importance of networking, both within and between metropolitan and rural health services. In the case of rural health, we also recommend a package of reforms in transport, workforce, aged care and funding which is essential to guarantee that people in rural and remote communities have access to effective and sustainable health services.

PRINCIPLES THAT SHOULD GUIDE THE PLANNING OF METROPOLITAN AND RURAL HEALTH CARE SERVICES

We believe that the following principles need to guide managers and the Government in decision-making about the future role and distribution of health services in NSW.

- The priority is to meet the needs of communities by providing the most appropriate, highest quality health care services in the most appropriate location.
- All people in NSW should have access to the care they need, irrespective of where they live and where they enter the health system.
- A fundamental principle of the Australian health system is the patient's right to be treated according to clinical need regardless of where they live. Patients must continue to have choice of provider, and this choice must be protected and enhanced when decisions are made about the distribution of services.
- Priority should be given to minimising travel times, particularly for people living in rural and remote communities and people requiring ongoing treatment (such as people with chronic and complex health conditions).
- Upfront capital injections will be needed to support these changes. However, every effort will be made to recoup costs through redevelopment or disposal, and a reduction in operating costs.
- Services will need to be networked within Area Health Services, across the State and across metropolitan Sydney.
- The Government must support necessary major changes by rapid and decisive planning (for example, rezoning) and should coordinate the activities of relevant Government departments in the redevelopment of large sites.
- Community involvement must be structured into the planning process. There must be a clear timetable and opportunities for this involvement, and an openness about options and costs.
- All health workers should be involved in the planning process, have access to information and be supported during transition arrangements.
- Information about local health care services will be easily accessible to the community.

Recommendations:
Improving planning and decision-making for the metropolitan area

25. That a Metropolitan Planning Taskforce made up of metropolitan Area Health Service Chief Executive Officers, relevant clinicians and a senior Department Director should be formed immediately, to oversee and fast-track decision-making about the role and distribution of health services across the whole of Sydney.
26. That the metropolitan health service plan should be developed in three stages.
27. That the Metropolitan Planning Taskforce should have concluded its deliberations in time to allow implementation in the 2001/02 financial year. This includes priorities to address the uneven distribution of health care services, and the volume and location of key clinical services, such as:
    - Intensive Care Units
    - trauma
    - Emergency Departments
    - neurosurgery
    - interventional cardiology/cardiac surgery
    - renal transplantation
    - paediatrics
    - obstetrics
    - long-stay mental health services

    in time to allow Area Health Services to undertake local planning and implementation in the 2001/02 financial year.
28. That clinical plans should be developed in close and continuous consultation with leading expert clinicians.
29. That NSW Health should provide the necessary resources to fast-track this process.

IMPROVING PLANNING AND DECISION-MAKING FOR THE METROPOLITAN AREA

FINDINGS AND OBSERVATIONS

We believe that there is an urgent need to develop a single, coherent, long-term and agreed plan for metropolitan Sydney. From our examination of the progress to date within NSW Health in updating the distribution and role of Sydney's health services, we conclude that:

- There has been substantial reconfiguration, redistribution and upgrading of existing services, and construction of world-class facilities such as the New Children's Hospital.
- The process of reconfiguration and adaptation needs to be continuous, as there are still significant inequities between the ability of communities to access some services. For example, until recently, cancer patients in South Western Sydney were required to travel significant distances each day to obtain radiotherapy treatment.
- In addition, people in Greater Western Sydney had reduced access to GPs and specialists in 1997, with an average of one GP for every 1,050 people (compared with the metropolitan average of 887) and one specialist for every 1,585 people (compared with the metropolitan average of 1,086).[41]
- In areas such as trauma and cardiology services, speciality planning needs to be completed and decisions made about the mix, volume and location of these services.
- There is substantial agreement amongst Area Health Service Chief Executive Officers that there needs to be a health services plan for the whole of Sydney and that this should extend to a range of secondary services such as mental health and the role and function of district hospitals. The plan should also factor in the impacts of decisions for Sydney for the wider metropolitan area, including the Central Coast, Newcastle and Wollongong.
- The plan must address the uneven distribution of health services across metropolitan Sydney and the subsequent movement of patients across Area Health Service boundaries. This movement of patients (cross-border flows) accounts for $600 million of health expenditure annually.
- We strongly support and encourage hospitals and other health services to embark on increased network arrangements – and in particular, formal networks between metropolitan and rural health services. With advances in technology and increased specialisation, it is now essential to think of Sydney as one city of networked services, each performing complementary roles and with some providing services for the entire State. Although this means that patients may have to travel across the city to access some speciality services, we believe that it is simply not possible to provide all services in every location. It is not safe or appropriate to do so.

DIRECTIONS FOR CHANGE

Council saw three actions it could take to set a direction for the future:

- to outline the case for a plan for the whole of Sydney
- to ensure that decision-making about the future roles and distribution of services reflects the principles outlined earlier in this chapter
- to set out a process and desirable milestones for action

The rationale for a new approach

The following represents a background to the changes which have taken place in clinical care and the reconfiguration of health services, which necessitate a new approach to planning the future of Sydney's health services.

- There have been significant changes to the profile and distribution of Sydney's population. These essentially relate to a growth in population in the West, South West and Southern parts of Sydney.
- Over the past 10 years the priority of successive Governments has been to develop health care services in the areas of fastest population growth.
- There are some clinical services where the numbers and distribution need to be managed for Sydney as a whole. This is due to factors such as cost, the need for a certain volume of patient activity and the need for certain infrastructure such as theatres and Intensive Care Units (ICUs), or access to clinical expertise to maintain the quality of patient care.
- At the same time as new services have been developed in growth areas, more established Area Health Services (such as South Eastern Sydney, Central Sydney, Northern and parts of Western Sydney) have been responding to the need to redevelop and replace outdated infrastructure. They have been involved in substantial upgrading of facilities such as Prince of Wales Hospital, and in some cases the complete reconfiguration of the roles and responsibilities of all hospitals within an Area Health Service – as is the case for the Central Sydney Area Health Service.
- There have been significant changes to the provision of health care which affect the role and function of hospitals. Such advances in technology as minimally invasive surgery are providing more timely and effective treatment. However, in order to maximise the potential of these advances changes are required to infrastructure – such as increased access to operating theatres or procedure rooms. Similarly, information technology and telemedicine initiatives are facilitating a range of information, allowing care to be delivered from a variety of sites.
- There has been an increased focus on providing health care in the community. There have also been major reductions in hospital length of stay, and greater use of day-only admissions. This must be supported by changing the nature of hospital activity using day-only facilities and community and rehabilitation clinics.
- Some hospital infrastructure cannot easily be adapted to respond to these changes. Important facilities often lack the flexibility and adaptability required for a modern health system.

A plan for the whole of Sydney and networks across the State

Against this backdrop of rapid change, each Area Health Service has often planned its services in isolation, with a unique set of assumptions and methodologies. We are concerned about this approach, as decisions about the role and function of a facility in one Area can significantly impact on another Area Health Service. This approach also creates the potential for unnecessary service and costly duplication. We therefore recommend a plan for the whole of Sydney.

As we have stated, there is a need to increase the networking arrangements between Area Health Services, within Area Health Services, across metropolitan Sydney and across the State. This will require centralised coordination for some services. There are already successful State-wide and metropolitan networks operating in paediatric care and critical care. This highly successful approach to networking will need to be extended to include areas such as Emergency Departments and ICU services. To ensure that everyone in NSW has access to high quality and appropriate care, more formal networks will be needed between metropolitan and rural health services.

The formation of these networks will reduce duplication, and promote centres of excellence and will inevitably cross Area Health Service boundaries. It is therefore not practical for each Area Health Service to negotiate those networks individually.

We therefore recommend the immediate implementation of a better coordinated planning process, as set out below.

Processes and required timeframes

To develop a health services plan for metropolitan Sydney we believe that the following process and timeframe must be put into place:

The creation of a Metropolitan Planning Taskforce

The most important step in metropolitan planning is to create a structure for rapid, collegiate decision-making. We recommend that the Department create a coordinating taskforce made up of Area Health Service Chief Executive Officers, a senior Department Director responsible for keeping the process on track, and an independent full- or part-time Chair (preferably with a clinical background). This taskforce should have dedicated resources for at least six months, including full-time secondments of Area Health Service planners, possibly part-time secondments of leading clinicians and importantly, dedicated funds to commission and undertake research. The purpose of this group is to facilitate Government decision-making and to manage the impact of individual service developments across Area Health Services.

A staged approach

We believe there are three stages to this complex process:

- Certain decisions must be made for the whole of Sydney, facilitated by the Metropolitan Planning Taskforce. This includes addressing major gaps in services and the development of clinical plans for key specialities.

- Area Health Services need to incorporate these decisions into their Area Health Service planning, in consultation with their communities.
- The results of that Area level planning need to be assessed, decisions made quickly and the results incorporated into a Metropolitan Health Services Plan. This way, the NSW Government and the community will gain an overview of priorities and possible changes across the entire metropolitan area.

The Metropolitan Planning Taskforce will need to set a detailed timetable for this process. We recommend that the implementation should be scheduled to commence in 2001/02. This will mean that central decisions will need to be made in time to allow Area Health Services to undertake their local planning and consult with their communities, and for relevant capital priorities to be identified as part of the budget process.

Stage 1 – Planning for the whole of Sydney

As stated, a number of issues need to be resolved for the whole of Sydney, including:

- the need to address the uneven distribution of services and the flow of patients between Area Health Services
- the need to prepare clinical plans for the entire population of Sydney – both for specialty services, and for some secondary services which reflect the required volume of patient activity and infrastructure needed to provide the highest quality of care
- the need to address the role and function of district hospitals, to ensure they provide relevant and complementary services to a broader network of hospitals

Addressing the uneven distribution of services and the flow of patients between Area Health Services

There is an urgent need to address the problem of uneven distribution of services, which causes a significant flow of patients between Area Health Services representing $600 million of State health care funding per year. Decisions to reverse the flow of patients between Area Health Services will need to be carefully considered. The Metropolitan Planning Taskforce will need to consider a number of issues:

While in some cases the flow of patients reflects a lack of access to services, in others it reflects the choice of either the patient or their referring doctor. It may also simply be the case that a particular service is more convenient, in terms of transport or proximity ('natural flow'). Inevitably, there will always be some movement of patients between Area Health Services. In developing a health services plan for metropolitan Sydney, there are two priorities for NSW Health:

- to identify those services which need to be provided locally, and where it is unreasonable to expect people to travel long distances to access their health care
- to identify where there are gaps in these types of services which need to be rectified, particularly for people with chronic and complex conditions

Once gaps have been identified the Metropolitan Planning Taskforce would need to consider a further three issues prior to making a final decision to transfer an existing service or establish a new service.

First, they must give weight to the principle of choice, which is fundamental to the Australian health system. We applaud the exercise of this choice as a strength of a modern health system characterised by informed consumers, the promotion of excellence and innovation in service delivery, and advanced telecommunications and technology.

Secondly, many long established clinical units have become centres of excellence, and will attract out-of-Area patients. Therefore decisions about the relocation of units or the growth of new services and subsequent transfer of patients and possible funding, must take account of impact on existing services. The rapid loss of patients or funds could compromise the quality and safety of established clinical services, and produce uncertainty for health workers and managers.

Thirdly, where decisions are made to transfer services, NSW Health must put in place careful transition arrangements to ensure that new services are fully operational prior to the transfer of resources and patients.

We recommend early resolution of these issues in acknowledgment that they have significant implications on resource distribution, clinical service planning and budget certainty.

Metropolitan clinical service plans

Clinical plans are needed for a number of specialty services. In some cases this is because a certain volume of patient activity is needed to guarantee safety and quality. In other cases it is because certain infrastructure (such as access to operating theatres) is essential for the clinically effective operation of a service.

NSW Health has advised Council that the priority for clinical service plans is as follows:

- ICUs
- trauma
- Emergency Departments
- neurosurgery
- interventional cardiology/cardiac surgery
- renal transplantation
- paediatrics
- obstetrics
- long-stay mental health services

We recommend that panels of clinicians and managers (effectively sub-committees of the Metropolitan Planning Taskforce) should be involved in the completion and implementation of these plans.

We also recommend that priority should be given to early completion of clinical plans for services which are highly interdependent and which have a major

impact on the role of individual hospitals – such as trauma, ICUs, Emergency Departments and neurosurgery. This will provide Area Health Services with an early opportunity to assess the impact of decisions on their local services.

The clinical plans should consider:

- the profile of existing services (including numbers and locations)
- evidence about acceptable standards of clinical practice (including volumes, required infrastructure, skill levels and workforce requirements)
- evidence of the effectiveness of emerging advances in clinical practice
- current and likely future gaps in service distribution (based on demand forecasts)
- options to improve distribution and quality – examining whether services can be purchased from another Area Health Service or from the private or non-government sectors, and whether it will be possible to attract and retain a skilled workforce if services are to be relocated

Outcomes from stage 1

We recommend that there must be clear deliverables from stage 1, including:

- decisions are made about the level of intended self sufficiency for each Area Health Service, and the patient flows which are to be reversed
- decisions are made about the location and number of key clinical services, based on the completion of the key clinical plans

Stage 2 – Area Health Service planning

Once central decisions have been resolved, Area Health Services will need to incorporate them into their planning. Again, we emphasise the need to provide Area Health Services sufficient time to undertake important community consultation, and to finish stages 1 and 2 in time to allow for implementation in 2001/02. We note that many Area Health Services are well advanced with the development of service and asset plans.

Area Health Plans should contain the following elements:

Population profile

Including:

- size and distribution
- morbidity[42] and mortality
- socioeconomic status
- aged profile

Demand analysis

This should include a ten-year analysis of projected volumes of activity across all services – acute inpatient hospital admissions (including the percentage of day-only admissions), community health, day-only care, outpatient services, mental health and rehabilitation services.

This should make explicit assumptions about expected patient flows to and from other Area Health Services.

Service strategy
There should be a description of the proposed roles of each of the facilities in the Area Health Service, including how they will be networked (for example, a particular hospital may take the lead role in certain services such as orthopaedics) and how this will be communicated to consumers.

Asset strategy
This should build on the service strategy and include:

- an audit of existing infrastructure which outlines
  - capacity and functionality
  - capital value
  - utilisation (that is, what percentage is not being fully utilised and the recurrent costs of servicing that asset)
- current and projected recurrent maintenance liabilities
- identification of options to improve the match between services and assets or to address substantial maintenance liabilities

Community consultation strategy
This should outline the proposed process, structures, timeframes, how community input will be evaluated and assessed, and how contentious issues will be managed. Area Health Services will need to define clearly the role of every participant in the network.

Workforce transition
This is vital and must include identification of impacts, communication strategies and transition arrangements (including retraining and relocation consultation with relevant industrial bodies).

Budget resource implication (financial impact statement)
Area Health Services must identify all budgetary implications, including the costs of resourcing the planning process. More importantly, this should include an emphasis on capital requirements (upfront and ongoing), the percentage of funds to be recouped by sale or redevelopment or by a reduction in operating costs, and the impact on recurrent budgets, including the identification of appropriate additional services.

Information technology
This strategy should outline how information management, technology and telecommunications can best support the proposals of the Area Health Plan, and identify future requirements to enhance existing services and facilitate proposed service networks.

Outcomes from stage 2
We recommend that stage 2 must deliver the following:

- Area Health Plans are finalised and have been informed by comprehensive community consultation
- each Plan has addressed the prerequisites we have outlined, such as comprehensive service and asset planning

Stage 3 – Central decision-making

Area Health Services will expect central decisions to be made in time to influence the 2001/02 capital budget. The Metropolitan Planning Taskforce will be responsible for facilitating that decision-making process. No announcement about individual facilities should be made until stages 1 and 2 are completed.

Implementation should commence in July 2001. We emphasise that this will be an ongoing process and will need quarterly monitoring and annual review.

Clinical plans will need to be the subject of ongoing evaluation, monitoring and review to keep pace with changes in clinical practices.

Outcomes from stage 3

There is an agreed strategy for Sydney as a whole, and relevant capital and budget negotiations have progressed to allow for implementation by July 2001.

ENHANCING SERVICES TO RURAL COMMUNITIES

FINDINGS AND OBSERVATIONS

We believe that quality health care must be available to everyone in NSW, regardless of where they live and where they enter the health care system. Ensuring this equity of access in rural NSW present particular challenges. We have worked closely with a wide range of representatives from rural communities. They have raised a number of issues, which need careful consideration in any strategy intended to improve the distribution, access, quality and effectiveness of rural health services:

- People in rural communities do not share the same health status as metropolitan residents. They are more vulnerable to cardiovascular disease, asthma and injury.
- In many rural communities there is a high proportion of Aboriginal and Torres Strait Islander people, who have an even poorer health status than other rural residents, with a life expectancy 15 to 20 years below that of other Australians.[43] We believe that improvements to health care for Aboriginal and Torres Strait Islander people can only be addressed through a concerted approach by all areas of health service planning and not just through the specific and welcomed initiatives which have been set up by the NSW and Commonwealth Governments.

  As we have stated, Council has not comprehensively or separately dealt with Aboriginal and Torres Strait Islander health. However, we have consistently acknowledged the importance of the needs of this community. We support the implementation of the NSW Aboriginal Health Strategic Plan, and recommend that rural Area Health Plans specifically address the needs of Aboriginal and Torres Strait Islander communities and indicate specific strategies and targets for improving the health status of Aboriginal people, including the development of partnerships with Aboriginal service providers.
- There are significant shortages of health care providers, particularly GPs, in some rural communities.[44] This adds to pressure on public hospitals and

Emergency Departments. While in metropolitan communities there is one GP for every 887 people, in rural communities there is an average of one GP for 1,277 people.[45]

- The absence of providers also means that many communities are not accessing their potential share of Commonwealth-funded health expenditure. Compared with their metropolitan counterparts, on average rural areas are accessing one-third less Commonwealth funded services – that is, $335 per person in rural areas compared with $446 per person in the metropolitan area.[46]
- Successive NSW Governments have had a strong commitment to retaining as many local health care services as possible in rural areas. We commend this approach, but recommend more explicit recognition of the costs of maintaining services which often have lower than desirable patient activity and staffing levels. Maintaining as many services as possible at a local level may require changes to the role and focus of facilities, such as co-locating a number of services from one facility and a greater networking of services.
- We recognise the wider issues affecting rural communities, including the role of Area Health Services as major local employers.
- Rural communities must have greater certainty and predicability in service delivery, and local communities need to be closely involved in local service planning.

