

**INDEPENDENT PRICING AND REGULATORY TRIBUNAL
OF NEW SOUTH WALES**

NSW Health

FOCUSING ON PATIENT CARE



August 2003

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New South Wales Health: Focusing on patient care

An overview

The provision and use of health services is unique. Almost every one of us makes some direct use of health services at some stage in our lives. Many of us are carers for others who use the health system. Few of us are sufficiently well informed or qualified to make specific decisions about the health services best suited to our particular needs, even though we are the ultimate ‘consumer’. Few health services are directly paid for in full, if at all, by those who consume them. ‘Health’ is different.

Not surprisingly, we expect the ‘best’ possible health care—everywhere and always. And the best possible health care is increasingly more costly. New expensive technology and equipment, new expensive drugs and new procedures, combined with an ageing society with increased expectations, is placing substantial pressure on our health system. This pressure will increase dramatically over coming years.

In twenty years’ time health priorities will continue to be driven by the increasing prevalence of chronic disease related to lifestyle (diabetes, hypertension, chronic respiratory disorders) and living longer (dementias and other neurodegenerative disorders), mental disorders, cardiovascular disease and cancer.

We cannot expect the nature of health services in 2023 to be an image of those in 2003 simply adjusted for population growth. There is little doubt that the health services in 2023 will be as different to those in 2003 as today’s services are different to those of 1983. To take just one example, many of the same-day surgical procedures performed today required lengthy hospital stays twenty years ago. Just as there will be increasing demands on the health system driven by demographic and societal factors, the way in which the system delivers health care is more than likely to further change. Hospitals will increasingly become centres for high dependency care and specialisation, with a pronounced shift from acute hospital care to community and domiciliary services and improved interfaces between acute and residential aged care. The system must be capable of both planning to meet future pressures while being sufficiently flexible to meet changing health structures and protocols.

Our health system is not a single or simple system. Health care covers a range of activities and involves a variety of providers. It covers preventative and community health programs; primary GP, specialist physician and other clinician care, in-patient and outpatient hospital procedures and, increasingly, at-home chronic and acute care. Health care is funded by the Commonwealth, the States and Territories, as well as by private health funds and individuals through out-of-pocket payments. Hospital-based care is provided by the public and private sectors, both profit and non-profit institutions.

NSW Health is responsible for a substantial part of health care delivery in the State and received some \$9.8 billion in funding in 2003/04, about 27 per cent of the State budget. By any measure and on any basis of comparison with other countries or other Australian States or Territories, it does a good job. It does a remarkably good job, as do other Australian jurisdictions, given the relatively modest proportion of the nation’s resources (the percentage of GDP) that is spent on health.

However, no health system is perfect. There are obvious areas where the NSW Health system has failed to deliver fully: mental health and indigenous health stand out (as they do in other States and Territories). There are other areas where different stakeholders call for improvement in the system. Waiting times for some in-patient hospital procedures may be too long; at times emergency departments have unacceptably long waits; in some areas, both metropolitan and regional, not all services are readily or conveniently available; on occasions health care intervention has poor quality outcomes. The system is by no means in crisis, but there is room for improvement—particularly improvements which will deliver better patient care.

Perhaps the single most important message from this review is our conclusion that the NSW health system can deliver significant improvements—which it must do in order to maintain, let alone improve, patient care over the next five, 10 and 20 years as pressures on the system increase as the system itself evolves. While it is always open to governments to spend more on health, it is not obvious that increased government expenditure necessarily results in ‘better’ health outcomes. Governments have many demands to spend more of our money on many worthwhile things, ranging from schools, police, roads, public transport and a number of community and human services, including health care.

The major conclusions and recommendations arising from our review are unashamedly focused on system changes which are most likely to improve patient care and community health outcomes. This report is not about serving any narrow interests of clinicians and other health workers, hospital administrators, other health bureaucrats, Area Health Service Directors or community groups. These groups play an important part in our system. But the health system must deliver the best possible health outcomes for the people of the State within the constraints of the available resources, rather than meet particular sectional interests that may compromise these outcomes.

We believe that implementing the main recommendations in this report has the potential to improve patient care and community health in NSW. Our key recommendations revolve around better governance and institutional arrangements. We are not proposing that the Department of Health and the Minister give up responsibility and controls over the NSW health system. Rather, we are proposing that the roles and responsibilities of the key layers in the health system—the Department and the Areas—are clarified so that their accountabilities are strengthened. We believe that unless the health system functions more effectively, it will be much more difficult to maintain, let alone improve, the current level and standard of community health outcomes in NSW over the next 5, 10 and 20 years.

