

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 servicesin 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
- morbidity⁴² 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.

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.

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.

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.

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.

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



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.

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: 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.

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 Services⁵⁰) 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.

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 services⁵² 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.

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.

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.

A predictable growth formula

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

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 million⁵³ 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

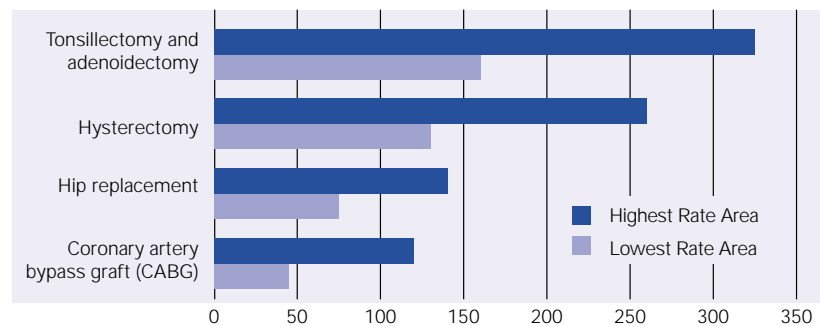
Managers and clinicians will also be able to compare the costs and appropriateness of certain admissions and identify areas where improvements can be made.

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 data⁵⁶, 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. Number of procedures per 100,000 persons

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 proactive 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 predictability 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.

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.

- 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

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 Tribunal⁶⁰ (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.