We believe that there are some practical and achievable initiatives which would improve health care for people in rural communities. These build on successful initiatives already underway and incorporate the work of the Ministerial Advisory Committee on Health Services in Smaller Towns. This Committee was asked to provide advice to the Minister on communities that will benefit from a Multi Purpose Service delivery model.[47] Their report was completed in December 1999.

The NSW Government's decision to provide three-year budgets is a great step forward for rural NSW. Communities and Area Health Services will now have the certainty and confidence to plan for the future. This will also provide a much needed incentive to attract and retain skilled doctors, nurses and allied health workers.

Recommendations:
Predictable and coordinated services

30. That all Area Health Services should update or prepare a three-year Area Health Plan in consultation with their community. The Plan will detail how they will set up and support a service network which includes primary health care workers, community health, non-inpatient services, local hospitals, rural referral hospitals and metropolitan principal referral hospitals.
31. That Area Health Services should fully involve the community and local Health Councils in this planning, and provide information about capital funding and recurrent funding levels over the next three years in order to facilitate community input.
32. That Area Health Plans should address priority areas such as mental health, Aboriginal and Torres Strait Islander health, aged care, and drug and alcohol services.
33. That the Department should facilitate the creation of formal clinical networks between rural Area Health Services and metropolitan Area Health Services. Rather than cutting across the successful networks in place, these should provide a default or backup capability.

DIRECTIONS FOR CHANGE

We suggest that the following directions for change will address the key challenges facing rural communities.

Predictable and coordinated Services

We recommend that Area Health Services should plan around a coordinated set of services, or a service network made up of:

- primary health care workers (GPs, nurses, community and mental health workers, and allied health workers) and community- and home-based services such as pharmacy services and Home and Community Care
- local hospitals with better links to rural referral hospitals, which will sometimes include aged care services funded by the Commonwealth

- rural referral hospitals, which will be the central focus of the acute health service network, providing a greater range of speciality services locally
- ambulance and community-based transport, which enable all the parts of a network to function as one
- extended service networks between rural and metropolitan health services

A first step to improving services to rural communities should be to take advantage of three-year budgets in order to develop a shared understanding of how services will be organised and networked over the next three years. Each Area Health Service will now be in a position to work with their local community, and to identify the role and distribution of services through their Area Health Plan.

An important part of the service network should be the establishment of formal links between metropolitan and rural Area Health Services. These links are intended to support existing formal and informal relationships, such as the critical care network which operates across the State.

The proposal is intended to ensure that a wide range of services are available in rural NSW. For example, every metropolitan Area Health Service will be required to provide back-up to a particular rural Area Health Service, for example in the form of visiting specialists.

The requirements to support these networks should be included in the performance agreement of Area Health Service Chief Executive Officers. There should be an effort to build on existing clinical networks and link Area Health Services with similar communities of interest and to linked transport arrangements.

Upgrading services and supporting rural health providers

The service network can work more effectively with the following supports:

- Peer support arrangements should require nominated specialists from rural referral hospitals and metropolitan principal referral hospitals to be on call to assist GPs, community health workers and mental health workers to deal with complex cases.
- The rapid implementation of the 24-hour Health Call Centre (see Chapter 6) will provide a point of advice, referral and information to consumers and providers across NSW. The Health Call Centre will be accessible to every individual in NSW, and will provide advice on local services and telephone access to a registered nurse who can provide advice on individual health problems.
- Primary health care workers (GPs, nurses, community and mental health workers and allied health workers) should be gradually co-located onto one site with Ambulance services and workers from other services such as Home and Community Care, so that health workers can provide each other with support and health care can be better coordinated.

Recommendations:
Upgrading services and supporting rural health providers

34. That Area Health Plans should detail priority clinical areas for service enhancement, together with strategies to attract and retain relevant specialists. Key areas which may be considered include acute psychiatric services, oncology, orthopaedics and renal services.
35. That Area Health Services should identify options and cost for co-locations of primary health care workers, Ambulance and relevant Government services such as Home and Community Care.
36. That there should be an immediate identification of, and agreement on, those facilities which need capital upgrading in order to improve patient care and working conditions, and to align facilities to defined service needs.

- The physical infrastructure in rural referral hospitals and local hospitals must be upgraded. Each Area Health Service will be required to complete an asset management plan, based on the Area Health Plan which outlines how assets will support the provision of local services.
- Effective telecommunications such as Internet and e-mail should be installed to connect all primary health workers with their rural referral hospital and with each other. This will also provide an opportunity to explore different ways of providing or enhancing access to advice, training and peer support.
- Key clinical services in rural referral hospitals (such as acute psychiatric services, oncology, orthopaedics and renal services) should be upgraded, in order to reduce the amount of travel that patients have to undertake. This will require the recruitment and retention of specialists located in rural areas, and the continued support of metropolitan specialists to travel to rural centres in order to provide speciality outreach care. Decisions about which services to upgrade will be the responsibility of each Area Health Service.

Funding

We propose that a number of changes are necessary to the funding arrangements which currently apply to rural Area Health Services, including:

- the need for more explicit recognition of the higher cost of providing health services in remote communities
- the need for different approaches to funding small local hospitals
- the need for the State and Commonwealth Governments to work together to address the problems of some communities which are not able to access their potential share of Commonwealth expenditure because of a lack of access to health care providers (most notably GPs)
- the need for a continuation of efforts to address the levels of debt that have accrued in some Area Health Services

In respect of community service obligations we note that the current estimate of the additional cost of providing services to rural communities is $96 million per year.[48]

While the resource distribution to Area Health Services currently takes some account of these additional costs, there is a case for further review. This should recognise that some Area Health Services are retaining services which are not cost-effective, due to a Government commitment to maintaining services. It should also recognise that there are additional costs in having to maintain a network of small hospitals spread over a wide geographic area.

A separate funding approach is necessary for small rural hospitals. Such hospitals have high fixed costs and are generally more restricted in their ability to predict and forecast the volume and severity of patient activity. Small rural hospitals must be available to respond to a variety of cases at any given time. We therefore recommend that they should be funded by way of annual grants and that Area Health Services should continue to monitor their efficiency – for

Recommendations:
Funding

37. That the Department should develop a community service obligation policy for rural health services which formally and explicitly accounts for the higher cost of providing rural health services.
38. That the Resource Distribution Formula used to guide the allocation of funds to Area Health Services should be reviewed to take into account this community service obligation, and to ensure that additional costs of rural health services take into account the cost of maintaining a number of small hospitals.
39. That NSW Health should work with the Commonwealth Government to develop notional budgets for rural communities which show the anticipated level of both Commonwealth and State expenditure.
40. That the Department should develop an approach to funding local hospitals where a significant proportion of funds are provided on a fixed basis, in recognition of their high fixed costs.
41. That the Department should continue to examine strategies to tackle the debt problems of rural Area Health Services.

example by monitoring the cost of each episode of care, admission rates and length of stay – to ensure that where it is practical and clinically effective to do so, greater efficiencies are achieved.

We recommend that immediate steps should be taken by the Commonwealth and State Governments to address the unequal expenditure of Commonwealth funds in many rural communities due to the absence of health care providers. As stated earlier in this report, Commonwealth Medicare expenditure is determined on the availability of providers rather than on a population basis.

We recommend that the Commonwealth and State Governments should develop notional budgets for selected rural Area Health Services which show the likely levels of expenditure of both Commonwealth and State funds over a 12-month period. This would allow Area Health Services to identify potential gaps in service availability and to enter into a dialogue with the Commonwealth Government about strategies to address that gap.

We recommend that the Department continue to identify options to reduce the level of debt which has accrued in some rural Area Health Services, and to prevent debt levels escalating further. The introduction of three-year budgets provides an environment where medium-term debt reduction strategies can be effectively introduced.

Workforce

A great deal of effort has gone into addressing the problems of attracting and retaining a skilled rural health workforce, since this is a major determinant of the quality and accessibility of health care.

Our recommendations seek to expand and accelerate some of these initiatives. We believe opportunities exist to:

- enhance remote allowances to allied health workers
- extend locum support to allied health workers, nurses and other community workers
- increase the number of rural clinical schools
- increase the number of accredited rural training positions
- incorporate mental health into the rural clinical schools

These recommendations will improve peer support, access to skill maintenance, and the provision of career paths. If the rural workforce is to sustain recruitment and retention, incentives and job offers must be seen as part of a total package.

Disincentives to recruitment in rural areas include a lack of suitable accommodation. This can prevent potential staff from even considering a position. We recommend that an examination of incentives for providing accommodation to health practitioners as part of their recruitment package should be a priority.

Recommendations:
Workforce

42. That the rural clinical schools due to commence in Wagga Wagga be expanded to Tamworth and Dubbo, and that mental health should be incorporated into the rural school model. This expansion will require appropriate negotiation with the Commonwealth Government on its implications for staff in the rural referral hospitals and for recurrent costs.
43. That there should be an extension of scholarships in nursing and allied health to students from rural communities, and that a plan for that extension should be completed no later than July 2000.

Recommendations:
Transport

44. That consideration be given to consolidating the management of community transport into one organisation, to provide Area Health Services with one point of contact for the coordination of transport and health services.
45. That the rural Area Health Services and the Department examine the feasibility of a second-tier transport network within the ambulance service.
46. That NSW Health investigate the benefits of implementing an electronic booking system to support better coordination of community-based transport.
47. That the guidelines for IPTAAS should be reviewed to ensure:
    - that where a clinically appropriate service is available within an Area Health Service and waiting times are considered appropriate, IPTAAS cannot be used to fund travel beyond the boundaries
    - that there is more flexibility regarding the 200-kilometre restriction, especially for financially disadvantaged people
48. That the Department should investigate the development of a new initiative to provide telephone access to every patient in a rural referral (and possibly local) hospital to enable them to keep in touch with their families and/or carers. This will need to be supported by Commonwealth initiatives to improve telephone access to those people in rural communities who do not have a telephone.
49. That as part of extended service networks, Area Health Services should examine options such as rostering specialists, allied health workers and other community health workers to local hospitals at set times, and to rural referral hospitals on set days, in order to reduce the amount of travel that people have to undertake.

Transport

Access to affordable and responsive transport is a significant problem for people in rural and remote NSW. Our objective here is twofold. We believe that NSW Health needs to reduce the amount of travel required to access health care services, particularly primary and community-based services. Where people are required to travel, we want to ensure that transport is properly funded, better coordinated and does not impede access to appropriate clinical care.

One of our key concerns is that community-based transport – which is essential to facilitate better access to primary health care services – is currently coordinated by over 131 separate community organisations and funded by eight Government departments. This has severely limited the ability of Area Health Services to create effective links between health service planning and community transport planning.

We are also concerned that the program set up to assist people to travel to health services, known as the Isolated Patient's Travel Assistance and Accommodation Scheme (IPTAAS), is regarded as having two key limitations. First, many regard the 200-kilometre restriction as inflexible. Secondly, our consultations with rural representatives reveal that even where a clinically appropriate service is available, there has been a lack of incentives to access local services.

We note the lack of a second-tier transport system within the ambulance service. Such a second-tier system would essentially be aimed at returning people home from hospital where they cannot access their own transport. The most notable example would be patients who were taken to hospital in an emergency via ambulance and have limited access to transport to return home.

We recommend that consideration be given to options for improving the coordination of community-based transport initiatives. This should include an examination of the feasibility of a single agency taking responsibility for funding community-based organisations, in order to provide a greater opportunity to link transport planning with Area Health Service planning. Consideration should also be given to implementing a computerised system that would assist community organisations to better coordinate their transport.

We recommend that the guidelines for IPTAAS be reviewed to provide greater incentives to use local services where clinically appropriate, and that there should be greater flexibility regarding the 200-kilometre restriction, especially for financially disadvantaged people.

Finally, we recommend that consideration be given to improving telephone access for patients in all rural hospitals. Although admission to hospital may have the effect of significantly isolating rural people from their families and friends, not all rural hospitals currently provide telephone access. Improved telephone access would also assist patients to make the necessary arrangements with their family for relevant support and assistance as they prepare for their discharge from hospital.

Information management, technology and telecommunications

We believe that the recommendations we make in Chapter 2 for the introduction of an Electronic Health Record and a strengthening of the telecommunications network will be of great benefit to rural communities, and that they should be supported by the fast-tracking of telemedicine throughout NSW.

Telemedicine is the delivery of health care services using digital telecommunications to transmit images, voice and data between two or more health units, in order to provide clinical advice, consultation, education and training services.

This means that as a patient is being examined in one location, a clinician (such as a ophthalmologist or radiologist) in another location has simultaneous access to relevant diagnostic information, so that they can provide immediate advice, referral or treatment. We believe that this type of patient care has the potential to revolutionise access to health care in rural communities. There are currently 61 telemedicine sites already operating in NSW, and a further State-wide expansion is underway.

We also recommend that health care workers in isolated and remote locations should be supported by the greater use of communications technology such as real-time interactive video, which would provide opportunities for training and support and receiving advice or a second opinion for other clinicians.

Both the introduction of expanded telemedicine sites and the greater use of technology such as interactive video will require an upgrading of the telecommunications network (see Chapter 2).

We recommend that the priority for expanding telemedicine should be to connect local hospitals with referral hospitals throughout NSW.

Recommendations:
Information management, technology and telecommunications

50. That as part of IMT&T, rural representatives work with the Department in preparing a State-wide strategy incorporating Internet, e-mail and telemedicine.
51. That the Department rigorously pursue the expansion of the telemedicine program to support the service networks and create a position in each rural Area Health Service to coordinate these activities.

Aged care

The provision of health, accommodation, care and support services is essential to the promotion of maximum independence, well-being and good health for older people.

The proportion of elderly people living in rural communities is marginally higher than the total NSW population: 14.1% compared to 12%.[49] The initiatives we have recommended will improve health care for all people living in rural communities. However, we are concerned that action must be taken by both Commonwealth and State Governments to address the problem of elderly people living in acute inpatient beds because there is a lack of appropriate aged care accommodation or access to support to remain in their own homes.

This is a serious problem for both levels of Government. When elderly people are unable to care for themselves and live independently, if they are supported by a range of community-based services they may be able to remain in their homes for some time at least.

Recommendations:
Aged care

52. That the Commonwealth and State Governments take urgent action to address the needs of elderly people living in hospitals.
53. That priority be given to assisting people to remain living in their local community.

However, for those whose homes are located at a considerable distance from towns and major centres there are limited opportunities for the provision of that type of care and support. As a result, many rural elderly people are required to consider residential care at an earlier stage than they would if they had better access to home support.

A lack of appropriate residential aged care in rural communities means that rural elderly people are often forced to take up residence in a hospital. We are concerned that acute care hospitals do not provide a satisfactory or appropriate living environment and that these facilities are not accredited aged care residential care settings. Older people who are living in public hospitals are missing out on many of the elements which contribute to a good quality of life and which are available in aged care facilities.

We recognise that this is a complex problem. We also acknowledge that the Commonwealth and State Governments have been working to address the problem by constructing multipurpose services which bring together accredited aged care services with traditional hospital activities.

We recommend further action, as follows:

- That the Commonwealth and State Governments work together to provide appropriate aged care accommodation for elderly people living in acute hospitals because of the unavailability of nursing home accommodation. This could include expansion of the multipurpose services (now incorporated into Regional Health Services[50]) upgrading existing facilities to provide appropriate aged care beds, expanding the number of additional hostel beds or nursing home facilities and (where appropriate) providing sufficient community support to allow individuals to remain living in their home.
- Any joint initiative must give priority to assisting people to remain in their local community, close to family and local support.

Recommendations:
Specific community participation strategies for rural communities

54. That local Health Councils continue in their current form, continue to be well resourced and that there be more formal communication between local Health Councils and Area Health Service Boards.
55. That there be at least one annual conference of representatives of all local Health Councils.

Specific community participation strategies for rural communities

Chapter 6 of this report deals in detail with the need to empower and engage communities in health care delivery. This is especially important for rural and remote communities.

Health services are often a major local employer, and any slight variation in services will have a social and economic impact on a town. The staff of the local health services are also members of the community and must be supported through any change process.

We have seen the excellent work of local Health Councils.[51] They have been successful both in providing advice to health managers and in driving initiatives such as prevention, transport and self-help groups. We recommend that local Health Councils stay in place, continue to be supported with proper training and be well resourced. We also recommend more formal communication between local Health Councils and Area Health Service Boards, and an annual local Health Council conference so that people can come together and share ideas.

Coordination between human services agencies

We believe that a priority for both State and Commonwealth Governments is to address the link between disadvantage and poor health. This is especially true for rural communities experiencing economic downturn. In our section on implementation (see Chapter 8), we recommend that two demonstration projects be established for Area Health Services, in order to bring together the implementation of our recommendations with an expanded coordination of human services agencies.

We recommend that at least one of these projects must involve a rural Area Health Service, in recognition of the substantial coordination which already occurs between the various levels of Government to provide more coordinated services.

Budgeting implications

We recognise that some of these initiatives will have budgetary implications. We recommend that they be funded from within the proposed growth budget allocated to NSW Health. This will require Area Health Services to plan and stage the implementation in line with resource availability.

Implementing rural health strategies

Finally, we recommend that the implementation of both our recommendations to improve rural services and those of the Ministerial Committee on Health Services in Smaller Towns be overseen by a coordinating group with some independent representation. This will ensure that a substantial change management strategy for rural Area Health Services can be properly coordinated.

Recommendations:
Implementing rural health strategies

56. That NSW Health establish a rural service steering committee with independent representatives. This should have responsibility for overseeing the implementation of our recommendations on rural health and those of the Ministerial Advisory Committee on Health Services in Smaller Towns.