The major recommendations include:

- The Commonwealth and the States and Territories must rationalise funding arrangements and responsibilities to better coordinate health care delivery. The current system fails to coordinate GP, specialist, in-patient, ambulatory, pharmaceutical, public health and nursing home funding and activities; this leads to inefficient use of resources and, importantly, does not support better patient care and health outcomes. We recommend a national inquiry under the auspices of COAG to address these funding arrangements and responsibilities.
- The Department of Health and the Area Health Services must rationalise and clarify their roles and responsibilities and strengthen accountabilities in order to better deliver patient care and

community health. To put it simply: the Department and the Areas need to get on with the jobs for which they are best suited. As IPART noted in its 1998 review of NSW Health, there was a lack of clarity of roles, responsibilities and accountabilities. Little has changed.

- The Department devotes too much effort to micro-management, where the Areas should be responsible and accountable for service delivery; too much effort to day-to-day ‘issues’ management, with too little to overall policy and long-term strategy formulation and coordination. Operational responsibilities between the Department and Areas are often confused; Areas often spend too much time ‘managing upwards’, rather than managing the delivery of services. There is some duplication and confusion in the development of detailed service delivery plans and strategies. There is a massive amount of *data* generated and relatively little timely, quality *information* that can be used by the various layers in the health system. There is surprisingly limited sharing of experience and best practice between the major service providers within the NSW Health structure, despite the seemingly endless number of circulars, written policies, committees and meetings.
- In terms of broad roles and responsibilities, the Department of Health should be responsible for transforming government’s health policy objectives into broad strategies and targets, fully reflected in a State health plan. The Department should take responsibility for longer-term population health scenario planning so that likely emerging trends and pressures can be better anticipated and reflected in the State health plan. The Department should direct overall funding in an equitable and efficient manner, primarily to Area Health Services, consistent with the State health plan specifically to ensure that the government’s health priorities and objectives are met. The Department should monitor the Area Health Services in terms of meeting specific health targets and outcomes, including quality outcomes. Areas must be fully accountable for meeting these obligations. The Minister and the Department will continue to have powers of direction and intervention.
- The main roles and responsibilities of the Area Health Services should be the delivery of quality health care to its population via a mix of the most effective in-patient, ambulatory and at-home services, as well as population health programs directed towards improved health of the community. Area Health Services are funded and need to be accountable for delivering the bulk of the activities and programs responsible for quality patient care and community health. Areas should prepare detailed service delivery plans that must be consistent with the State health plan. These detailed Area plans should cover immediate demands on health resources as well plan for the likely emerging demands of the future—such as community health services for an ageing population.
- A number of specific things are required for clear responsibilities and accountabilities to work. One of these is timely and meaningful performance indicators. The report proposes as a basis for this, the set of 20 key performance and management indicators developed by the Department of Health that can be tailored so that all layers of the health system have access to the information necessary to monitor activities and performance. It is essential that patients and their carers, clinicians, the community, hospital management, Area executives and Area Boards, as well as the Department of Health and the Minister, have timely access to meaningful and reliable information that is relevant and useful to their particular roles and responsibilities. Without such information, accountability mechanisms will be at best tenuous. More work still needs to be done to fully develop the various sets of indicators to be made available to the various participants in the health system.