Achievable benefits – Enhanced services for metropolitan and rural communities

- NSW Health will be united by increased networking which will improve access to health services for all the people of NSW.
- Networks will reduce costly duplication and promote centres of excellence.
- There will be a structured process of planning and decision-making in rural and metropolitan communities.
- Communities and providers will be closely involved in planning and decision-making about the distribution of services.
- Advanced technology such as the use of telemedicine will be a feature of clinical care, and will allow clinicians to communicate about diagnostic information and provide advice, treatment and referral irrespective of where a patient is located.
- Rural Area Health Services will have an improved capacity to attract and retain a skilled workforce.
- There will be a reduction in the amount of travel to receive health services in rural and remote communities because more services are available locally.
- When travel to receive health services is necessary, it will be better coordinated and affordable.
- There will be an agreed plan between the State and Commonwealth Governments to provide more appropriate accommodation for elderly people living in rural hospitals.

39 Estimated Resident Population, Australian Bureau of Statistics, June 1999.

40 NSW Department of Urban Affairs and Planning, 1999.

41 NSW Department of Health, Medical Workforce Survey, 1997.

42 The proportion of sickness in a locality.

43 Strong K, Trickett P, Titulaer I, Bhatia K, Health in Rural and Remote Australia, Australian Institute of Health and Welfare, Canberra, AIHW Cat. No. PHE 5, Commonwealth of Australia, 1998.

44 Birrel B, The Distribution of Doctors in Non-metropolitan NSW, prepared for the NSW Farmer's Association and the Local Governments and Shires Association of NSW, July 1998.

45 Medical Workforce Survey, 1997.

46 Medicare data, 1997/98.

47 The MPS initiative was designed to facilitate funding for a more flexible range of Commonwealth and State services in rural communities. The pooling of resources under one single planning and management structure enables the flexibility to meet the needs of the community. The service components include community based, acute health services and residential aged care services (nursing home and/or hostel services). Source: Healthy Horizons – A Framework for Improving the Health of Rural, Regional and Remote Australians 1999-03, A joint development of the National Rural Health Policy Forum and the National Rural Health Alliance, March 1999.

48 Information supplied by the Structural Funding Policy Branch, 1999.

49 Australian Bureau of Statistics, 1996.

50 Regional Health Services are a Commonwealth Initiative that brings together a number of existing initiatives intended to provide for innovation and flexibility in service delivery. These initiatives include Multipurpose Centres, Multipurpose Services and the Rural Multipurpose Health and Family Services Network.

51 Local Health Councils are advisory groups that identify local health needs and provide input to health service planning, delivery and evaluation.

4 Funding Arrangements

OBJECTIVE

The creation of equitable, efficient and effective funding systems which increase the value for money of expenditure on health care.

FINDINGS AND OBSERVATIONS

How NSW currently funds health services

NSW Health uses a number of approaches to fund health services. We are committed both to retaining the strengths of the current arrangements and to addressing those issues where we believe improvements are needed.

In contrast to the arrangements in most other States the main characteristic of funding arrangements for NSW Health is a global allocation of funds to Area Health Services for the full range of health services (hospital, mental health, community and population health services). This global allocation reflects historical funding but has also been shaped by a population-based formula known as the Resource Distribution Formula. The Resource Distribution Formula takes account of those characteristics of the population which influence demand – such as size, growth and age profile. It should be noted that to date, there has been no population-based approach for mental health services.

Area Health Services use a variety of approaches to fund services such as hospitals and community health services. The most common approach is the use of historical allocations. Some Area Health Services are now using approaches such as episode funding to pay for acute services. Under an episode funding approach the component of a hospital's budget which relates to planned and acute activity is based on the following: the price for each category of treatment (following clinical advice which reflects recommended clinical practice) and the planned volume of patient activity based on the needs of the population.

A comparison of how different States fund health services[52] shows that in overall percentage terms there is reasonable consistency across all the major States in terms of the shares of expenditure on each broad service category. For each major service type the average shares of health expenditure across NSW, Victoria, Queensland and South Australia are:

- acute hospital services including inpatient admissions, outpatients and Emergency Departments (70%)
- mental health (8%)
- sub- and non-acute care, such as rehabilitation and palliative care (12%)
- population and community health (10%)

In regard to the various funding allocation methods, episode funding is well established in Victoria, Queensland and South Australia for acute inpatient admissions, with other services generally funded on an historic annual grant.

Issues identified

Our funding strategy addresses what we perceive as weaknesses in the way health services are funded in NSW. Our goal has been to ensure that funding arrangements support quality health care and that resources are both equitably distributed, and being used efficiently.

Lack of predictability and timing of budgets

Throughout this report we highlight the difficulties facing both managers and clinicians due to the lack of budget certainty. This occurs not only at a State level but also at an individual service level, where a hospital or community health team may not know the level of their budget until well into a financial year. The Government's decision to provide three-year funding should largely overcome this problem, but budget certainty will also need to flow onto other parts of NSW Health, such as hospitals and community and mental health teams.

Unequal distribution

There has been a genuine effort through the Resource Distribution Formula to take account of growth in developing parts of the State. However, some major disparities between allocations to Area Health Services remain, and the pace of redistribution has been slow.

At the time of conducting our review, seven of 17 Area Health Services were receiving less than their correct proportion of State funds for the size of their population. We believe that the Department must move quickly to assist those Area Health Services not receiving their correct proportion of funds, as part of the planning exercises which we have outlined for metropolitan and rural Area Health Services.

Links between policy objectives and funding systems

A stronger link is needed between policy objectives, funding distribution and the way certain services are funded in NSW Health.

We believe that the Department has a legitimate role to play in providing more direction in both areas. This is not to compromise the autonomy and flexibility of Area Health Services, but to ensure that the right funding incentives are consistently used to achieve the best outcomes for consumers.

There is a need for greater consistency in the way certain services are classified, in respect of the standards expected and the outputs intended. We believe there is currently a lack of transparency about the way that each Area Health Service allocates funds to services within its Area. This inhibits the analysis and management of variations in costs or priorities between Area Health Services.

This is especially true for services such as community health, outpatient services, and teaching and training where there is very little transparency about what is expected of providers.

There are insufficient incentives at the local level to encourage efficiency. Currently, efficiency is often measured retrospectively at the end of the financial year. We recommend that efficiencies should be built into the design of funding systems from the outset, and negotiated up-front as part of Area Health Service planning.

Finally, we recommend opportunities should be explored for improving the level of cooperation between the public, private and non-government sectors, in order to contribute to a more effective use of health care expenditure.

DIRECTIONS FOR CHANGE

We propose a comprehensive approach to resolving the above issues by focussing on the following goals and initiatives:

- improving budget certainty at all levels in NSW Health
- the need for an agreed growth formula to ensure that health funding remains responsive to changes in population size and increases in costs
- the need for a continued focus on achieving efficiencies
- the retention of a population-based approach to health service funding
- the introduction of an episode funding system between Area Health Services and hospitals for all planned and acute hospital admissions
- new funding arrangements for Emergency Departments and Intensive Care Units (ICUs) to improve service delivery (as recommended in Chapter 2)
- stronger performance agreements and more transparent funding arrangements for community health, mental health, training, research, population and public health
- exploring the potential for new funding arrangements for people with chronic and complex health conditions
- improving Commonwealth-State funding arrangements
- increasing the level of cooperation between the private, public and non-government health sectors
- the need to provide incentives for better use of capital by the gradual introduction of a capital charge

We believe this is a comprehensive approach to improving funding arrangements. It fits within a wider package of reforms centred on improving patient care and on the distribution of services to metropolitan and rural communities. We recommend that these changes should represent the foundation of a new financial strategy for NSW Health.

Certainty – three-year budgets

The decision to provide rolling, three-year budgets to NSW Health will be welcomed by clinicians and managers.

Recommendations:
Three-year budgets

57. That to improve budget certainty at all levels of NSW Health, Area Health Services be required to identify how they will broadly distribute funds to services for the three-year period, consistent with metropolitan and rural planning processes.
58. That the Department continue to conduct rigorous annual reviews, with a greater focus on the balance between meeting budgets and meeting policy objectives and health outcomes.

To take full advantage of this decision a number of additional changes are needed:

- Area Health Services must be given their allocations as quickly as possible so that they can start to prepare or update their Area Health Plans for the next three years. (It should be noted that negotiations were well under way at the time of completing this report.)
- Area Health Services should be required to indicate broadly how they would allocate their funds over the three years, consistent with the metropolitan and rural plans. In this way a hospital or a community or mental health team will also get the benefits of a three-year approach and will be able to plan its service priorities and staffing requirements.
- Three-year budgets must continue to be accompanied by a rigorous annual review, to ensure that funds are being applied appropriately.

A predictable growth formula

Recommendations:
A predictable growth formula

59. That the Department develop a long-term growth formula by July 2001, to guide funding levels beyond 2003.
60. That the growth formula be updated annually, and used to determine future budget strategies.
61. That it be explained and documented in Annual Reports, to improve community understanding about the drivers of health expenditure
62. That it be independently audited.

A key part of any health funding strategy will be planning and budgeting for future growth in demand and costs, to ensure that funding is responsive to these factors. We argue that as part of the long-term budget process, the Department should adopt an agreed growth formula to be updated every three years. The Government has decided to provide a growth factor in funding of 2.25% for a three-year period up to 2003.

There is a strong case for the Department to adopt a stable and transparent growth formula to guide resource allocation at a State level. Once agreed, this will provide even greater certainty beyond the new three-year allocation. The following factors should make up a future growth formula:

- population growth, based on figures provided by the NSW Department of Urban Affairs and Planning
- ageing of the population
- increased utilisation of health resources, caused by the use of new technology and increased demand

This long-term growth formula should be developed and agreed no later than July 2001. It should be independently audited and open to public review by publication in future Annual Reports of the Department.

Incentives for ongoing efficiency

Recommendations:
Incentives for ongoing efficiency

63. That the Department establish efficiency expectations in negotiation with each Area Health Service as part of the allocation of three-year budgets.
64. That Area Health Services be allowed to retain efficiencies, but should demonstrate that their reallocation to agreed priorities as part of Area Health Service Plans represents value for money.
65. That where possible, Area Health Services should in turn allow local level services such as a hospital or community health team to reinvest efficiencies to other agreed priorities, provided it is demonstrated that this represents value for money in the context of agreed plans.

Increased Government expenditure is one way of achieving additional capacity to respond to growth in demand and rising costs. However, it is imperative that there are also incentives to continue to achieve efficiencies and that those efficiencies are reinvested in activities that improve the quality of health care.

A number of the initiatives that we have recommended – such as admission on the day of treatment and wider use of day-only procedures, avoiding inappropriate admissions and benchmarking the length of stay – will generate greater efficiencies in the health system. Area Health Services have also demonstrated in the past an ability to improve efficiency by improving the

organisation of their clinical services and by changing the roles of their hospitals in order to avoid duplication.

We believe that local providers and Area Health Services must be given incentives to operate as efficiently as possible. By efficiency, we do not mean cutting budgets. We mean providing incentives to increase service capacity (that is, assisting more patients) or to provide new and innovative services (that is, redirecting resources from one service to another).

Three changes must occur in order to create this kind of environment:

- Area Health Services (and wherever possible, local providers) must be allowed to retain the efficiencies they achieve. That is, funds should not be withdrawn from an Area Health Service because it has provided an innovative or more efficient service.
- Retention of any efficiencies or decisions to increase capacity must be made in the context of efficient service planning. That is, local providers and Area Health Services must be able to demonstrate that either the reapplication of resources to other services or capacity and throughput represents value for money and will result in improved service outcomes.
- Efficiencies must be negotiated with individual Area Health Services and local providers to reflect local circumstances.

Improving equity of access to health services and strengthening a population funding approach

The current population-based funding approach – whereby Area Health Services are funded based on the needs of their population – is a great strength of the NSW health system.

In this way, the needs of a population are the prime consideration in the allocation of health dollars. Funds are allocated to Area Health Services according to the size and health needs of their populations, ensuring a fair share for all people living in NSW. In consultation with providers and the community, Area Health Services determine the most appropriate mix of services – including preventative health strategies, population health initiatives and treatment – to achieve the best health outcomes for their population.

Council believes that this system of funding must be retained, with the following enhancements:

- The Resource Distribution Formula must be reviewed in respect of rural health and mental health.
- There should be a concerted effort to improve equity of resource distribution across NSW in the context of growth funding.
- NSW Health should not move to a rigid budget-holding approach where Area Health Services hold all of the funds for their population. Instead, funding should be gradually transferred, as part of a robust planning process, which identifies the services that need to be provided locally.

Recommendations:
Improving equity of access to health services and strengthening a population funding approach

66. That NSW Health retain the system of funding each Area Health Service based on the needs of its population.
67. That the Resource Distribution Formula be reviewed as a matter of urgency, to ensure it adequately meets the needs of both rural communities and mental health services.
68. That the Resource Distribution Formula be the subject of greater transparency and that its methodology be published in all Annual Reports.
69. That the Department prioritise the allocation of growth funds to those Area Health Services which do not currently receive an allocation which reflects the size of their population.
70. That NSW Health expedite metropolitan and rural planning exercises in order to identify priorities and transition arrangements to reverse the flow of patients between Area Health Services in cases where it is unreasonable for patients to travel to receive appropriate care.

Strengthening the Resource Distribution Formula

The purpose of the Resource Distribution Formula is to ensure that the distribution of funds takes account of the differing needs of the population. The factors that make up the Resource Distribution Formula include the size of Area Health Service populations, the age structure, mortality, socioeconomic status and various rural factors.

It is important that a methodology such as this be as simple and as transparent as possible. It must also be stable, and not subject to constant review. This reinforces the certainty of three-year budgets and the stability of planning. There may be some benefit in ensuring that the Resource Distribution Formula is only subject to review periodically (for example, three years in line with budget cycles).

There are, however, a number of matters requiring urgent review. As we argue in Chapter 3, the special nature of rural communities needs greater emphasis, although it is important to acknowledge that the Resource Distribution Formula already takes some account of the needs of rural communities. However, in our discussions with rural community representatives, clinicians and managers they argued that there was insufficient recognition of the higher fixed costs of local hospitals and the costs of maintaining and servicing a large number of local hospitals spread over a wide geographic area.

Additionally, the Resource Distribution Formula needs review in relation to mental health services. Mental health services are not currently factored into the Resource Distribution Formula on a population basis. The mental health component of the formula needs urgent finalisation to take account of the costs of long-term patients being treated in psychiatric hospitals. The formula must also reflect the need for greater priority to be given to mental health services for children and adolescents.

Finally, there is a strong case for greater public review of the Resource Distribution Formula, and potentially considerable value in publishing the way the formula is constructed and the assumptions that sit behind it in the Department's Annual Report. This will allow for a more informed debate about the factors that influence resource distribution across the State.

Improving fairness in resource distribution

It is important to state that considerable progress has been made in recent years to redistribute health dollars between Area Health Services, and to target new funds to those Area Health Services which have experienced a substantial growth in the size of their population.

We recommend that the Department should give priority to allocating growth funds to those Area Health Services which are currently not receiving the correct proportion of overall funding that reflects the size and make-up of their populations.

This exercise must be done in the context of careful planning in metropolitan Sydney and in rural NSW that reflects local service priorities, cost-effectiveness and the capacity to attract and retain a skilled workforce.

Clarification of Area Health Services as budget-holders

There has been a long debate in NSW about how to manage the movement of patients between Area Health Services. This issue arises when a patient uses a service outside the Area Health Service in which they live. As stated in our work on metropolitan planning, this accounts for approximately $600 million[53] of expenditure annually.

These decisions reflect the history of the development and distribution of health services and the referral patterns of patients and providers. The debate has centred around whether an Area Health Service should be funded as a budget-holder for the total needs of its own population, irrespective of whether patients use services provided by other Area Health Services, or be funded in a way that centrally adjusts funding for services delivered to patients travelling from other Area Health Services to receive care.

There is an urgent need for clarity on this matter. Area Health Service Chief Executive Officers have expressed concern that unless this matter is managed carefully, it will impact on their capacity to plan with certainty about what their overall level of funding is likely to be.

There are some obvious advantages in Area Health Services holding all of the funds for their population. Obviously, this would put them in a better position to choose who will provide services and thus give them the potential to achieve improvements in both price and quality. They could either choose to purchase from another Area Health Service or to provide the service locally.

There are, however, some serious difficulties with the uniform implementation of this approach outside a rational planning exercise about where services need to be located and where there are gaps in services (such as transferring a service or growing additional services). If NSW Health moves to this way of funding Area Health Services too quickly it would require a substantial re-allocation of resources between Area Health Services. This would create uncertainty and potentially disrupt services, as Area Health Services would have to compete for work and may not be able to predict the volume of work that is likely to be retained.

Also, under the principles of Medicare, all Australians are entitled to treatment without charge in any public hospital, and it is not feasible to restrict a patient's choices. However, strategies that seek to influence, rather than restrict, these choices might be permitted under the Medicare principles. This will need to be resolved with the Commonwealth Government. To be effective purchasers, Area Health Services need to be able to exert some influence on treatment choices of their residents.

This move to a rigid budget-holding approach is also likely to create additional transaction costs and additional bureaucracy as Area Health Services enter into and manage purchasing agreements with each other. While this is probably necessary in some Area Health Services where patients travel considerable distances, it is unnecessarily complex and expensive in locations where accessing care from another Area Health Service is only a case of a move between suburbs.

We conclude that NSW cannot move to a rigid budget-holding approach that would compromise choice and add to transaction costs. As we have said in our work on metropolitan planning in Chapter 3, this means that it will be unrealistic to expect that all Area Health Services will ever fully reach their pure Resource Distribution Formula target (that is, before patient flows are accounted for).

Rather, the priority for NSW Health must be to accelerate metropolitan and rural planning exercises to determine the priorities for reversing the flow of patients between Area Health Services. The priority must be to determine what services need to be provided locally, and the gaps in services that disadvantage patients by forcing them to travel. Finally, priority must be given to the needs of people with chronic and complex conditions who frequently use health services.

Decisions to relocate or expand new services must consider the impact on existing services, and careful transition arrangements must be put in place to ensure that funds are not withdrawn prematurely before a new service is fully developed, thus resulting in a reduction of key clinical services.