- Accountability requires all parties to be clear about their roles and the roles of others. In particular, the Department and the Areas should not duplicate activities. The Area CEO and executive as well as the Area Board must be fully accountable for the delivery of quality patient care and community health improvements for which the Area is funded. Areas which fail to deliver must be held to account; with the ultimate sanction of the Minister replacing the Board and/or the Executive. This requires a strong monitoring and auditing capacity by the Department. Monitoring and auditing must focus on clearly specified outcomes and key activities; it must not be another form of micro-management or duplication of functions.
- In order for Areas to deliver quality patient care and community health to their residents (as well as residents from outside the Area), funding arrangements must be consistent with accountabilities. Most government budget funds will continue to flow via the Department to Areas to meet the resource needs of the Areas. The Department may directly fund some specific activities if that better meets government policy objectives—such as indigenous health and mental health for example. The resource distribution formula (RDF) is being refined by the Department to better reflect the Areas' population health and community needs as well as the nature of the facilities and their workloads. The allocation of funds to Areas must have regard to equity of access to facilities as well as the best possible outcomes in terms of quality patient care. With the greater certainty of four-year rolling budgets, together with the publication of individual Area budgets in the State's budget papers, Areas should be both better placed and more clearly accountable for the delivery of quality patient care and improved health outcomes to their community.
- Rationalising and clarifying the roles of the Department and the Areas will allow for a number of organisational and system improvements. A major area where there is scope for rationalisation is corporate and system support services. There is widespread agreement that many corporate and overhead activities, such as IT, food, laundry, telecommunications, energy and drugs and equipment purchasing, for example, can be more efficiently and effectively delivered by some level of shared services. Communications and IT systems are critical to patient management as well as system efficiencies. There is substantial scope to improve performance in the IT and systems area. This does not mean that all corporate and shared services should be delivered by one State-wide agency. Many services will be better delivered at an Area level. Others will be more effectively delivered across several Areas. We recommend that a statutory health shared services corporation be established which will develop a clear business case for the most effective structures for purchase and delivery of such services from the perspective of improving quality patient care.
- Workforce issues should also be better managed with a clearer delineation of roles and responsibilities. Labour costs are by far the largest single item of expenditure by NSW Health. However, there remain serious shortages of skilled workers overall, particularly in the rural and regional areas of the State. This will worsen as demands on the health system increase. The Department should put in place a single workforce planning unit to develop an integrated State-wide workforce plan to ensure an adequate skilled and flexible workforce across the State, including overseas recruited clinicians as appropriate. This will require working with the Commonwealth and the Colleges. The Department also has a role in ensuring that Areas are able to develop, train and retain a pool of nurses (including casual pools) and other health workers that maximises retention and flexibility. Areas will continue to have responsibility for specific workforce management, which must be consistent with

the State-wide workforce plan, including the best use of salaried and visiting medical officers and other health workers to best meet the needs of quality patient care.

- One of the most notable changes in the NSW Health system since the 1998 IPART review has been the greater role of clinicians and, to a lesser extent, the community as a part of the decision-making structures of the health system. Clinicians deliver health services and patient care; they have expertise in the technology and procedures involved in patient care and the activities that may improve community health. Clearly, clinicians have a legitimate and important role in informing the broad health policy debates as well as in the development of specific strategies to deliver better health outcomes.

In recent years, clinicians increasingly have engaged with the Minister and the Department through a variety of clinical reference and advisory groups. On occasions, some of this engagement has been seen to conflict with the work of the Department and some of the Areas. There is also a concern that too many bodies have been created, often with duplicate responsibilities and confused outcomes. Notwithstanding such concerns, it is clear that in general clinicians, the Department and the Areas are more aware of the nature of the pressures and constraints on the system and the need to work together to deliver better quality patient care. This can be seen in the work of the Clinical Council and the clinical streams that are being established in some of the Areas.

- A key recommendation in this report is to build on the work of the various clinical and community groups that have been established in recent years across both the Department and the Areas. A new umbrella advisory body, the Health Care Advisory Council, should be formed to provide advice to the Department on clinical and health issues, including guidance in the development of the State health plan. Health Priority Taskforces within the new Council would also work with the Department on developing detailed guidelines for both clinical practice and quality indicators for the major clinical and operational areas such as aged and continuing care; mental health; critical care services; public health; rural health; workforce development and information management and technology. Areas should have parallel structures (appropriate to the Area) for community and clinical input to the development and delivery of detailed service delivery strategies. There is no doubt that improvement in the health system must strengthen the involvement of clinical leaders working with other stakeholders within the health system.
- Perhaps not surprisingly, in parallel with increased clinician involvement in the ‘administration’ of the health system there has been an emphasis on ‘quality’ outcomes and ‘quality’ care. While managing financial outcomes and corporate governance are critical to the longer-term sustainability of the health system, quality and safety in patient care is a fundamental obligation and an ongoing challenge. There have been several initiatives directed to improving quality, ranging from aspects of the work of the Greater Metropolitan Taskforce and other clinical groups in their development of specific service plans designed to enhance quality care, to the specific activities of the Institute for Clinical Excellence. We believe even more can and should be done. We recommend a stronger role in setting standards and developing guidelines for quality patient care and safety by a better resourced Institute for Clinical Excellence and Patient Care, with monitoring, auditing and transparent reporting by the Department of Health on quality compliance and performance by the Areas and facilities.

Health is different. It is important to all of us and it is emotive; we all have stories of how wonderful the nurses, doctors and other health workers are. We also know the horror stories of how things go wrong. Health is complex, involving many layers and many stakeholders—all of whom in their own way want the system to be as good as possible. There is no doubt that the NSW health system is good, and it delivers. There is also no doubt that the pressures on the system are not going away; indeed, they will increase as the system itself transforms. The system has the capability to improve, delivering better quality patient care and health outcomes for the community. We believe that if implemented properly the reforms proposed in this report will go a long way to ensuring that improvement.