We propose that the current arrangements – whereby Area Health Services continue to receive part of their funding based on the work they perform on behalf of another Area Health Service – should continue. As services transfer or are developed as part of metropolitan and rural planning exercises, resources should be adjusted accordingly. While this should not preclude Area Health Services entering into purchasing agreements to improve price and quality, these should not add to transaction costs.

Improving the effectiveness and efficiency of health services

In addition to improving equity and certainty, we believe it is vital to improve the effectiveness and efficiency of the way some services are funded. Funding systems can create powerful incentives for best practice.

As we have argued throughout this report, different types of services require different approaches. For example, the way rural communities are funded must reflect their higher costs of providing services.

We have examined the major service streams of NSW Health and tried to improve the link between outcomes in respect of quality of care, outputs and efficiency. We propose new funding arrangements in the following areas:

- planned and acute hospital admissions
- critical care, Emergency Departments and ICUs

Recommendations:
Improving the effectiveness and efficiency of health services

71. That Area Health Services fund all acute admissions, other than those components of costs relating to use of Emergency Departments and Intensive Care Units, based on an episode funding approach from 1 July 2000. Admissions to small rural hospitals and mental health acute inpatient activity are exempt from the episode funding approach.
72. That new funding arrangements for Intensive Care Units and Emergency Departments should be introduced from 1 July 2000.
73. That Area Health Services enter into contracts with their hospitals based on the planned volume of activity and the price for each type of treatment.
74. That the Department ensure that episode funding to hospitals makes allowance for aftercare and discharge planning from the hospital. This should give priority to conditions identified in the Priority Health Care programs.
75. That the Department work with Area Health Services to develop a standard classification of community-based, primary and ambulatory services, research and training activities and a standard measure of outputs. That this should also apply to population and public health programs.

- primary and ambulatory services and population health initiatives
- the need to explore new approaches in providing care to people with chronic and complex conditions

The introduction of episode funding for planned and acute hospital admissions

Planned and acute hospital admissions represent 57%[54] of all health expenditure. It is therefore vital that every effort is made to achieve the maximum value for the dollars invested in these services.

We have examined the various approaches used to fund this activity in NSW. Some Area Health Services are using an historic grant to hospitals, while others have successfully introduced an episode funding approach or surgical payment approach. An episode funding approach involves negotiating a price for a certain treatment based on recommended clinical practice. The cost will be influenced by the volume, length of stay, the severity of illness and use of services such as operating theatres, nursing, pathology and accommodation.

We recommend that NSW Health should move to an episode funding approach, for all planned and acute admissions other than services provided in Emergency Departments, ICUs or small rural hospitals. Mental health acute inpatient activity will also be excluded from the application of the episode funding approach until a suitable classification for mental health is available.

All Area Health Services will be required to fund the planned and acute activity component of a hospital's budget using an episode funding approach. This component of a hospital's budget will be based on the following: the price for each category of treatment (following clinical advice which reflects recommended clinical practice) and the planned volume of patient activity which reflects the needs of the population.

This will cover all acute hospital admissions other than the component of costs relating to the use of Emergency Departments and ICUs. If patients are admitted via the Emergency Department, the time they spend in the Emergency Department will be covered by the budget provided to the Emergency Department. Once the patient moves into a ward or operating theatre, the hospital will be funded on an episode basis.

The episode payment will cover all medical and surgical treatment, and both day-only and overnight inpatient stays. The implementation of episode funding also needs to recognise that one component of funding should be related to the fixed costs of a hospital, and another to variable costs.

The rationale

We recommend that NSW Health take the best features of episode funding operating in other parts of Australia and internationally, and the surgical payment or episode funding operating in NSW hospitals. We have used the term 'episode funding' to reflect that the provision of health care is more than a stay in hospital. An episode of care is also made up of pre-admission activities and discharge activities such as the provision of aftercare and a comprehensive discharge plan.

The advantages of this system of funding are summarised below.

Reduction in cost variations

Variations in cost, length of stay and admission rates will be highlighted and can be examined. We have noted considerable variations in these elements across NSW Health.

We are concerned that a hip replacement in one hospital can cost up to 1.5 times more than in another hospital of similar size and function, with no discernible difference in the quality of care or severity of condition.[55] The extra costs incurred because of this apparent inefficiency result in a reduction of other patients' access to services.

Focus on appropriateness

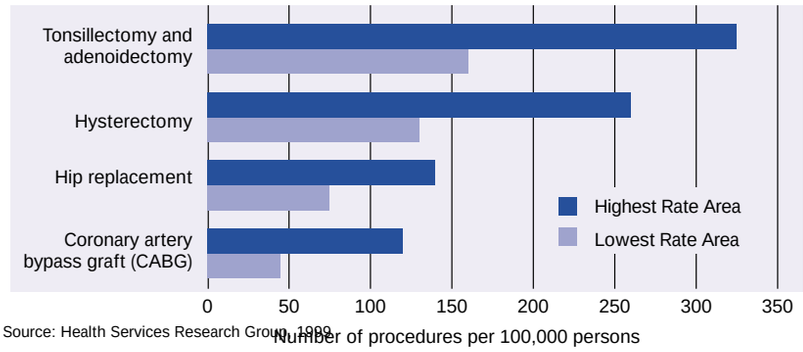
Managers and clinicians will also be able to compare the costs and appropriateness of certain admissions and identify areas where improvements can be made.

Episode funding can help identify variations in admission rates for certain procedures and conditions, and initiate a review by clinicians of the reasons for these variations. For example, based on an analysis of NSW Health inpatient data[56], women living in one Area Health Service are twice as likely to undergo a hysterectomy (259 per 100,000 women) than women of similar age in another Area Health Service (127 per 100,000 women). Similarly, there are twice as many tonsillectomies (324 per 100,000 people) performed on patients in one part of NSW versus similar types of patients in other parts of NSW (169 per 100,000 people).

Some of the key variations are selected procedures in NSW Area Health Services are set out in Figure 2.

Figure 2

Variation in use of selected procedures across NSW



Source: Health Services Research Group, 1999

Focus on quality

Episode funding can also serve as a way of improving the quality of health care. The episode payment to the hospital must ultimately make provision for pre-admission and aftercare such as community nurse follow-up and the use of a comprehensive discharge plan when the patient leaves hospital.[57] There must be a financial incentive to get the treatment right the first time.

We conclude that this method of funding the largest component of health expenditure will help ensure greater efficiency and improvements in the effectiveness of health care. It is essential that NSW Health takes a more pro-active role in managing what are often large variations in cost and admission rates, and in reinforcing the need for Area Health Services to consider the overall health needs of their communities.

The episode funding system must, however, be introduced in a context of improved monitoring of health outcomes. That is, NSW Health must develop a better capacity to monitor readmission rates and the extent to which a person's health improves because of their treatment.

The operation of an episode payment

This will involve a contract between an Area Health Service and a hospital or clinical stream. It will be based on the planned volume of patient activity to be performed and the agreed prices for each episode of care provided.

Differences from approaches in other States

There are some marked differences between the approach we are recommending and the introduction of episode funding in other States:

- This method of funding will be in the context of population funding. Area Health Services will be able to retain the flexibility to move funds between services to achieve the best outcomes for their community.
- It is being proposed as a way of improving the value of health care expenditure by managing and reducing unnecessary variations in admission rates and costs between hospitals.
- It is being introduced in NSW in the context of overall growth and budget certainty, whereas in other States it has often been introduced with major reductions in health funding.
- Episode funding is being introduced as only one part of a comprehensive package of reforms we recommend for NSW Health, centred on improving patient care and on the distribution of services to metropolitan and rural communities.

Critical care

This has been discussed in Chapter 3 of this report. Funding arrangements for both Emergency Departments and ICUs must recognise that they have high fixed costs (staff and equipment) and need to be available 24 hours a day to deal with those patients who are critically ill. In the case of Emergency Departments, there is the added difficulty of predicting the volume and seriousness of patients needing treatment. The following approach is recommended.

ICUs would receive an annual allocation based on the availability of an agreed number of beds. A small percentage of that funding should reflect peaks in demand. Their allocation would be made up of the required staffing and equipment that they need to provide that agreed number of beds.

A similar approach would apply for Emergency Departments. That is, an Emergency Department would receive an annual allocation which would allow it to be available 24 hours a day, and be able to treat the most critically ill patients urgently and respond to peaks in demand. Its allocation would thus principally reflect required staffing and equipment levels, with only a small percentage provided to reflect the expected volume of patients treated. There is one difference between the method of funding Emergency Departments and that applying to ICUs. The level of funding would reflect the role it is expected to play within a broader network of Emergency Departments. The metropolitan and rural planning processes will determine this.

These approaches allow both Emergency Departments and ICUs to provide better services to patients by giving clinicians and managers more predicability about their annual funding allocations and by allowing them to organise their staff and resources accordingly.

Funding to primary, ambulatory, mental health and community-based services

We recommend that NSW Health should introduce a number of changes to funding methodologies for these services. The practice of providing annual (now preferably three-year) grants should continue. However, there should be clearer performance contracts with providers of these services that specify the standard of service to be provided, more clearly stipulate the priorities for service provision and more clearly identify performance expectations.

There must be greater consistency between Area Health Services in classifying the types of services being funded under these programs so that Government and the community can analyse how Areas are allocating their funds, whether sufficient emphasis is being placed on agreed State-wide priorities such as the Priority Health Care programs. Greater transparency will allow the evaluation of the success of such initiatives as providing more care in the community or investing in early detection and prevention programs. We are particularly concerned that population health activities and research and training should be separately identified in the funding arrangements of Area Health Services.

Exploring new approaches for people with chronic and complex conditions

This report recommends the creation of three Priority Health Care programs (see Chapter 2). We have also proposed that NSW Health should explore new funding options for these conditions and believe that over time it may be possible to create a separate funding stream for these conditions. That funding stream would see the capacity to identify the separate cost components of providing care including all services such as hospital admissions, allied health, community health care, home care and visits to the GP.

As stated in Chapter 2, we have raised a number of issues that need to be addressed. This is vital to overall funding arrangements, as Government must have confidence that consumers with the greatest need are getting the right service at the right time. These questions must inform the development of any new approach to funding for patients covered by the Priority Health Care programs.

The first priority is to improve patient care. This could be achieved in the short-term by ensuring that episode funding includes the cost of after care and discharge planning, and that priority for extending the episode payment is given to patients with chronic and complex conditions.

Commonwealth-State issues

Existing health funding structures involving Commonwealth and State Governments are sometimes confused and can create limitations in the ability to link health providers (such as GPs) with services funded by the State (such as hospitals). Despite these difficulties the Australian system generally works well, delivering high quality, accessible services at a moderate cost. However, there is a widely held view that reforms to the current arrangements between the Commonwealth and the States are required.

The Council has not seen its role as including the making of recommendations on reforming the broader Australian health system. However, there are a number of issues where incremental but important reforms could be progressed.

- Australia does not yet have in place a national health policy that clarifies the respective roles and responsibilities of the State and Commonwealth Governments, the desired health outcomes for NSW and Australian communities and the most effective ways of delivering patient care. Cooperative arrangements are required to allow Governments to focus on linking shared objectives for a healthy community to the financing and delivery of health services.
- Depending on whether a patient elects to be a 'public' or 'private' patient, there is a different source of Government funding for exactly the same medical service. This distortion creates inappropriate incentives which elevate the issue of 'who pays' above the issue of 'what is the best means of delivering a service', to the detriment of patients and of public patients in particular. Similar issues apply in the case of pharmaceutical benefits. To remove these distortions, one level of Government – the Commonwealth – should be responsible for all public funding for medical and pharmaceutical services.
- Regional communities should have access to clear information about both Commonwealth and State funding for each community, to compare and identify gaps that arise from the lack of access to a health care provider.

Recommendations:
Commonwealth-State issues

76. That the Department develop, together with the Commonwealth Department of Health and Aged Care, an agreed description of regional funding allocations under all State and Commonwealth programs for all Area Health Services. A summary of this description should be published in the Department's Annual Report, and details should be included in the Annual Reports of each Area Health Service.
77. That the Government join with other State Governments to commence negotiations with the Commonwealth on transferring further responsibility for medical and pharmaceutical services to the Commonwealth level.
78. That the Department identify and remove barriers preventing Area Health Services from negotiating contracts with health insurance funds for the treatment of, and payment for, privately insured patients.

- We need to maximise the benefits of private health insurance for consumers. At present, over 60% of people with private insurance who use public hospitals choose not to use their insurance.[58] Benefits paid to public hospitals for treating private patients do not reflect the real costs of providing these services. Furthermore the Commonwealth Government has indicated it will claw back, through adjustments to hospital funding, additional revenue gained by public hospitals for treating additional private patients. A longer-term issue is the need to clarify the role of private insurance in the health system – that is, whether it should be an add-on to the entitlements under Medicare, or whether it should cover the entire range of services.
- We need an agreed Commonwealth and State approach to improving health information technology and linking general practice to other parts of the health system. The absence of linkages contributes to poor coordination of patient care, particularly for those with chronic and complex diseases.
- We need to address the lack of progress – particularly in rural areas – in providing appropriate care for aged people who are living in hospital beds due to the shortage of suitable nursing home or hostel accommodation.
- We need to provide certainty for staff who are employed under Commonwealth funded programs where the Commonwealth has not provided additional funding to the States to compensate for wage increases – for example HIV/AIDS programs and Home Nursing Services.
- We need more equal commitment by both levels of Government in allocating funding for growth. We note that since the commencement of Medicare, Government increases to health funding have exceeded Commonwealth increases by 33%.[59]

Recommendations:
Increasing cooperation between the public, private and non-government sectors

79. That the Department develop a strategy for increasing private and non-government cooperation.
80. That the Department require all Area Health Services to involve private and non-government providers in the planning of services, particularly Divisions of General Practice.
81. That the Department progress work on the implementation of a capital charge commencing with all new capital projects.
82. That a strategy should be developed to attract private finance in the provision of capital, drawing on the PFI approach operating in the UK.
83. That NSW Health work with the Commonwealth Government and the non-government sector to identify opportunities for increasing the involvement of the non-government sector in the delivery of aged care, including the provision of sub-acute services from existing public hospitals.
84. That NSW Health continue with its efforts to fully cost all clinical and non-clinical services.
85. That NSW Health investigate options for further improving the effectiveness of support services such as cleaning and catering.

Increasing cooperation between the public, private and non-government sectors

Increased involvement of the private and non-government sectors is essential if NSW Health is to improve the value and effectiveness of its expenditure on health care. Diversity and innovation are also important to improving the quality of patient care.

There is already a long and successful history of private and non-government cooperation in NSW. At present, there are 84 private hospitals and approximately 350 non-government organisations providing a variety of services such as community health and mental health services and drug and alcohol services. These are in addition to GPs and specialists and other private individual health care providers. There are also many successful examples of non-government organisations running public hospitals, most notably St Vincent's Hospital in Sydney.

Our recommendations seek to build on that success and to identify areas where further cooperation will be beneficial to consumers and to the overall effectiveness of the State's health care system. Specifically, we have examined:

- some of the challenges which might be impeding greater cooperation
- areas of health care delivery where cooperation could be increased

- some of the prerequisites for greater diversity in service provision, such as greater cost transparency and an improved capacity to measure the performance of all providers
- some immediate steps which might promote increased involvement

Challenges

While there has been a long history of cooperation, there are a number of challenges which need to be overcome in order to increase the involvement of other sectors.

- The first challenge is one of culture. In our discussions with private and non-government providers, Area Health Service Chief Executive Officers and a wide range of clinicians, we observed some degree of mistrust and suspicion between different providers. We believe the first step towards greater cooperation is the promotion of a culture of mutual understanding and respect. This should value diversity and innovation, and promote an understanding of the strengths and activities of all players in the health system.
- We believe that there needs to be a more informed and thoughtful community debate about the role of the private sector in the delivery of health care. There is a legitimate role for other sectors, which should not compromise the Government's oversight of standards of care and clinical practice. This debate should acknowledge that all Governments have finite resources and competing pressures. Involving other sectors in areas like capital investment will be essential to allow scarce public resources to be applied to areas like patient care. Again, the example of non-government organisations running public hospitals is important. There are already examples where the ownership of the assets is separated from the provision of clinical services, which provide a high quality, respected service to the community.
- A second challenge to be overcome is the lack of transparency in costing products and services. A lack of transparency about what constitutes the cost of an episode of care or the cost of non-clinical services such as catering and cleaning impedes the comparisons of the performance of providers. At the time of writing this report, the Department had substantially progressed a costing of products and services. The rapid implementation of a full costing of all clinical and non-clinical services is essential.
- There needs to be greater clarity of policy objectives at a State-wide level so that the purpose of promoting greater diversity is clear. The purpose is to improve the quality of care and the cost-effectiveness of health expenditure. Parameters and guidelines should be developed at a State level for measuring the performance of providers and managing contracts. The community and the Government must have confidence that contracts with other sectors can be managed effectively, and will lead to improvements in service quality and service access.
- Finally, there are differences in business processes, financial management systems and industrial awards which need to be carefully taken into account in promoting greater diversity and in out-sourcing to other sectors.

Opportunities for involvement

We believe there are three areas where action should be taken to improve cooperation: planning, capital investment and the provision of support services.

Area Health Service planning

We propose that Area Health Services be required to involve other providers in the preparation of both Area Health Plans and, where appropriate, in the preparation of local plans for hospitals and community health teams. At an Area Health Service level, plans should factor in all the resources of the health system – that is, existing private and non-government activities, and expected expenditure by the Commonwealth, particularly for GPs. While we acknowledge that this already occurs in some Area Health Services, it is essential for NSW as a whole so that providers and communities can see the full range of resources and identify gaps and priorities.

For example, a private or non-government facility may be able to assist an Area Health Service in managing peaks in demand. Similarly, to avoid duplication it may provide a particular service as part of a wider network of Government and non-government services. This would be particularly relevant in the management of patients with chronic and complex conditions.

We also propose that as part of rural and metropolitan planning processes and the expenditure of growth funds, decisions to grow new services or expand existing services must identify whether another provider could provide these services. Clearly, these decisions must relate to achieving the best quality and value in health service provision.

Finally, it is essential to involve GPs, through the Divisions of General Practice, in planning at an Area or at a facility level. Again, this already happens in many Area Health Services but is not uniform across the entire State. GPs can play an important part in assisting with peaks in demand in Emergency Departments and in the provision of care to people with chronic and complex health conditions.

Involving other sectors in providing new capital infrastructure and better utilisation of existing facilities

This report has highlighted the need for the continuous adaptation of existing infrastructure, including hospitals and other facilities such as aged care facilities and community health centres. We believe that the resources of the Government alone will not be sufficient to generate the investment in capital required over the next ten years.

It is important to stress that new capital funding should not be confined to hospitals. Indeed, the health system of the future will be characterised by the need for new arrangements for health facilities, particularly in rural communities, such as co-locating community health teams, ambulance services and mental health services in conjunction with aged care facilities and acute inpatient beds.

The Government needs to look for new ways of sharing risk, of increasing funding for capital and promoting a more business-like approach to the use of capital. It is important to achieve full transparency about the cost of capital (particularly new capital), an understanding of maintenance liabilities, and a better understanding of assets which are performing poorly because they are under-utilised or inefficient due to inflexible design.

There are a number of options that NSW Health could pursue to increase the involvement of other parties in capital projects. We have selected two. First, the need to generate additional capital by exploring private sector financing initiatives along the lines adopted in the United Kingdom. Secondly, to utilise existing facilities better by exploring further opportunities for non-government organisations to provide services such as non-acute services for the elderly.

Private financing initiative

The UK Private Financing Initiative (PFI) is one approach that could be considered. In simple terms, it allows the private sector to be involved in the design, construction and ownership of assets, and in facilities management such as maintenance and cleaning. The public sector's role is to focus on providing clinical services and the performance management of contracts. To date, 25 hospital developments in the UK have been approved under this initiative.

We believe that there could be significant advantages in pursuing this type of funding arrangement in NSW. It allows the public sector to retain control and management over the critical activities of providing patient care while sharing the risk and cost of design, construction and facilities management.

We propose that NSW Health should accelerate the development of private financing initiatives, drawing on the evaluation of the use of the PFI approach in other parts of Australia and overseas.

Supporting capital initiatives by introducing a capital charge

For NSW Health to progress greater opportunities for involving other sectors in capital projects such as PFIs, we argue there must be greater rigour in understanding the costs of capital. The Independent Pricing and Regulatory Tribunal[60] (IPART) has recommended that NSW Health progress the development and implementation of a 'capital charge'.

IPART argued that capital is often seen as a free good, and that the application of a capital charge would provide an incentive for better decision-making about acquisition, maintenance and redevelopment. Under capital charging, public service providers must pay explicitly for their capital through the mechanism of an annual charge, based upon the value of assets used in service provision. This forces the cost of capital to be recognised and properly managed.

We agree that a capital charge is an important part of any sensible financial management strategy. We would, however, argue that its introduction should be staged, starting with new capital and then expanded to existing capital when the following matters have been resolved:

- A capital charge must be used as a management tool to drive better decision-making. If it is not, the bureaucratic and administrative costs of introducing it will outweigh the advantages of a more business-like approach to the management of assets.
- The outcome of the metropolitan planning process in respect of the distribution of services must be known. This will ensure that Area Health Services are not unfairly disadvantaged when they provide facilities, which will operate on a State-wide basis.
- The method of allocating a capital charge should reflect the special needs of rural Area Health Services, which are required to maintain a significant number of smaller hospitals per head of population and are often restricted in decisions to dispose of an asset – even when it is not performing – because of the Government's commitment to maintaining services in certain communities.
- There must be a consistent approach to valuing assets. However, the application of a capital charge should consider factors outside the control of Area Health Service managers, such as regional differences in real estate prices across NSW.

Involving the non-government sector in aged care in the health system

Our report makes a number of comments about the need to improve health care for elderly people. Elderly people are often vulnerable to urgent admissions through the Emergency Department and are often burdened with chronic illness such as heart disease and respiratory problems. There may be more effective ways of providing care to respond to these problems. For example, many elderly people will not be able to be admitted on the day of their surgery/treatment or will not be able to be discharged in the same time frame as other patients. This may be due to a lack of home support, or simply because they are frail and not fully recovered. However, they may not need to occupy an acute inpatient bed in a hospital. It may be more effective to provide 'step down' services, which continue to provide sub-acute care.

We are aware of some examples of providing sub-acute care, such as at the Royal Newcastle Hospital, where a non-government organisation caters for the rehabilitation and placement of frail aged patients after acute care provided in hospital.

NSW Health should work both with the non-government sector and the Commonwealth Government to investigate new approaches to providing aged care. This is particularly the case in rural communities.

We also recommend that NSW Health sponsor greater involvement of the non-government sector in the management of people with chronic and complex conditions through the Priority Health Care programs. We acknowledge the enormous contribution of the non-government sector in these areas to date and believe the ongoing involvement of this sector is vital.

Improving the effectiveness of support services and facilities management

NSW Health has increased the level of involvement of the private and non-government sectors in the management of services such as laundry, food, logistics, pathology and cleaning. We believe that the Department should explore further opportunities for improving the efficiency of these services. This would include identifying opportunities for Area Health Services to combine their contracts to create greater economies of scale, and progressing the implementation of costing of products and services, to allow for greater benchmarking and market-testing of these types of services.

The steps toward achieving greater cooperation

We believe a number of steps are necessary to achieve greater involvement of other sectors:

- The Department should expedite the development of a broad policy for cooperation between private and non-government organisations. This should identify priorities, gaps, and initiatives to foster increased involvement. It should set out performance expectations for all providers and provide guidelines about how greater contestability will be managed.
- As part of our work on governance, Council has recommended that Area Health Services should enter into specific performance agreements with all providers. These should clearly stipulate performance expectations, output targets and service standards. This will allow for a comparison of performance of all providers.
- NSW Health should be required to fully comply with the Premier's Service Competition Guidelines, particularly the requirement to undertake cost benchmarking.
- There may be some considerable advantage to establishing a working group as part of the implementation of this report, to progress these ideas and to guide the development of an overarching strategy for NSW.

Achievable Benefits – Improvements to funding arrangements

- There will be a coherent and comprehensive financial strategy for NSW Health
- There will be a continued emphasis on population funding – that is, funding Area Health Services in a way that reflects the size and characteristics of their population.
- Three-year budgets will give clinicians and managers the confidence to plan their services, to allocate resources and to respond to peaks in demand.
- The introduction of episode funding will improve the utilisation of hospital resources, through reducing variations in cost and admission rates and focussing on the appropriateness of admissions.
- Providers will have clear performance expectations in respect of service outputs, service standards and performance targets.
- Health managers will have a greater capacity to compare and contrast the performance of all providers in the State's health care system.
- Increased participation by the private and non-government sectors will reduce the financial burden on the Government and will promote diversity and innovation in the provision of care.
- Improved Commonwealth-State funding arrangements will improve the effectiveness of all health funding, by reducing costly duplication and providing incentives for improving coordination between GPs, hospitals and community health providers.

52 Sourced from NSW, Victorian, South Australian and Queensland Health Department Annual Reports, 1997/98 and 1998/99.

53 Information supplied by the Structural Funding Policy Branch, 1999.

54 NSW Health Unaudited Annual Returns of Area Health Services, 1998/99.

55 NSW Health Annual Cost Data Collection, 1998/99.

56 Analysis undertaken by the Health Services Research Group, University of Newcastle, 1999.

57 This is additional to funds provided by the Commonwealth to GPs to coordinate care.

58 Commonwealth Department of Health and Aged Care. Hospital Data Analysis Consultancy, 1999.

59 ABS. Australian Government Financial Estimates (Cat No. 5501.0) and Commonwealth and State Government Budget Papers, 1999/00.

60 Independent Regulatory and Pricing Tribunal, A Review of NSW Health, Report to the NSW Treasurer and the Minister for Health, 1998.

5 Clinical Leadership

OBJECTIVE

Increased involvement of clinicians (doctors, nurses and all other health workers) in determining health care priorities and in setting and monitoring standards of clinical practice.

FINDINGS AND OBSERVATIONS

The involvement of clinicians in setting and monitoring standards of clinical practice will be critical to improving service delivery and the quality of health care. We conclude that more structured processes are needed to involve clinicians in setting and monitoring clinical practice standards, both at a State level and within Area Health Services.

The implementation of advances in clinical practice, which will improve health outcomes and/or improve the cost-effectiveness of health care, will need the highest levels of clinical and bureaucratic leadership in order to be successful. Innovation must be documented and evaluated and there must be clear processes and accountabilities for widespread implementation.

We have noted the new directions of 'clinical governance' in the UK National Health Service[61,62,63] and the comprehensive attempts to involve health professionals in the development of clinical practice guidelines (with doctors leading the way) and case management or clinical pathways (with nurses leading the way).

We note the accumulated evidence on the quality of care in Australian hospitals, including:

- high adverse events in Australian (and by assumption, NSW) public hospitals[64] compared with United States hospitals[65]
- clinically inexplicable variations in the surgical intervention rates of non-invasive diagnostic cardiology services[66]
- impressive action by some NSW public hospitals to benchmark the quality and relevance of their services against measures used by hospitals in other nations[67]
- a growth of Intensive Care Units (ICUs) in NSW private hospitals, often in small units without full-time ICU physicians or trained ICU nurses
- the relatively slow speed of development of clinical practice guidelines by the Colleges of the medical and nursing professionals (acknowledging that there are exceptions, such as the development of six clinical practice guidelines by the Royal Australian and New Zealand College of Psychiatrists)

We also conclude that NSW Health needs to involve clinicians more actively in setting and monitoring clinical policy, and in supporting clinical leadership throughout NSW Health. This is essential to guarantee the quality and safety of health care and to improve the accountability of health care providers in hospitals and medical practices.

DIRECTIONS FOR CHANGE

There are two issues that must be reconciled if NSW Health is to sponsor clinical leadership. On the one hand, the medical profession is concerned about the growing interference of non-medical (mostly financial) administrators into the clinical domain of hospitals. On the other hand, this perceived intrusion comes at a time when NSW Health has finite health care resources to meet a growing demand, and when there is continuing evidence that the efficiency and quality of health care can be improved.

The net result is that the NSW Government has insisted that the agreed growth in funding must be tied to demonstrable improvements in the efficiency and quality of care. This will require a change in the relationship between managers and clinicians to create a collegiate, accountable and patient-centred culture for the State's health care system.

We recommend that:

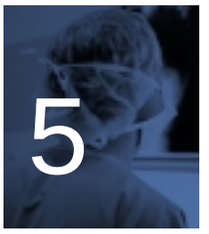
- The Department establish a number of Clinical Implementation Groups to involve clinicians in setting and monitoring standards of clinical practice for specific health conditions.
- The Department establish a Clinical Council in order to bring together the Chairs of the separate clinical groups to provide advice on broader strategy.
- That there be greater transparency about the performance of providers.
- That there be increased clinical input and clinical representation on the Boards of Area Health Services.
- NSW Health continue to provide executive level financial and management training to senior clinicians in management positions.

Clinical Implementation Groups

In Chapter 2 we proposed the establishment of Clinical Implementation Groups made up of expert clinicians and managers to address the problems of ICUs and Emergency Departments, planned admissions and the care of people with chronic and complex health conditions. We recommend the creation of two additional groups for super-specialty care – for example, liver transplantation and paediatric care.

It is essential that these groups are ongoing, and not perceived as working parties. The groups must:

- be medium- to long-term so that they have the opportunity both to set and monitor standards of care
- include a broad range of clinicians – that is, nurses, doctors and allied health workers – and be jointly sponsored by a leading clinician and an Area Health Service Chief Executive Officer to foster bureaucratic and clinical alliances
- be well resourced, with a permanent secretariat and a capacity to commission research
- be assigned an identified Departmental senior manager with accountability for implementing agreed actions identified by the groups



It is crucial that these groups become the focus of clinical leadership in NSW Health and undertake the following roles:

- setting standards of clinical practice
- identifying data sets to monitor variations in practice
- serving as a focal point for new ideas, and for research into the most effective ways of providing clinical care
- evaluating both new technologies, and the evidence that the application of those new technologies will lead to improvements to patient care and are cost-effective
- ensuring that the way funding is allocated or services are funded does not jeopardise the quality of patient care
- examining training and workforce requirements to improve health services

Clinical Council

We recommend the establishment of a Clinical Council reporting to the Minister and the Director-General made up of the Chairs of the Clinical Implementation Groups and other clinical leaders. This will enhance the overall strategy for patient care.

The Chair should be full- or part-time, and the Council should be well resourced in order to provide advice on overall clinical strategy, high level clinical priorities, budget priorities, population health initiatives and community education.

Seconding senior clinicians into the Department

The strengths of the Clinical Implementation Groups will be their ability to deliver clinical leadership and their capacity to unite clinicians across Area Health Service boundaries, across Commonwealth-State boundaries and to influence clinical practice at the point of care.

We therefore propose that in addition to continuing in their clinical roles, the clinical leaders of these groups be offered secondments in order to devote adequate time to servicing the Clinical Implementation Groups.

We believe that bringing clinicians into the Department in a more structured way is vital to a quality health care system. The input of people who are involved in the actual delivery of health care into State-wide clinical practice guidelines will facilitate the widespread implementation of best practice. The clinicians will provide up-to-date input into overall Departmental strategy, and play a leading role in advising on information technology systems and funding systems.

Clinical representation on Area Health Service Boards

In Chapter 7 we recommend that Area Health Service Boards should be retained and strengthened. We recommend that there be increased clinical representation and clinical input on Area Health Service Boards.

Openness and transparency about the performance of health care providers

We reaffirm the directions of the NSW Quality Framework[68] and its six principles of safety, effectiveness, appropriateness, consumer participation, access and

Recommendations:
Promoting clinical leadership

86. That the Department move immediately to establish Clinical Implementation Groups to sponsor the initiatives outlined in this report, with representation determined in close consultation with the relevant medical and nursing colleges.
87. That a Clinical Council be formed made up of representatives from these groups and other leading clinicians, with a full- or part-time Chair.
88. That the Department offer full- or part-time secondments to leading clinicians to support the Clinical Implementation Groups.
89. That within 12 months the Department establish a website providing comparative data on the performance of all NSW hospitals.
90. That NSW Health expand its training programs for clinicians in the areas of health care financing, management and information technology. This should include sponsoring selected senior clinicians to participate in leading executive management programs.

efficiency. We believe that its implementation will be greatly enhanced by the establishment of a 24-hour Health Care Call Centre (see Chapter 6), an Internet site and an Electronic Health Record (see Chapter 2).

These must form the core of an information system which can be used as a reference point by doctors, nurses and consumers.

We also recommend that comparative data for all NSW hospitals – on factors such as admission rates, readmission rates, mortality rates and surgical intervention rates for the major planned surgical procedures – should be included on the website within 12 months.

Clinical management

The human resource management strategy in NSW Health must continue to promote adequate and appropriate training and support to clinicians who undertake management roles. Priority areas include:

- training and development in health care financing and management tools (it is suggested that a number of training posts be made available within the next 12 months)
- increasing the awareness of hospital-based clinicians and nurses of modern information technology, including the Internet

We further recommend that NSW Health expand the provision of executive management training to support clinicians who are increasingly asked to perform executive as well as clinical roles.

Achievable benefits – Promoting clinical leadership

- Policies, standards, practices and information technology will be informed by those undertaking clinical practice.
- A new collegiate relationship will be established between leading clinicians and managers.
- There will be structures to evaluate clinical innovation and to promote widespread implementation across NSW.

61 Designed to Care, Renewing the National Health Service in Scotland, Guidance on Clinical Governance, National Health Service in Scotland, 1998.

62 The New National Health Service Modern Dependable, The Department of Health United Kingdom, 1997.

63 Saving Lives: Our Healthier Nation, The National Health Service, The Department of Health United Kingdom, 1999.

64 Wilson R, Runciman W, Gibberd RW, Harrison BT, Newby L & Hamilton JD, The Quality in Australia Health Care Study, Medical Journal of Australia, 1995; 183: 458-471.

65 Medical Care (in press).

66 Robertson I, Richardson J, & Hobbs M, Edwards M, The Impact of New Technology on the Treatment and Costs of Acute Myocardial Infarction in Australia, Technical Report 10, Centre for Health Program Evaluation, 1998.

67 Benchmark Activities in the NSW Public Health System, NSW Department of Health, 1999.

68 NSW Health, The NSW Ministerial Advisory Committee on Quality in Health Care, The State Continuous Improvement Steering Committee, 'A Framework for Managing the Quality of Health Services in New South Wales', February 1999.

6 Consumer and Community Participation

OBJECTIVE

The empowerment of individuals and communities in decisions about health care.

FINDINGS AND OBSERVATIONS

In Chapter 1 of our report, we argued that there needs to be a more informed debate in the community about what the health system can realistically achieve, and the desirability of achieving a better balance between the promotion of health and the treatment of illness. We emphasise that these changes will not occur unless consumers and communities are actively involved in the health debate and in identifying priorities. Consumer and community participation will help ensure that health care dollars go to those in greatest need and not, as has sometimes been the case, to the most powerful and articulate.

We have also argued that substantial changes are needed in clinical practice, and that the role and distribution of services in metropolitan and rural communities must change to ensure that services are relevant, appropriate and affordable. Unless individual consumers have access to information and communities are involved in decision-making, the substantial changes which we believe are essential for an up-to-date, sustainable health care system may be misunderstood by the community – or worse, rejected.

In the course of our review we therefore examined current initiatives to provide information to consumers of health care in NSW, and to improve the accessibility of that information. We also examined the levels of consumer and community participation in planning and in the making of decisions affecting their access to health care. We are particularly impressed with the work of the local Health Councils. Our meetings with them convinced us of the value of greater support to community participation initiatives and more access to information.

We examined both local and international initiatives to improve access to information, such as health call centres and Internet services. We believe these initiatives have enormous potential to involve consumers more actively in decisions about their own health, and to improve access to health services.

DIRECTIONS FOR CHANGE

We propose immediate action in three areas. First, NSW must increase consumer access to specific types of information by creating a State-wide, 24-hour Health Call Centre, together with expanded Internet advice services. Secondly, opportunities for local communities to participate in decisions about the type and location of health services must be enhanced. Thirdly, the Department must create a structure for consumer and community representatives to participate in identifying health priorities at a State level.