This review of NSW Health by IPART has benefited from the input of many people working in the health system. The IPART team has benefited from and acknowledges the input from and support of many people in the Department, the Areas, clinicians, and community representatives. We have been privileged to have been invited to undertake this review.

Thomas G Parry
August 2003

I Introduction

In December 2002, the Director-General of NSW Health asked the Independent Pricing and Regulatory Tribunal of NSW (IPART) to review NSW Health¹ under Section 9 of the IPART Act. The terms of reference for this review were wide ranging (Attachment 1). They included examining improvements in the performance of NSW Health since the last IPART review in 1998, and identifying opportunities to further improve the effectiveness, efficiency and equity of health care especially by improving NSW Health's governance structures. They also asked that IPART consider these matters in the context of NSW Health's four key goals: healthier people, quality health care, fairer access and better value.

IPART found that NSW Health has successfully implemented a range of important reforms since its 1998 review and subsequent reviews. Some of the positive outcomes of this process include greater budget certainty through the introduction of three-year budgets, increased clinician involvement in developing and implementing the Department's reform agenda and formulating its metropolitan hospital strategy, better facilitation of community input into planning local health services, and a wide range of service enhancements enabled by increased Government funding. IPART recognises the important benefits of these reforms to the health system as a whole, and the contribution the Department, Area Health Services (AHSs), clinicians and community members have all made to their implementation.

However, in other respects little has changed. Shared Commonwealth and State responsibilities for funding and providing health services continue to impede better health care—despite initiatives and trials aimed at improving coordination. NSW Health cannot remove these obstacles on its own: a national inquiry into the future directions of the Australian health system is required. IPART believes such an inquiry, undertaken under the auspices of the Council of Australian Governments, has the potential to deliver the reform of funding and service delivery arrangements for health services that is widely recognised as essential to ensuring a sustainable and high-quality Australian health care system in the future. (See Chapter 2.)

Looking at issues with the control of NSW Health, IPART found that the roles and accountabilities of the Department and AHSs remain confused. The approach adopted for increasing clinician involvement has further blurred accountabilities by adding parallel decision-making processes. Performance agreements between the Department and the AHSs are too long and complex and there is 'too much data and not enough information'.

In addition, although IPART's review of the current 'health of the health system' indicates that the NSW health system is *not* in crisis—health expenditure is broadly under control, and health outcomes are relatively good—pressures on the system will continue to increase in the coming years. In particular, upward pressure on health expenditure will intensify—due to growth in the population, ageing of the population, availability of new treatments, higher workforce costs and increasing community expectations as we collectively become a wealthier and more educated

¹ Throughout this report, NSW Health refers to the various agencies funded by the NSW Government through the budget for NSW Health. This includes the Department of Health, the Area Health Services, hospitals providing public services and community health service providers and Statutory Corporations. Unless indicated, the term Area Health Services also covers the Statutory Corporations: the Ambulance Service, Corrections Health Service, the New Children's Hospital and the Institute for Clinical Excellence.

society. Further, these pressures will step up strongly from around 2020, when the baby boom generation starts to enter the high health expenditure age group of 75 plus. (See Chapter 3.)

Therefore there is both a need and an opportunity to build on the success of recent reforms, and create a NSW health system that is designed primarily to meet the needs of patients and the community and deliver the most appropriate health care.² Based on its review, IPART believes health care services cannot remain the same in the medium to longer term. It envisages that major structural change will be required to the role of hospitals, private health providers, community services and support for the aged. Hospitals will increasingly become centres for high-dependency care and specialisation and there will be a pronounced shift from acute hospital care to community and domiciliary services and improved interfaces between acute and residential aged care.

In addition, as recognition of the prevalence of behaviour-related illnesses and mental disorders increases—along with recognition of the human cost of these illnesses—the delivery of effective public health programs and mental health services must be given a higher priority. The NSW health system will need to reorganise to provide coordinated health care programs designed around patient care needs—not around the traditions or preferences of doctors, nurses, allied health clinicians and health administrators.

IPART believes strongly that NSW Health's performance against each of its four stated goals can and must be improved over the next five years to ensure it can meet future demands on the system. Based on its analysis of the health system, together with its wide stakeholder consultations, IPART believes the most critical improvements are as follows:

Healthier people

- To increase the health system's focus on patient and community needs, by revising its high-level vision and strategic direction, and enhancing its structures and processes to better support patient-centred care.
- To enhance the system's ability to anticipate and respond to future patient and community needs by using scenario planning to develop a medium- to longer-term vision and State health plan, and form the basis of area and local plans.
- To better meet current and emerging patient and community needs by increasing the priority of public health programs, including population and community health.