Recommendations:
Improving access to information

91. That NSW Health establish a 24-hour Health Call Centre, to operate with full coverage across NSW.
92. That the Department prepare an action plan for the establishment of the 24-hour Health Call Centre, which should specify:
    - what services it will provide, and how they will be phased in
    - how clinical protocols will be developed and endorsed
    - how to incorporate the call centre activities which already operate in various hospitals
    - whether the call centre should be established under contract arrangements with expert private sector operators, or as a stand-alone unit within NSW Health
    - how disadvantaged people and people with low incomes can obtain equal access to the service
93. That the Government fund a new health care Internet site to provide information which supports the advice available through the 24-hour Health Call Centre.
94. That consumer and clinical representatives be clearly involved in the establishment of both the Internet site and the 24-hour Health Call Centre.

Improving access to information

NSW Health must take a leadership role in empowering individuals and families, patients and providers through several new, State-wide developments.

We propose the funding of a new, State-wide 24-hour Health Call Centre which would make the following information available on request:

- how to access appropriate types of care in both emergencies and non-emergencies, including telephone access on a 24-hour basis
- advice about the types of services which are available locally
- how to measure quality of care and select high quality providers of hospital and medical services
- how to negotiate with providers of care to obtain information and appropriate access to care
- how to digest information on medical breakthroughs or otherwise highly technical information, in order to gain a better understanding of the role of modern medical technology
- risk factors affecting the health of the public, and methods to reduce them
- how to undertake self-care when the situation is appropriate

To support the information available through the State-wide 24-hour Health Call Centre, we recommend that the NSW Government fund a new Internet site to provide other types of information – including reviews of evidence of the effectiveness of new surgical interventions, diagnostic tests and modern medicines. This Internet service would be part of a State-wide network that could be accessed by both consumers and their doctors. Dedicated Internet access could be made available from a number of locations, including pharmacies and public libraries.

Both the 24-hour Health Call Centre and the Internet service must be designed to meet the needs of people from non-English speaking backgrounds (NESB) and people with disabilities which affect their capacity to use such services. We recommend that NSW Health actively involve clinicians and consumer representatives in the development of both the 24-hour Health Call Centre and the Internet site. It is also important that NSW Health should take advantage of the considerable work that has been undertaken in Western Australia[69] and within NSW (for example, at the New Children's Hospital[70]), to agree on and prepare relevant clinical protocols to be used by call centre operators. We note the Commonwealth Government's decision to provide funds to Western Australia, and believe that there is an equally strong case for NSW to be assisted.

Improving community involvement

Communities must be involved in decisions about the way health care is delivered and about the types and location of health services. Given the changes taking place to the way health care is provided, this involvement is vital. These changes include new medical technology, the provision of more care in the community and new ways for hospitals to provide care, including shorter stays and more services provided on a day-only basis.

In the course of our review, we examined the adequacy of current arrangements for consumer and community participation, including:

- the level of information available to individual consumers about local priorities, services and treatment options
- the degree to which local communities have been involved in planning and decision-making about the distribution of services
- the degree to which the broader community has been involved in debate at the State level about setting health care priorities

We believe that it is a fundamental right for all members of the community to be involved in the management of changes to their health care system. As taxpayers, citizens and residents, they are the principal stakeholders and are entitled to a sense of ownership of the health care services they receive. This is especially true in rural communities, where (as stated in Chapter 3) the local health facility is often a major source of employment, so that the loss or scaling down of a health service can lead to a decline in other services, such as schools and retail activities.

Community organisations can also play an active role in promoting the overall health of a community. We were impressed with the work of many local Health Councils, who are involved in providing self-help groups and quit smoking initiatives, and are assisting State-funded transport services by providing voluntary transport to assist people to visit their GP or have a test done at a local hospital.

We conclude that permanent and continuous structures for involvement are essential for community participation to be effective. There must also be openness about planning and budgeting processes, so that communities can obtain accurate information and make timely input. Finally, communities must be supported and well resourced in the participation process.

Recommendations:
Improving community involvement

95. That formal structures for ongoing community participation should be established in each Area Health Service, and:
    - be published in each Area Health Service's Annual Report
    - that each Area Health Service indicate how it has involved local communities in the development of its Area Health Plan
    - that the performance agreement of each Area Health Service Chief Executive Officer must include expectations about levels of consumer and community participation
96. That Area Health Services should make their planning and budgeting processes and timetables clear to the community
97. That each Area Health Service establish a sub-committee of the Area Health Service Board with responsibility for overseeing community participation.
98. That each Area Health Service designate at least one position to facilitate community participation activities and to provide support and resourcing to community organisations.

Recommendations:
State-wide representation

99. That the Department should establish a State-wide Consumer and Community Representative Forum to provide advice on planning, policy development and resource allocation at the State level. This forum should report to the Minister via the Director-General.
100. That the Department should develop a central resource group to support consumer organisations to be more actively involved in health care service planning at the State level.

State-wide representation

At present there is no permanent structure for consumer organisations or peak organisations to influence State-wide health care policy. There are a number of specific issues where community representatives have had extensive involvement at a State-wide level, such as mental health and Aboriginal and Torres Strait Islander health. There has also been State-wide consultation on specific policy initiatives, such as drug and alcohol and HIV/AIDS programs.

We propose that the Department should establish a permanent and continuous forum for consumer and community participation in setting State-wide directions and priorities.

We believe that there is considerable value in obtaining advice, input and external review of decision-making from people who are closely connected with consumers and local communities. Ideally this forum should contain representatives from particular population groups, such as older persons and people knowledgeable about conditions such as mental health and diabetes. It should also include representatives from the rural regions of NSW (for example, from local Health Councils) and from peak non-government organisations who bring a wider perspective to health care policy – particularly about the interface between health care and other Government services, and the relationship between disadvantage and health.

The Consumer and Community Representative Forum must be well resourced, and consideration needs to be given to creating a central resource group to sponsor and resource consumer and community participation activities. This could be either a non-government organisation funded by the Department, or run and administered by the Department itself.

Achievable benefits – Consumer and community participation

- Everyone in NSW will have improved access to information on health care services and treatment options and the performance of providers.
- Consumers will be more involved in decisions about their own health care.
- Community organisations will know which decisions they can influence.
- There will be a clear and permanent structure for involvement.
- Community representatives will be well resourced.
- Consumers and communities will have a focal point for participation at the State level.
- Decisions about resource allocation will be more transparent, and subject to external review.
- There will be an opportunity to improve the public debate about demand, and the need for public education and realistic community expectations.

69 In May 1999 the Health Department of Western Australia launched HealthDirect. This help-line allows people to talk directly to a registered nurse and receive information and advice on which health service can provide help, on the level of urgency, and what people should do until they receive face-to-face medical attention.

70 Kidsnet is a telephone advice service for parents run by the New Children's Hospital. Calls are answered by experienced paediatric nurses supported by the medical staff of the Emergency Department. The line provides advice on what to do for a sick child, appropriate health care and how to access services.

7 Corporate Governance, Planning and Accountability Arrangements

OBJECTIVE

Improved planning, administrative and accountability arrangements to ensure the effectiveness and efficiency of decision-making.

FINDINGS AND OBSERVATIONS

The successful implementation of the changes we recommend will depend on the effectiveness of the structures and capabilities of the key players in NSW Health, namely the Department of Health, the Area Health Services and the Area Health Service Boards and State-wide services.

We examined:

- the roles and relationships between the players
- the effectiveness of the present planning and accountability structures
- the appropriateness of Area Health Service boundaries
- opportunities for improved efficiency in administrative structures

On the matter of **roles and responsibilities** we believe that in the short- and medium-term there must be a greater devolution of decision-making throughout all parts of the system – that is, from the Department to Area Health Services, and from Area Health Services to local clinicians and managers. We believe this must be carefully managed to ensure that at each level, increased responsibilities are aligned with appropriate skills and capabilities.

We also recommend that greater devolution will not be possible unless there is a clearly articulated health strategy for NSW Health with defined and measurable performance indicators to ensure that Area Health Plans are more closely aligned with health objectives for the whole of the State's health care system.

On the matter of **planning and accountability** we believe that there are important and urgent improvements needed to support many of the recommendations we advocate. We are concerned that at the time of commencing our review there was no collectively agreed plan about the future role and distribution of health services across the whole of Sydney, and no long-term agreed directions to improve the quality and accessibility of services to rural communities.

The issue of **Area Health Service boundaries** is a more complex one. We have not recommended major structural changes at this time. More important and urgent changes are needed, such as improving clinical practice, overhauling patient information systems and introducing major changes to funding systems. These changes will be of greater benefit to consumers and health workers than structural change, and should be given priority.

Finally, on the matter of **efficiency** we believe that some short- and medium-term improvements should be introduced to improve the value for money of administrative arrangements. This is especially true in areas such as contracting to other sectors for the provision of support services, for example cleaning and catering.

Recommendations:
Short-term priorities to support Council's reforms

101. That the Department update the strategy of NSW Health to take account of Council's recommendations, the NSW Government's allocation of three-year budgets and the recommendations of the Ministerial Advisory Committee on Health Services in Smaller Towns.
102. That the Department develop a consolidated financial strategy to bring together all aspects of funding policy and resource allocation, as recommended in Council's funding strategy.
103. That the Department develop a consolidated, simple set of performance indicators which reflects a balance between health equity, health outcomes and financial indicators, and which can be used at all levels of the system.
104. That planning arrangements be improved to create a single, consolidated, three-year Area Health Plan.
105. That Performance Agreements for Chief Executive Officers and Area Health Boards should be changed to reflect the priorities of the Area Health Plan.
106. That the Department take a stronger role in mandating the requirements of information technology systems, and examine options for Area Health Services to share or aggregate their information technology support services.
107. That the funding for information technology be separately identified from the funding for physical infrastructure, to promote greater transparency of expenditure on information technology.
108. That Area Health Services be required to enter into specific agreements with local providers to allow for comparison in the performance of public, private and other non-government providers.
109. That the Department examine further opportunities for efficiencies in purchasing services such as cleaning and catering, and corporate transactions such as finance and payroll.
110. That the Department specify the required skill mix for Area Health Service Boards, and establish criteria for the performance of individual Board members.

These matters should be reviewed within the next year, having regard to the response of NSW Health to the initiatives proposed in our report which we believe require visible leadership at all levels.

DIRECTIONS FOR CHANGE

We do not support a retention of the status quo, and have put forward some realistic and achievable suggestions for change. First, they focus on some short-term changes which we believe are essential for the successful implementation of the range of reforms we have suggested to clinical practice and funding.

Secondly, we have outlined some medium-term goals that we believe both the NSW Government and NSW Health should be moving towards to ensure that structures, capabilities and accountabilities reflect the needs and complexities of a modern health system.

Short-term priorities to support Council's reforms

There are six areas where we believe change is needed immediately:

- strengthening the Department's strategic and funding capabilities
- strengthening the planning and accountability arrangements
- strengthening the purchasing role of Area Health Services and their Boards
- devolving decision-making from Area Health Service administration to local providers
- improving efficiency by implementing immediate changes to the purchasing of corporate services and the sharing of corporate activities between Area Health Services
- increasing the authority of Area Health Service Boards and the skill mix and accountabilities of Board members

Revising the strategy for NSW Health

It is the central role of the Department to facilitate an affordable, sustainable strategy for NSW Health. This strategy should guide and assist local managers and clinicians in their decisions about local services.

As a result of the NSW Government's decision to guarantee three-year budgets and in response to the substantial changes recommended in this report as well as by the Ministerial Committee on Health Services in Smaller Towns, there is an urgent need to revise the strategy for NSW Health. There is also a need to develop some robust performance indicators that can be used by all parts of the system.

The revised strategy for NSW Health should include:

- an articulation of desired health outcomes for the community
- agreements on health priorities – including both existing priorities such as mental health, drug and alcohol services and Aboriginal and Torres Strait Islander health – and the incorporation of the new Priority Health Care programs we recommend
- developing population health priorities – that is, priorities that take into account the needs of large areas with a mix of health problems
- setting service priorities and targets for rural communities
- setting service priorities and targets for the whole of Sydney
- setting workforce and training priorities and performance
- setting efficiency and productivity targets

We recommend that the Department develop a set of key performance indicators for the whole system that clearly measure how well NSW Health is performing against the strategy it has set itself. We commend IPART's report on NSW Health, which we believe should be used as a basis for action. In addition to health outcomes, the performance indicators should cover a number of broad categories as recommended by IPART. All parts of the system should use these categories to guide their individual performance.

Improving the financial strategy and financial capability of NSW Health

We have put forward a comprehensive financial strategy that covers issues ranging from the way funds are allocated at the highest level to the way services are funded at the point of care. It is essential that this coherence be maintained, and that there should be a system-wide financial strategy for NSW Health.

The implementation of a coherent financial strategy will improve the alignment between broad funding policy (such as an overall growth formula to respond to demand), resource distribution to Area Health Services and the specific methods for funding health services (such as episode funding). In turn, this will improve the links between the financial strategy and overall health strategy, and performance monitoring and accountability.

Improving planning arrangements

In this report we have highlighted the important role the Department must take in coordinating and resourcing rural health and metropolitan health services planning (Chapter 3). We have stressed the need for key decisions to be made centrally, to assist Area Health Services in planning their local services.

We recommend that the priority for improving the effectiveness of planning arrangements be to improve the links between the overall strategy for NSW Health, Area Health Plans, budget allocations and performance agreements for Boards and Area Health Service Chief Executive Officers.

The Department must require Area Health Services to demonstrate how they will implement State-wide priorities as set out in the overall strategy for NSW Health. This would include priorities such as the Priority Health Care programs, and predicted service levels and expenditure for the three-year period. Performance Agreements for both Chief Executive Officers and Boards should then reflect these priorities and targets.

It is essential that Area Health Services articulate their priorities, and that these be negotiated and endorsed so they can then implement their Plans with confidence and certainty.

In turn, the accountabilities of the Department must be clearly stated and incorporated into all executive level performance agreements. We recognise that many of the activities and performance targets of an Area Health Service are dependent upon the Department taking certain action in respect of resource allocation, forecasting growth and coordinating State-wide services, and successfully negotiating overall funding levels with the Commonwealth Government as part of the Australian Health Care Agreement, and with the NSW Treasury.[71]

Performance monitoring and performance management

A key role for the Department must be to measure the performance of Area Health Services in respect of their compliance with the overall strategy for NSW Health.

Activities that need to be strengthened immediately to support the changes we recommend, include:

- measuring health outcomes, and developing and measuring new key performance indicators
- benchmarking service costs – for example, variations in the costs of episodes of care and monitoring the appropriateness of admissions and treatments
- 'market-testing'[72] the performance of public facilities against private and non-government providers

Our principal concern follows on from comments made in the IPART report about the need for greater clarity in performance agreements with Boards and Chief Executive Officers.

While we acknowledge that the Department has made progress in this regard, we advocate further improvement. The Area Health Plan must become the primary guiding strategy for the performance agreements for the Board and the Area Chief Executive Officers, and must reflect the strategy set for NSW Health. We also recommend that performance agreements should be simplified, and critical accountabilities identified.

We would also support IPART's call for a balance in the agreements between meeting budget priorities and meeting the health needs of the community. Linking performance agreements with the Area Health Plan provides a way to achieve that balance.

Information management and technology

We have recommended an overhaul of the IMT&T strategy for NSW Health to fast-track the development of an Electronic Health Record, and in the short- and medium-term to improve the effectiveness of patient information systems.

This fast-tracking will require the Department to take a greater leadership role in mandating standards for patient information systems.

We also recommend that the Department take a stronger role in mandating standards in areas such as costing products and services, financial reporting, and classifications for patient management systems.

We also believe there may be some advantages to investigating the opportunity for greater efficiencies in areas like information technology support services (such as help desk services). These are currently provided at a number of locations around the State. We believe that greater efficiency could be achieved if Areas share or aggregate information technology support activities.

Finally, we recommend the Department should enter into negotiations with the NSW Treasury to separate capital funding for information technology from capital funding for physical infrastructure.[73] This will provide greater transparency and accountability for information technology expenditure.

Improving the purchasing role of Area Health Services

The role of Area Health Services as both purchasers and providers is an ongoing tension in the current administrative arrangements of NSW Health. There are inherent conflicts in the concurrent performance of both roles.

Our review of funding and metropolitan planning has highlighted the fact that under the Medicare Agreement, Area Health Services are limited in their capacity to perform a purely purchasing role. The purchasing role could only work through influencing and not restricting choice.

We have, however, recommended that funds and services be redistributed across NSW to reflect local needs and gaps in existing services (see Chapter 3). This will increase the purchasing role of Area Health Services. We recommend that there must be greater contestability of service provision within the public system and between the public, private and non-government sectors. Achieving better outcomes for consumers and better value for money should be the twin goals of this action.

We recommend two changes. First, Area Health Services need to enter into clear performance agreements with local providers. Providers must be clear about expected output targets, service standards and performance targets. There must also be full transparency about the cost of service provision, which will provide the capacity to compare the performance of different providers. Secondly, Area Health Services should be required to plan their services in conjunction with private and non-government providers and with the Divisions of General Practice (see Chapter 4). In this way the full range of potential services

will be understood and factored into Area Health Plans. Under the pressure of escalating demand and limited public resources, Area Health Services must explore involvement with the private and non-government providers.

Improving efficiencies in corporate service activities

We have highlighted the need for NSW Health to explore potential further efficiencies in the management of information technology support services which are currently performed separately by 17 Area Health Services.

We conclude there are likely to be efficiency gains in the sharing of resources or consolidating contracting arrangements with private providers in matters such as cleaning, catering, pathology, facilities management, and in the management of financial transactions, particularly billing.

These areas represent considerable costs, including the costs of Area Health Services having to manage a number of contracts with private providers. While we acknowledge that NSW Health has made progress in the streamlining of purchasing and outsourcing, we recommend further action to consolidate contracting activities. Greater efficiency in these areas can also be achieved by creating a separate Departmental focus on external contract arrangements and assists Areas to improve quality, value and performance.