Quality health care

- To increase the focus on the quality of patient care by strengthening clinical governance structures.
- To ensure strong, ongoing clinician and community involvement in the planning and development of health care services by integrating and rationalising community governance structures.
- To improve health outcomes for individual patients by exploring opportunities to work with other government departments to integrate and coordinate all human services.

² Patients are defined in the broadest sense to include all people in NSW who access any form of health service.

Fairer access

- To improve equity of access to health services by developing more specific equity strategies and relating these strategies to specific groups with poorer access to health services and outcomes.
- Ensuring the allocation of funds to AHSs more closely matches the health needs of their community, and that funding arrangements allow AHSs to make the most effective use of their resources.

Better value

- To improve the performance of the Department and AHSs by better delineating their respective roles and responsibilities and strengthening accountabilities.
- To increase and accelerate efficiency gains in the delivery of corporate and other support services by establishing a shared services corporation and ensuring that savings flow back to the health system.
- To better measure the health system's performance and strengthen accountabilities for performance by prioritising and simplifying key performance indicators.
- To improve information management on a coordinated basis across the health system to improve health care and the effectiveness of the use of resource.
- To achieve more efficient and effective utilisation of the health care workforce by developing an integrated workforce plan designed to address the key challenges facing NSW Health, including supply, distribution, flexibility and costs.

Chapters 4 to 12 discuss each of these improvements in detail, including the rationale for each, and specific recommendations for action.

Box 1.1 IPART's review process

IPART based its findings and recommendations primarily on its extensive consultations with stakeholders, including the Department of Health (the Department), Area Health Services (AHSs), consumers and other providers of health services. (Attachment 3 provides a complete list of stakeholders consulted.)

As part of this consultation process, NSW Health established technical working groups for each of the issues included in IPART's terms of reference. These groups prepared papers that outlined the existing situation, key issues and proposals for the future. IPART also participated in a number of workshops and forums on issues relevant to the review and hosted a workshop on governance issues in NSW Health.

In addition, IPART drew on the findings of its consultants—Hardes and Associates, who analysed the utilisation of health services in NSW, and Inspirit Management Services who provided advice on how to use performance information to drive improvements in the health system. It also conducted its own research, including reviewing what is happening in health systems in other states and overseas and how performance information is used in other jurisdictions and industries.

2 Reform of the national health system

The Australian health system comprises a mix of public and private service providers funded by the Commonwealth Government, State and local governments, health insurance funds and individuals. The Commonwealth Government partially funds the acute health care system (hospitals), and subsidises pharmaceuticals, specialist and primary medical care, and residential aged care. The States, with financial assistance from the Commonwealth, fund and administer public hospitals, mental health services and community care services, and regulate the health care labour force. (See *Overview of the Australian health care system* on page 6) for more detail.)

This mix of private and public funding and shared responsibilities across governments presents many challenges, and has resulted in tension between the levels of government in recent years. State and Territory governments have been highly critical of the Commonwealth. From their perspective, the Commonwealth has concentrated on controlling its own expenditure on subsidy programs³ and reforming the private health insurance industry rather than leading comprehensive national reforms, to the detriment of the public hospital system. NSW believes incremental Commonwealth reforms have made it very difficult for the NSW health system to institute reforms that would fundamentally improve patient care and provide an integrated health service for the NSW community, particularly for people with chronic and complex care needs and for older people moving between the acute and residential sectors.

The Commonwealth has its own complaints about the states and territories. These include the level of health care funding by the States and Territories and the lack of discussion with the Commonwealth about new models of service delivery and patient care.

IPART's review of the issues arising from Commonwealth and State responsibilities for funding and providing health care services found that:

- The dual responsibilities of the Commonwealth and State Governments for funding, administering and delivering health care services hamper the delivery of high-quality patient care and efficient use of the limited resources available.
- The Commonwealth and State Governments have collaborated on a range of projects, some of which were initiated by NSW Health, which delivered some improvements. NSW Health should continue to work with the Commonwealth Government to progress innovative and joint service delivery models that lead to better health outcomes.
- Real progress will not be achievable until there is national commitment at the highest levels to the need for reform. IPART therefore proposes that a wide-ranging national inquiry into the future directions of the Australian health system be undertaken under the auspices of the Council of Australian Governments (COAG).

Each of these findings is discussed in more detail below.

³ These include the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS).

Box 2.1 Overview of the Australian health care system

Australia's health care system is complex. Both the Commonwealth and State Governments are involved in the funding, administering, regulating and providing health care services. The strong private hospital and health insurance sector also plays a large part in delivering services.

The dual responsibilities for health of the Commonwealth and State Governments under the Constitution, and the blurred relationship between them, mean that the Commonwealth's role in relation to delivering health care services is ambiguous. However, broadly speaking, its current role is to:

- set national policies for health care
- regulate and part-fund GP services, pharmaceuticals and nursing home care
- regulate private health insurance that partially funds the purchase of health services in public and private hospitals
- provide part-funding to the states for public hospital care
- largely determine the number of places available for training clinicians at universities and tertiary teaching institutions.

The Commonwealth provides funds to the NSW Government for specific programs—for example, it partially funds hospital care through the Australian Health Care Agreement (AHCA). In 2001/02, it provided a total of \$2.37 billion to NSW in specific-purpose payments. It also provided \$201.8 million in payments for the treatment of veteran patients in NSW public hospitals. In addition, the Commonwealth funds reimbursements to NSW consumers for health services eligible under the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). Total reimbursements in NSW were around \$2.84 billion for MBS items and around \$1.63 billion for PBS items in 2001/02. The Commonwealth also subsidises private health insurance arrangements. The budgeted cost of the national rebate for 2002/03 is around \$2.3 billion.

The State and Territory Governments' role is to:

- provide health care directly (for example through public hospitals, community health and aged care services)
- purchase health care through arrangements with non-government private sector organisations and visiting medical officers, as well as through agreements with Area Health Services (in NSW)
- fund health services by raising revenues (for example through state-based taxes) that are appropriated for direct expenditure on health care.

2.1 Dual responsibilities for health compromising patient care and effective resource allocation

The complexity, size and importance of health care systems create major challenges for governments around the world. In Australia, these challenges are exacerbated, and additional challenges created, by the fact that two levels of government have responsibility for developing health care policies and funding, regulating and providing health care services. These dual responsibilities and the funding arrangements associated with them lead to a range of problems, which ultimately result in sub-optimal patient care and resource allocation. For example, the current arrangements:

- 1 **create incentives for both the Commonwealth and State Governments to shift costs to each other.** The same medical service can be funded through a different source, depending on the context in which it is provided. For example, if a patient with a laceration that needs stitching is treated in the emergency department of a public hospital, the cost will be paid by the State Government. If the same patient goes to a GP, some or all the cost will be paid

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by the Commonwealth via Medicare. In another example, the cost of residential aged care is subsidised by the Commonwealth if the patient receives the care in a nursing home, but not if they receive the care in a hospital (usually due to the shortage in nursing home places).

This situation encourages service providers to address *who pays* above *what is the best means of delivering a service*, and thus can result in poorer quality of care and less appropriate models of care. In turn, this can place higher costs on the system. For example, the use of emergency departments to provide GP-like services in NSW is estimated to cost an additional \$110 million per year, while the use of hospitals in lieu of nursing home care is estimated to cost an extra \$87 million per year.⁴

- 2 **are out of step with contemporary models of care and clinical practice.** Despite significant changes in clinical practice and the relative roles of the public and private sector in providing and funding health care, Commonwealth–State funding arrangements remain largely unchanged. For example, 20 years ago most health care was provided in hospitals on an in-patient basis. Now many types of care, including dialysis, radiation oncology and chemotherapy, are routinely performed in the community, in the patient’s own home, or as outpatient services in a public hospital. However, the Australian Health Care Agreements (through which the Commonwealth funds public hospitals) still focus on admitted in-patient services, and private health insurance does not cover services provided at hospitals on a non-admitted basis. Thus funding is tied to the context in which services are provided, rather than following the patient.
- 3 **hinder effective, long-term planning for the provision and improvement of health services.** In NSW, AHSs are responsible for planning health services to meet the needs of their area. However, an AHS can only plan for those activities for which the State health system is responsible and funded. The interface between GP and hospital-based care and community care is important and changes in GP-care policy can have a very significant effect on AHS plans. At times, the State or Commonwealth Government provides funds to improve a service that is the responsibility of the other level of government. It is extremely difficult to make such improvements without appearing to trespass on the other’s ‘territory’. Similarly, service improvements might result in cost savings for one planning group, and cost increases to the other. Such dilemmas reduce the incentive to make changes and limit planning for the long-term health needs of the community. In addition, Commonwealth and State priorities for health may be inconsistent.

Many of the stakeholders IPART consulted believe the recent reforms undertaken by the Commonwealth to increase the number of Australians with private health insurance are a poor use of health resources. These reforms, which included the introduction of a 30 per cent rebate for those with private health insurance, have increased Commonwealth spending on health, but have resulted in little improvement to the health care system.