Area Health Service Boards

Throughout this report we advocate the need for greater devolution of authority to Area Health Services, and the need for Area Health Services to involve their communities more closely in decisions about the role and distribution of health services.

Greater devolution to Area Health Services has major implications for the role and skill mix of Boards and must be supported by greater accountability, openness and community involvement, as well as clinical involvement at the local level. Without these local checks and balances there is a lack of contestability of advice and a potential for services to become detached from community interests.

We believe three changes are necessary for Boards to perform their role effectively. First, they must play a greater part in setting and monitoring local strategy. Secondly, their skill profile and skill mix should be enhanced to reflect the substantial public responsibility that has been devolved to them. Finally, they must be held accountable and subjected to a strong performance management system.

Increasing the involvement in local strategy

We have argued the case for improvements to planning and budgeting arrangements in NSW Health, and the use of one comprehensive plan for Area Health Services. We recommend that each Area Health Service Board have responsibility for developing an Area Health Plan on advice from its Chief Executive Officer, and for establishing the performance criteria to ensure the Plan's objectives are achieved. These criteria should include identification of key performance indicators, a performance management cycle, reporting requirements, and a risk management strategy. Each Board should also have responsibility for meeting all quality requirements.

Finally, Area Health Service Boards should ensure adequate input from the community and other relevant stakeholders, to increase the contestability and accountability of advice.

Skill mix

We recommend that the Department should identify the required skill mix for Area Health Service Boards and ensure that this skill mix is maintained. It should be stressed that Area Health Services are significant business enterprises, and that it is essential that each Board's skill mix reflects the scale and complexity of their operations. Based on their role, that skill mix should include:

- clinical representation
- business skills (particularly business planning) and contract management skills
- financial skills
- legal skills
- information technology skills
- facilities and asset management

We believe that it is vital that the Boards maintain their community of interest representatives (that is, key community interests relevant to the successful functioning of the Area Health Service).

We recommend that the Department require Area Health Services to develop a skill profile of its current Board membership, and that future vacancies should be filled in a way which addresses gaps in the profile.

Performance management

Finally, we recommend that the Department continue with its annual performance reviews of the Area Health Service Boards. These should have a greater focus on measuring performance against both the Area Health Plan and the overall strategy for NSW Health. If Board members are to be paid (as is currently being canvassed within NSW Health), then to ensure full accountability the performance management must be at the individual as well as the collective level.

Recommendations:
Medium-term priorities

111. That the Minister and the Department should work together over the next three years to ensure that administrative arrangements reflect a substantial devolution of authority to all levels of the system. This should include the Board advising the Minister on the appointment of the Chief Executive Officer, and the appropriateness and efficiency of Area boundaries.

Medium-term priorities

We believe that the changes we have outlined are essential to the success of our recommendations. However, we recommend that in the medium term NSW Health must continue to improve the effectiveness of administrative structures, as follows:

- There must be an ongoing devolution of authority and decision-making. We believe that the most effective approach for a system as large and complex as NSW Health is for Area Health Services to function as semi-autonomous bodies, with Boards taking on full governance responsibilities, including advising the Minister on the appointment of the Chief Executive Officer.
- Area Health Services should have greater autonomy to purchase services on the basis of price and quality, and greater levels of control over the budget allocated to meet the needs of their population.
- The points of accountability should be clear – for example, three-year plans for Area Health Services should form the basis of performance agreements.
- Performance agreements should reflect a greater balance between financial and health outcome criteria.
- There should be complete transparency of all costs associated with providing health care. This will strengthen the purchasing role of Area Health Services.
- There must be greater benchmarking of costs and market-testing in order to determine the effectiveness of the performance of the public, private and other non-government sectors.
- Where there are well-developed markets – as in areas such as non-clinical services (for example catering and cleaning) – there should be robust market-testing and a greater level of competition.
- Consumers, communities and clinicians should have increased levels of involvement in decision-making.
- The efficiency and appropriateness of Area Health Service boundaries should be reviewed, having regard to informed research about the optimum size of an Area Health Service and the cost-effectiveness of changes or alterations to boundaries.

We believe that the benefits of additional funding, more certainty about budgets and our recommendations for improving patient care will not be sustained unless the NSW Government and NSW Health work to ensure that the administrative structures are characterised by the features we have outlined.

Achievable benefits – Corporate governance, planning and accountability arrangements

- A revised and clearer strategy will provide guidance and clarity.
- A single financial strategy will improve the coherence of financial planning.
- A single Area Health Plan will improve accountability, and increase the opportunities for community input into decision-making.
- Performance agreements will be linked to Area Health Plans, and will improve accountability.
- IMT&T changes will provide greater leadership and fast-track the Electronic Health Record.
- Local clinicians and managers will gain improved authority and accountability as a result of greater specification of outputs and targets.
- There will be improved opportunities for private and other non-government providers to be involved in the delivery of health care.
- Boards will have greater authority, and therefore priorities will better reflect local needs.

71 Commonwealth funding is provided through two main agreements: the Australian Health Care Agreement (AHCA), which replaced the former Medicare Agreement in 1998/99, and the Public Health Outcome Funding Agreement (PHOFA). The AHCA is a five-year agreement under which Commonwealth funding is linked to population growth and ageing, increased hospital activity above growth, and a cost index linked to efficiency gains. Funding under this Agreement is also tied to the level of uninsured people in the population.

72 'Market testing' in the public sector is a mechanism where an outside organisation is given the opportunity to provide a service in order to demonstrate the most efficient and effective mode of delivery, which is then compared with the performance of an internal provider.

73 There is no separate capital budget set aside for information technology. Physical infrastructure refers to facilities such as buildings.

8 Implementation and Change Management

FINDINGS AND OBSERVATIONS

We believe we have put forward practical and realistic changes that will improve the quality of health care for the people of NSW and relieve pressure on health care workers. The success of our recommendations will depend on leadership from both NSW Health and clinical experts. Some of the ideas and suggestions contained in this report are already operating in NSW hospitals, many community health teams and many communities. These initiatives must be extended to the system as a whole to promote equity and greater effectiveness.

There are a number of elements that would support a successful change management strategy, including:

- the establishment of a coordinating body to oversee implementation
- the identification of key recommendations, and their inclusion in all executive level performance agreements
- a critical and continuous appraisal and evaluation of our recommendations
- demonstration projects which would see at least two Area Health Services fast-track the implementation of our recommendations, with a renewed focus on coordinating health services with the activities of other Commonwealth and State Government services, particularly human services agencies

DIRECTIONS FOR CHANGE

The establishment of a coordinating body to oversee change management

There are a number of reasons for recommending the establishment of a coordinating body. These include:

- A body focussed on implementation with independent representation can provide greater clarity about intended outcomes and the most effective means of achieving them.
- Many elements of the change management strategy need to be linked. For example, decisions about the role and distribution of health services across the whole of Sydney will impact on the capacity of Area Health Services to undertake local planning, and this in turn will impact on their budget allocations. Similarly, our recommendations to improve the delivery of health care services in rural areas need to be brought together with those of the Ministerial Advisory Committee on Health Services in Smaller Towns in order to achieve a comprehensive focus on rural health. In short, it is important that the key interactions between separate elements of the reform program be understood and carefully managed.
- We have stressed the need to link increased funding to reform. To maintain the confidence of the NSW Government, the progress of implementation must therefore be the subject of ongoing review.

Recommendations: Implementation and change management

112. That a coordinating body with a significant proportion of independent representation be established to oversee the implementation of the recommendations contained in this report.
113. That key recommendations be included in all executive level performance agreements.
114. That the coordinating body oversee the critical appraisal of our recommendations.
115. That the majority of reforms are implemented within two years.
116. That two Area Health Services be set up as demonstration projects in order to fast-track both the implementation of our recommendations and the increased coordination of human services agencies.

- Some changes need to be linked with other Government activities. For example, the implementation of new approaches to providing care to people with chronic and complex conditions will require the support of a number of agencies, including community services, housing, ageing and disability services.

We recommend that the coordinating body be made up of Department representatives, central agencies (Cabinet Office and Treasury) and representatives from the key implementation structures we recommend, namely:

- the Clinical Council
- the Metropolitan Planning Taskforce
- the Rural Health Steering Group
- the State-wide Consumer and Community Forum
- a person or group specifically focussed on achieving better cooperation between the private and non-government sectors

Clearly, the Minister and Director-General will have the discretion to include other representatives who can contribute to advancing the reform process.

The coordinating body should:

- report to the Minister and have a formal work program and executive support
- the coordinating body should have the role of developing and overseeing a detailed implementation plan which spells out relevant time frames and responsibilities
- progress those matters that we have not been able to address because of our limited time – such as training, research, public and population health
- ensure that our recommendations are subjected to critical appraisal
- take responsibility for ensuring that those matters that require Commonwealth Government support are appropriately progressed

We recommend that the coordinating body operate for approximately two years, after which its continued role will be subject to review by the Minister and Director-General.

Key recommendations

We consider the following key recommendations to be fundamental to the success of both the reform program and the overall effectiveness of the State's health care system.

They should be included in all executive level performance agreements, which should specify the expected role and contribution of individuals and providers to deliver on both the recommendations and the required timeframes.

Our key recommendations are as follows:

- the development of a revised strategy for NSW Health, and new performance indicators
- the implementation of the changes to clinical practice, including admission on day of treatment/surgery and day-only admissions

- the introduction of episode funding for all planned and acute hospital admissions
- the implementation of the 24-hour Health Call Centre for consumers, and an expanded Internet site accessible by every NSW resident
- the fast-tracking of decisions about the role and distribution of health services for the whole of Sydney
- the implementation of strategies to improve rural health services – in particular, fast-tracking telemedicine, improving the telecommunications base, extending rural workforce initiatives such as scholarships and remote allowances, and formally networking rural and metropolitan health services
- the development and implementation of the three-year emergency care plan to improve the effectiveness of Emergency Departments and their links with the wider hospital
- the implementation of the development of Priority Health Care programs for people with chronic and complex conditions
- the establishment of Clinical Implementation Groups and an umbrella Clinical Council
- the establishment of the State-wide Consumer and Community Forum
- the creation in each Area Health Service of structures and dedicated resources to support consumer participation
- the implementation of demonstration projects in two Area Health Services
- the updating of the information management, technology and telecommunications plan with a staged timetable for the implementation of an Electronic Health Record for every individual who accesses the State's health care system, commencing with the introduction for Priority Health Care programs across the State and in demonstration projects in two selected Area Health Services
- the implementation of a Unique Patient Identifier, commencing with the Priority Health Care programs across the State and in demonstration projects in two selected Area Health Services
- the development of a three- to five-year growth formula to guide funding allocations from Treasury beyond this current three-year budget

Continuous and critical appraisal

It is essential that Council's recommendations be subjected to continuous critical appraisal to determine whether the intended outcomes have been achieved. We have based many of our recommendations on discussions we held with a wide variety of health workers and consumers, and on our own observations about what is already working well and could be successfully applied across the State's health care system as a whole. However, it may be the case that particular recommendations (such as the Priority Health Care programs) should be adapted to suit local circumstances and local practices.

Independent and ongoing appraisal and review will therefore be essential and should be overseen by the coordinating body responsible for the overall implementation of our recommendations.

Demonstration projects

We recommend the establishment of demonstration projects in at least two Area Health Services, for two reasons: First, we have identified significant challenges in the management of chronic and complex conditions, and the potential benefits to individuals and their families of improving the delivery and coordination of care. These challenges are typified by a disproportionate number of hospital admissions (particularly unplanned admissions through the Emergency Department) which means that a large share of resources are being consumed by a small number of people. With the proportion of the population aged over 65 years and expected to rise to 18% by 2021, the State's health care system must be able to demonstrate that it can successfully manage the care of people with chronic and complex health conditions.

Secondly, we have outlined the substantial benefits which would result for all consumers of health care in NSW from the introduction of an Electronic Health Record. We have also emphasised the significant privacy, confidentiality and logistical issues which will need to be overcome to ensure its successful introduction and acceptance by the community.

NSW Health must demonstrate that it can successfully introduce both the Electronic Health Record and a single Unique Patient Identifier. Their benefits will need to be articulated to the community, and NSW Health must ensure that the privacy and confidentiality issues can be managed. Finally, NSW Health must demonstrate to clinicians that information technology can become a useful and even critical part of clinical practice at the point of care. This will require a building of trust about the accuracy and reliability of information.

We therefore recommend that NSW Health implement demonstration projects in two selected Area Health Services, which represent a significant enhancement of the coordinated care trials operating in NSW and other parts of Australia.

These demonstration projects are intended to be structural, clinical and patient focussed. We recommend they include the following characteristics:

- information technology and telecommunication links between health care providers to bring together primary, acute and community health providers – these would include computerised discharge summaries and the use of telemedicine to transfer diagnostic results
- sponsoring teams of clinicians to implement the Priority Health Care programs with an emphasis on community education and health promotion
- the use of Unique Patient Identifiers to assist in providing continuity of care for people with chronic and complex conditions, where linkage of data is critical to patient outcomes
- fast-tracking the introduction of the Electronic Health Record for an entire population
- changes to clinical practice, such as admission on day of treatment/ surgery, day-only admissions, and the use of clinical case managers and clinical pathways

- linking human services agencies in the development of a single human services plan, either for an entire Area Health Service or for key communities
- developing notional budgets which would reflect the totality of health care expenditure between the State and Commonwealth Governments
- establishing a single, local consumer forum to provide advice on both a human services plan and wider budget priorities, and to participate in the implementation of the Priority Health Care programs (at present, Government departments often use separate forums for community involvement)

The Government has provided $15 million over three years to these projects.

We recognise that certain Area Health Services are already well advanced in clinical reforms, the use of episode funding, the integration of patient information systems and links with other human services agencies. These Area Health Services may be ideal candidates for the demonstration projects, since they would provide opportunities for early assessment of benefits such as increased access, improved productivity and consumer satisfaction.

We recommend that at least one of the demonstration projects be in a rural Area Health Service.

Achievable benefits

- Implementation will be open and accountable.
- Implementation will be coordinated to ensure that priority areas of reform are progressed rapidly.
- Accountabilities for implementation will be clear.
- Demonstration projects will provide an opportunity to focus on and fast-track the totality of reforms for two Area Health Services, alongside better coordination with human services agencies.
- Demonstration projects will allow for the early assessment of productivity gains and improved access – for example, reductions in waiting times.

Appendix 1 – List of written submissions received by the NSW Health Council

Organisation/Individual	Title
Aboriginal Health and Medical Research Council	Local Aboriginal Health Plans & Monograph Series on Primary Health Care
Diana Aspinall	Submission to the NSW Health Council
Auburn Council SubCommittee	Preservation of Auburn Hospital as a fully Functional Acute Medical and Emergency Facility
Auburn Hospital and Community Health Services	1. Metropolitan Health Service Plan 2. Medical Staff Council submission on the Role of the Community Hospital, with particular reference to Auburn Hospital and Community Health Services
Catholic Health Care Services Ltd	Submission to NSW Health Council
Council on the Ageing (NSW)	Submission to NSW Health Council
Council of Social Service of NSW	1. Rural Health Related Transport 2. Consumer/community participation 3. NGO program 4. Earlier Discharge from hospitals
David Cross	Presentation to the NSW Health Council on Allied Health issues
Faulding Healthcare Hospital Services	Procurement of Pharmaceutical & Medical & Surgical Products
Hunter Urban Network for Consumers and Healthcare	Submission to the NSW Health Council
Dr Neil Merrett	Re: Health Council Report to the Minister
Macquarie Bank	Presentation to New South Wales Health Council
Sue Wade,National Rural Health Alliance	Presentation to the NSW Health Council
NSW Rural Doctors Network	NSW Rural Medical Training Forum
Pharmacy Guild of Australia	Community Pharmacy and the NSW Health Strategy
Royal Flying Doctor Service (NSW)	Submission – A Future for Rural Health Service Provision in NSW
Rural local Health Councils	Presentations from the 1999 Rural Health Council Forum
Dr Antony Sara	Issues of Medical Informatics in hospitals and Area Health Services
The Health Services Association of NSW	Submission to NSW Health Council
Uniting Ministry with the Ageing, NSW Synod, Uniting Church in Australia	Developing partnerships between NSW Health and not-for-profit providers of health/aged care services to enhance the quality of healthcare
Centre for GP Integration Studies, University of NSW	Integration between GPs, hospitals and community health
VMO Board of the Greater Murray	Issues relating to Rural Centres in NSW
Walcha Support Group	Changes to Aged Care at Walcha Hospital

Appendix 1 – List of written submissions received (continued)

Organisation/Individual	Title
Submissions from the NSW public health system:	
Sydney Children's Hospital, Randwick	Submission to the NSW Health Council
Macquarie Area Health Service	Submission to the NSW Health Council
New Childrens Hospital	Submission to the NSW Health Council
Northern Sydney Health, Intensive Therapy Unit, Royal North Shore Hospital	Winter Bed Strategy for 2000: Intensive Care Unit
South Eastern Sydney Area Health Service	1. Vision for the Future of NSW Health 2. Dialysis Services – A problem in SESAHS
Sydney Hospital & Sydney Eye Hospital	Statewide Service role for Sydney Eye Hospital
South West Sydney Area Health Service	1. Submission to NSW Health Council 2. Health Services In NSW – What should be done within the next 4 years Rural to Metropolitan Health Service Links
Far West Area Health Service	Regional Health Plan for the Lower Western Sector (north)

The above submissions have been handed over to the Minister for Health and the Director-General of the NSW Department of Health to assist in the implementation of the NSW Health Council recommendations.

Appendix 2 – List of consultations

List of the Parties Consulted by the NSW Health Council
We have attempted to identify all those people we met with in the course of the Council's work. We apologise if there are any omissions. In addition to this list, a wide reference group of people assisted with the production of the background papers. Those people are listed in the appendix of those papers.