The increase in private health insurance coverage has led to increased activity in private hospitals but this has been in the less-complex, discretionary procedures. NSW Health believes that the reforms have not significantly reduced the demand for public hospital services. If the intent was to relieve pressure on the public health system, it would have been more efficient to

⁴ Source: NSW Department of Health.

have transferred the same gross funding to this system. One estimate suggests that with additional grants equal to the cost of the rebate (\$2.3 billion a year), public hospitals could treat almost 60 per cent of **all** patients now treated in the private system.⁵

A further concern is that the States are increasingly responsible for the long-term financial risk of time-limited Commonwealth-funded programs and increased community expectations arising from direct Commonwealth purchasing of services. An example is the new Pathways Home program in the Australian Health Care Agreement that ceases after five years when aged care programs will have been set up and operating for some time.

2.2 NSW should continue to collaborate with the Commonwealth

The Commonwealth and NSW Governments have engaged in a range of collaborative projects with the aim of delivering better coordinated services and patient care, many of which have been initiated by NSW Health. Most of the problems outlined above require more fundamental reform to resolve. However, IPART believes NSW Health should continue to work with the Commonwealth on these initiatives, to strengthen the partnership between the two levels of government and help deliver better coordinated services despite the immediate barriers.

In the past, the States, Territories and Commonwealth have argued about which level of government puts the most money into health services. These debates have generated a lot of statistics but they have not improved patient care. IPART believes a cooperative way forward founded on goodwill and commitment to reform is urgently needed. It also believes it is important that cooperative projects emphasise building partnerships with all stakeholders to improve health outcomes for the community through better quality care, fairer access and better value rather than by minimising or shifting costs.

Recent and ongoing collaborative projects are discussed below.

2.2.1 Australian health ministers' reform agenda

The Australian Health Care Agreements (AHCA, formerly known as the Medicare Agreements) have traditionally been the key vehicle through which health care system reforms have been pursued. However, this process has not succeeded in achieving large-scale change in the system, largely because the AHCA focus on the public hospital system and do not deal with overarching health and financial policy.

For the 2003–2008 negotiations, the health ministers developed a reform agenda with the help of eminent clinicians and industry experts (including economists, administrators and others). This agenda covers the following areas:

- the interaction between hospital funding and private health insurance
- improving health outcomes for people in rural areas
- the interface between aged and acute care

⁵ John Deeble, *The private health insurance rebate*, January 2003.

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- the continuum between preventative, primary, chronic and acute models of care
- improving health outcomes for indigenous people
- improving mental health
- use of information technology, research and e-health
- quality and safety issues
- collaboration on workforce, training and education.

The reform agenda is broader than can be addressed through the AHCA. The two levels of government are working together to progress this agenda, though there is some concern by the States about separating this process from the AHCA negotiations.

2.2.2 Joint funding efforts

Both Commonwealth and State Governments have worked to improve the coordination of health services through the development of collaborative programs, some of which include funds pooling to varying degrees. Two examples that have worked well are the Multipurpose Services Program and the Coordinated Care Trials.

While useful, these efforts to improve care delivery have not resulted in a model with a sustainable structure that allows key groups to jointly manage and plan health services effectively for regional populations. Prescriptive rules and conditions surrounding these models to safeguard fund-holder interests can also prevent managers and providers from working together to plan and resource the full range of health services for the community.

To address these issues, the NSW Government developed the HEALTHshare model, which it launched in a discussion paper in March 2001. HEALTHshare is a funds pooling mechanism that includes arrangements for joint planning and delivery of all health services for the entire population of a geographic region. One of its key features is a governance structure that will jointly plan and fund the agreed services, and will include representatives from:

- Area Health Services
- the Commonwealth Government
- general practitioners
- non-government health care providers.

NSW Health developed pilots in the Hunter, Far West and Central Coast Area Health Services, and approached the Commonwealth to work collaboratively to further develop and implement the HEALTHshare concept. The model developed for the Central Coast Area Health Service has now received Commonwealth funding. These types of models have received support in peak forums such as the 2000 Senate Inquiry into Public Hospital Funding. IPART believes that these models are worthy of greater support and development by the Commonwealth and State.

2.2.3 Initiatives to increase access to GP services

Declines in the number of general practitioners in Australia and the affordability of their services over the last five years have placed increased pressure on public hospital services (See *Impact of access to GP services on public hospitals* below, for more detail.) The NSW and Commonwealth Governments have been working together to address this problem, but overall progress has been slow. Indeed, NSW Health believes the proposed *Fairer Medicare* package will put further strain on public hospital emergency departments by increasing out-of-pocket costs to patients attending GPs.