Australian College of Health Service Executives
Mr Warren Westcott
Ms Sue McApin
Mr Raad Richards

Allied Health Alliance
Ms Sue Olsen
Ms Helen Wilson

Ambulance Service of NSW
Mr Greg Rochford
Mr John Ducker
Mr Malcolm Voysey

Australian College of Rural and Remote Medicine
Dr Richard Abbot

Australian Medical Association
Dr Kerryn Phelps
Dr Robyn Napier
Mr Laurie Pincott

Australian Salaried Medical Officers Federation
Mr Peter Sommerville
Dr Geoff Duggin

Bernie McKay and Associates
Mr Bernie McKay

BGP Pty Ltd
Mr Rodney Swan

Cabinet Office
Mr Roger Wilkins
Ms Kate McKenzie
Ms Jenny McDonald
Ms Mary Darwell
Mr Mark Degotardi

Catholic Health Australia
Mr Francis Sullivan

Catholic Health Care Services Ltd
Mr Chris Rigby

Central Coast Area Health Service
Mr Jon Blackwell

Central Sydney Area Health Service
Dr Diana Horvath AO
Prof. John Horvarth
Dr Alistair Corbett
Dr Patrick Bolton

Chairmen of NSW State Committees of Medical Colleges
Dr Stephen Cahill
Dr Peter Henke
Dr Donald Holt
Dr Theresa Jacques
Dr J Leigh
Dr David Lillystone
Mr David Storey
Dr Shane Wiley
Ms Bev Lindley
Mr R Carruthers

CHIC
Sally Glass

Consumer Health Forum of Australia
Mr Lou McCallum

Commonwealth Dept. Health & Aged Care
Mr Andrew Podger
Mr David Borthwick
Mr Nick Blazlow
Mr Nick Merciades
Mr Peter Davidson
Ms Rosarina Murace
Ms Lyn Brick
Mr Richard Eccles
Dr Louise Morauta
Dr Charles Maskell Knight

Corrections Health
A / Prof Debbie Picone
Dr Richard Mathews

Consumer Representatives
Ms Betty Johnson
Mr Bruce Huggett
Ms Jan Clifford

Department Infrastructure, Victoria
Dr John Patterson

Department of Human Services
Dr Campbell Miller

Department of Human Services South Australia
Ms Christine Charles
Mr Jim Davidson
Mr Peter Davidge
Dr Arthur van Deth

Appendix 2 – List of consultations (continued)

Dr E Price and Associates
Dr Eddie Price

Durri Aboriginal Medical Service
Mr Steven Blunden

Eurest
Mr Raymond J Capdevila
Stewart McGrow

Far West Area Health Service
Mr Gary Crase
Dr Hugh Burke
Ms Kim Browne
Ms Betty Mitchell – Remote Nurses
Ms Colleen Edgar

Fellowship of Emergency Physicians
Dr Paul Gaudry
Dr David Cooper

Greater Murray Area Health Service
Ms Karen McPeake
Dr Joe McGirr

Health and Medical Research Strategic Review Committee
Mr Peter Wills

Health Care of Australia
Vicki Taylor – Strathfield Private Hospital

Health Care Complaints Commission
Ms Merrilyn Walton

Health Department of Western Australia
Mr J Kirwan
Mr E Rohwedder
Ms K Patterson
Mr T McGuire
Mr Peter Collard
Mr Kim Snowball

Health Funds Association
Mr Alan Kinkade
Dr Frances Cunningham

Health Insurance Commission
Dr Jeff Harmer
Dr Brian Richards
Ms Andrea Hope
Ms Leone Cooper
Dr Andrew Parkes
Ms Ellen Dunne

Health Services Association
Mr Paul Naylor
Mr Brian Johnston

High Performance Healthcare
Dr Andrew Wilson
Ms Julie Baker

Hunter Area Health Service
Prof Katherine McGrath
Dr Julia Lowe
Dr Mark Foster
Dr Arn Sprogis
Mr Tony Maher
Ms Janet Cohen
Dr N Lyons

Lower Hunter Health Council
Mr Graham Smith

Upper Hunter Health Council
Mr John Piper

IBM Health Solutions
Mr Paul Sulkers

Illawarra Area Health Service
Dr Rod McMahon (Chairman of the Board)
Mr Ian Southwell
Mr Terry Clout
Mr Michael Spence
Ms Tineke Robinson

Integration SERU
Prof Mark Harris
Gawaine Powell-Davis

Independent Pricing and Regulatory Tribunal of NSW
Prof. Tom Parry
Mr Eric Groom

Intensive Care Units Working Party
Dr T Jacques
Dr R Herkes
Dr Malcom Fisher

KPMG
Mr Richard Stone
Ms Deborah Smithers
Mr David White

Local Governments & Shires Association of NSW
Mr Chris Vardon

Macquarie Area Health Service
Mr Allan McKinney (Chairman of the Board)
Mr Ray Fairweather
Ms Angela Honeysett

Macquarie Bank
Ms Mary Reemst
Mr David Shearwood
Ms Kerrie Mather

McKinsey, Inc
Mr Cuong V Do

Medical Staff Council (Coffs Harbour)
Dr Phillip Houlton

Medical Staff Councils Chairs (Metro)
Dr Greg Brggs
Dr Barry Duffy
Prof. John Dwyer
Dr Suzanne Hodgkinson
Dr Andrew Keegan
Prof. Reginald Lord
Dr Lou McGuigan
Dr Charles Pawsey
Dr John Pitkin
Prof. Kevin Rickard
Prof Graeme Stewart

Mental Health Coordinating Council
Ms Felicity Reynolds

Mid North Coast Area Health Service
Mr Bob Gore
Dr Victor Carey

Mid Western Area Health Service
Mr Martin Bowles
Dr Theam Eng Khoo

Midwifery Association
Ms Pat Brodie
Ms Hannah Dahler

Ministerial Advisory Committee Quality in Health Care
Dr Ross Wilson

National Council of Social Services
Mr Gary Moore
Ms Ros Bragg

National Rural Health Alliance
Mr Gordon Gregory
Ms Sue Wade

New England Area Health Service
Ms Christine Kibble
Mrs Christine Robertson
A/Prof. Debbie Picone
Mrs Jenni West

New Children's Hospital
Prof. Kim Oates
Ms Bronwyn Exley
Dr Ralph Hanson

NSW College of Nursing
Professor Judy Lumby
Ms Julienne Onley

NSW Nurses Association
Ms Sandra Moaitt
Mr Brett Holmes

NSW Health Funds Association
Mr Alan Kinkade
Dr Frances Cunningham

NSW Treasury
Mr John Pierce
Mr Tony Miller
Ms Judy O'Connell

Northern Sydney Area Health Service
Dr Stephen Christley
Ms Linda Smith
A/Prof. Kathy Baker
Mr Peter Lemon
Dr Kim Hill
Ms Joanne Fisher
Prof. Norbert Berend
Mr Bernie Harrison

Northern Rivers Area Health Service
Dr Tony Sherbon
Dr John Beard
Ms Pam Jones

North Western Health
Mr Chris Gibbs
Professor Len Gray
Ms Anna Burgess

Pharmacy Guild of Australia
Mr Ian Campbell

Postgraduate Medical Council of NSW
Prof. Kerry Goulston

Premiers Department
Dr Col Gellatly
Ms Kate Dundas
Mr Glenn Ball

Private Hospitals Association of NSW Inc
Ms Janene Eagleton
Mr Graham McGuinness
Ms Tina Penney
Mr John Pitsonis
Mr George Toemoe
Mr Andrus Tonismae
Mr Pat Grier
Mr Robert Glynn
Mr John Tucker

Appendix 2 – List of consultations (continued)

Ramsay Health Care
Mr Patrick Grier
Mr Christopher Rex

Rural Doctors' Association
Dr Ken Mackey

Rural Doctors' Network
Dr Ian Cameron
Ms Kirsty McEwin

Royal Australasian College of Physicians
Mr Paul Long
M Craig Patterson

Royal Flying Doctor Service
Captain Clyde Thomson GM

Rural Health Support Unit's Reference Group
Mr Paul Braybrooks

Rural Health Training Units
Dr Bruce Harris
Ms Louise Lawler

Services for Rural and Remote Allied Health Alliance
Mr David Cross

Sisters of Charity Health Service
Dr Stuart Spring

Shadow NSW Health Spokesperson
Dr Jillian Skinner

Shadow Federal Health Spokesperson
Ms Jenny Macklin

South Eastern Sydney Area Health Service
Ms Deborah Green
Prof John Dwyer
Dr Ian Rewell
Dr Lynette Lee
Dr David Goldstein
Dr Denise Robinson
Prof. Ronald Penny AO

South Western Sydney Area Health Service
Mr Graham Bush OAM (Chairman of Board)
Mr Ken Brown
Prof. Ken Hillman
Ms Kate Tynan
Mr Colin Froud
Dr Betty Andersen AO
Mr Tim Wills
Mr Denis Norsworthy
Dr. Suzanne Hodgkinson
Prof. Bruce Hall
Dr Liz Young
Prof. Stephen Deane

Southern Area Health Service
Mr Gratton Wilson (Chairman of Board)
Mr Kieran Gleeson
Ms Carol Madge
Dr Paul van Bynder

University of NSW
Prof. Peter Baume AO

University of Wollongong
A/Prof Kathy Eager

University of Adelaide
Errol Bamford

University Teaching Hospital Association
Dr D Robinson
Dr Christine Bennett

Western Sydney Area Health Service
Mr Allan McCarroll
Prof. Graham Stewart
Prof. Mekeller
Dr Christine Bennett

Wentworth Area Health Service
Dr Elizabeth Barrett
Mr Graham Jenkins

NSW Department of Health staff who assisted the NSW Health Council

Mr Robert McGregor
Dr Tim Smyth
Dr Andrew Wilson
Mr Charles Pace
Ms Margaret Coffey
Mr David Gates
Mr Ken Barker
Ms Karen Crawshaw
Dr Stephen Boyages
Prof Beverley Raphael
Ms Judith Meppem
Ms Catherine Katz
Ms Kathy Meleady
Mr Jim Pearse
Ms Deb Hyland
Dr Jim Hyde
Mrs Lyn Brown
Ms Tim Agius
Ms Claire Croumbie Brown
Ms Leonie Baden
Ms Lucelle Wills
Dr Allan Patterson
Ms Sue Looyschelder
Dr Steevie Chan
Ms Lynda Smart
Ms Melissa Gibson
Dr Tim Churches
Ms Carmen Parter
Ms Margaret Banks
Ms Gillian Wood
Ms Margitta Olup
Ms Justine Waters
Dr Janine Stennett
Mr Michael Stewart
Mr Michael Stokes
Mr Bernard Gibson
Ms Maureen Thomas

Meetings/Forums Attended

Senior Executive Forum, NSW Health
Health Economic Reform Committee
Ministerial Advisory Committee on Health Services in Smaller Towns
Quality Committee Meeting
Committee of Chairmen (College of Surgeons)
Post-graduate Medical Council
National Nursing Workforce Forum
Directors of Health Service Development
Rural Health Council Forum
Australian Institute of Management
Peak Nursing Forum
Australian Council of Health Service Executives
University Teaching Hospital Association

Services/Organisations Visited

Ambulance Service of NSW
Northern Sydney Area Health Service
Corrections Health
Macquarie Area Health Service
South West Sydney Area Health Service
Central Sydney Area Health Service
South East Sydney Area Health Service
Wentworth Area Health Service
Mid North Coast Area Health Service
Greater Murray Area Health Service
Far West Area Health Service
Wagga Wagga Aboriginal Medical Service
Walgett Aboriginal Medical Service
Dubbo Aboriginal Health Service

Consultants utilised by the Resource Group

Dr Nandini Keuhn
Ms Dragina Kessip
Ms June Hefferan
Prof John Deeble
Prof Stephen Duckett
Ms Vivien Twyford
Mr Stuart Oliver

Presentations made to the Council

Optus/GMD
Dr Kleinholz
Mr Greg King

Glossary

Access block
Delay experienced by people presenting to Emergency Departments in accessing acute hospital beds.

Access
Extent to which an individual or population can obtain health care. Access can be measured in terms of distances to facilities and the range of services offered locally.

Acute care
Acute care is where the principal clinical intent is to do one or more of the following: manage labour, cure illness or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care); reduce severity of an illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, perform diagnostic or therapeutic procedures.

Area Health Services
Area Health Services are constituted under the Area Health Service Act 1997. There are seventeen Area Health Services in NSW: nine metropolitan (including Central Coast, Hunter and Illawarra) and eight rural Areas. The New Children's Hospital, Ambulance Service, Blood Transfusion Service and Corrections Health Service are single operating units outside of the Area administration structure and often referred to as statewide services.

Benchmarking
A continuous and systematic process to identify and introduce best practice into an organisation.

Best practice
Documented and/or accepted widely as providing and/or leading to optimal outcomes for consumers of health care and/or health professionals from a quality, health and/or economic perspective.

Capital charge
Where public service providers explicitly pay for their capital through the mechanism of an annual charge, based upon the value of assets used in service provision.

Chronic clinical pathway
Of long duration or frequent recurrence

A clinical pathway is developed by expert clinicians in order to define on average how long a person should be in hospital, when they should be discharged and the various health milestones they need to reach in the course of their treatment.

Clinician
Doctor, nurse or allied health professional.

Community health services
A range of services provided in the community for the purposes of disease prevention and health promotion. Services may include after hours and home nursing, audiometry, counselling, diabetes care, dietetics, drug and alcohol services, early childhood services, footcare/podiatry, health education and promotion, home modifications, occupational therapy, palliative care, physiotherapy, psychiatry, school-based programs, sexual assault services, social work, speech pathology and women's health.

Consumer participation
The process of involving health consumers in decision making about their own health care, health service planning, policy development, setting priorities and addressing quality issues in the delivery of health services

Consumers
Any person or group of people who use or have the potential to use health services

Continuity of care
The extent to which each individual episode of care is integrated into overall care provision.

Coordinated Care Trials
An initiative of the Commonwealth Department of Health and Aged Care as part of a range of endeavours designed to reform aspects of the health and community services sector. The trials tested models that may achieve better delivery of care for people with complex care needs, within existing levels of resources.

Coordination of care
The integration of services provided in the primary and community health and acute care (hospital) settings.

Discharge planning
Involves organising for the patient to be reviewed/followed up as appropriate and organising the provision of hospital care and support as required.

Effectiveness
The extent to which a treatment or intervention has achieved the desired outcome.

Efficiency
Health care of the desired quality being produced at the lowest cost, or, health care produced at a fixed cost being of the highest quality.

Efficiency has two aspects:

Technical: the degree to which the least-cost combination of resource inputs occur in production of a particular service; and

Allocative: the degree to which maximum benefit (or outcomes) is obtained from available resources.

Episode funding
Assigning an estimate of cost (or price) to each treatment category in an episode classification for use in funding health services

Episode of care
A phase of treatment during which the patient receives a particular type of care eg. acute care, rehabilitation. When that type of care is concluded the episode of care is ended and the patient either changes to a different type of care or leaves the hospital/health care facility.

Full-time equivalent (FTE)
Equivalent full time, excluding overtime hours.

Health information
Information about all facets of health care, including health promotion, health services, health conditions, treatments, procedures, medications consumer rights and responsibilities

Health outcome
The effect of health care on a patient or population. An outcome that affects a patient's health status.

Health priorities
Health conditions or population groups identified as priority areas for action.

Health promotion
A range of approaches aiming to create environments to support health, reduce health inequalities between groups within the population and enable individuals and communities to make health choices

Health protection
Measures, usually mandated by legislation, to mitigate the risks to health arising from environments and activities over which the individual has no control such as the prevention and management of outbreaks of communicable disease.

Individual care plan
An individual care plan involves:

- Working with the client who has ownership of the plan
- A comprehensive assessment of the client/consumer/patient's health and well-being.
- It specifies each client's unique care needs eg, nutrition, medical treatment, physiotherapy
- The plan specifies goals of care (objectives of care) required over a specified period of time
- It details the range of scheduled services, treatments and interventions required to ensure that a client's health and community care needs are met.
- It allows monitoring of the client to provide early intervention and avoidance of crisis hospital admissions.
- The plan will have ongoing review to assess the health outcome and further requirements of the client

It may be developed by a variety of service providers such as GPs, hospital-based physicians, or community or allied health workers.

Inpatient
Person admitted to hospital or health service facility

IPTAAS
Isolated Patient's Travel Assistance and Accommodation Scheme

Local Health Councils
Groups of people from local communities formed to advise their Area Health Services on local health needs, issues and developments

Market-testing
Where a publicly owned organisation seeks to sell services to, or by services in, from a privately owned organisation with a view to improving efficiency, effectiveness and quality of service by introducing a greater degree of competition and service innovation.

Morbidity
The proportion of sickness in a locality.

Outpatient
Person who receives medical, surgical, allied health or diagnostic services in a hospital outpatient facility who is not formally admitted to the hospital at the time of receiving the service.

Performance agreements
Agreements between the Director-General and Area Health Services which identify targets and performance measures.

Performance indicators
A quantitative measure designed to monitor performance on an ongoing basis.

Planned admissions
An admission is planned if in the opinion of the treating clinician it is not essential within 24 hours. A planned admission usually results from a GP consultation, referral to a specialist and a recommendation for admission to hospital by the specialist (or GP where appropriate)

Population health
Aims to promote health and reduce the incidence of preventable disease and disability by improving access to opportunities and pre-requisites for good health.

Primary health service
Health care services provided by a general practitioner (GP) in a community setting.

Private patient
A person who elects to be treated as a private patient and to be responsible for paying applicable fees. Private patients can also elect to be treated by a doctor of their own choice.

Public patient
A person who receives or elects to receive a public hospital service free of charge

Resource Distribution Formula (RDF)
A population-based formula used by the Department of Health in the development of budgets for Area Health Services.

Rural Clinical Schools
A component of the University undergraduate medical degree is the gaining of clinical skills. The Rural Clinical Schools have been established to offer opportunities to Medical Students in the fourth, fifth and sixth years of their training to acquire rural clinical experiences.

Service network
The formalised and clearly defined linkage of health services across a range of sites and settings to provide an appropriate, effective, comprehensive and well coordinated response to health needs.

State-wide service
A service provided in a limited number of facilities used by the population of the whole of the State.

Telemedicine
Telemedicine or telehealth is the transmission of images, voice and data between two or more health units via digital telecommunications, to provide clinical advice, consultation, education and training services.

Telemedicine is more specifically the delivery of healthcare services involving the patient/client or management of a patient/client.

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