However, some joint projects limited to small geographic regions or short time frames have successfully piloted solutions to problems associated with the interface between hospital and community-based services and primary medical care. For example, the Commonwealth and NSW have established and extended the Maitland After Hours Service in the Hunter AHS. This project is a close partnership between the Hunter Urban Division of GPs, the AHS and the Commonwealth. It comprises:

- a GP clinic (co-located with the Maitland Hospital Emergency Department)
- a telephone triage and advice line
- a home visiting service
- taxi transport service to and from the GP clinic, for those requiring urgent GP intervention, but with no means of transport.

Local GPs have joined forces to share the load of the clinic's after-hours roster, ensuring the provision of after-hours care by GPs is sustainable. The project was recently extended to a wider geographical region.

Box 2.2 Impact of access to GP services on public hospitals

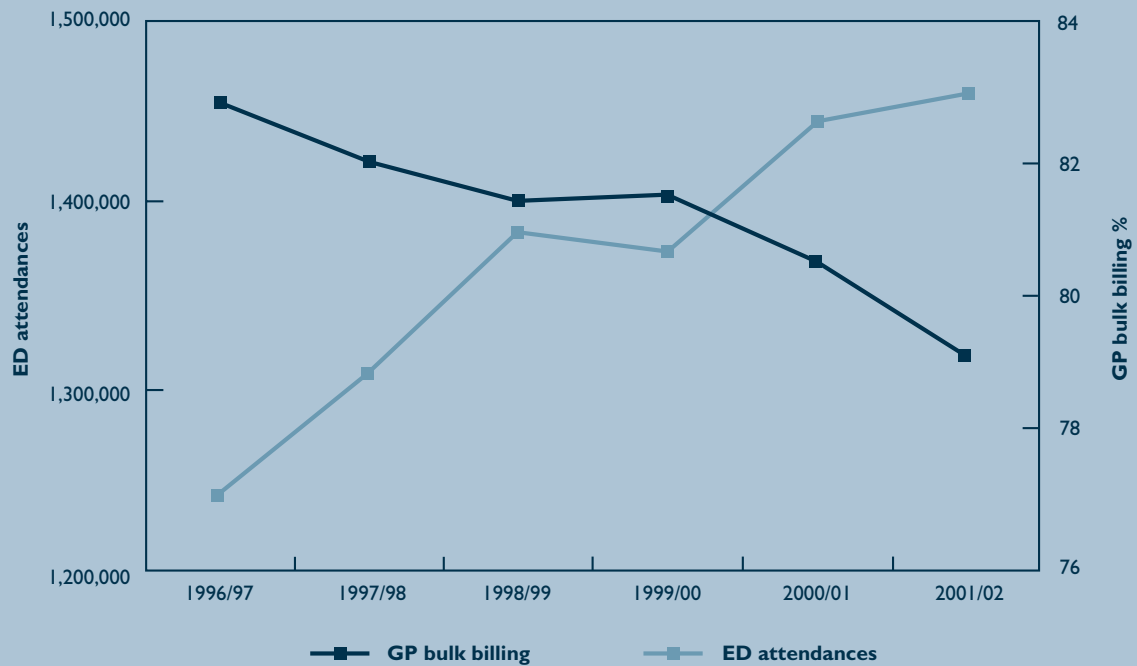
Between 1996/97 and 2000/01 the number of GPs in Australia decreased by nearly 3 per cent,⁶ while their bulk-billing rates fell by 3.6% and the availability of after-hours GP services declined, especially in rural areas. In NSW, this has resulted in:

- increased pressure on public hospital emergency departments. Over this time, emergency department attendances increased from 1,240,460 to 1,441,595⁷ while the GP bulk billing rate decreased from 82.7 per cent of all visits to GPs to 79.1 per cent (Figure 2.1)
- increasing hospital costs and average length of stay in hospital for patients located in areas with no local GP services. This suggests that reduced access to GP services may contribute to more and longer hospitalisations, because these patients present in crisis and with greater complications than would have been the case if they had seen a GP earlier.

⁶ Australian Institute of Health and Workplace (AIHW). *Australia's Health 2002*.

⁷ NSW Department of Health. *Annual Report 2001–02*.

Figure 2.1 NSW emergency department attendances and GP bulk-billing rates



A substantial number of the additional patients attending emergency departments have conditions best managed by their GP. For example, in 2001/02, 22 per cent of the attendances resulted in admission to hospital. Triage Categories 4 and 5 attendances were 34 per cent of all emergency department attendances,⁸ which indicates that their condition was similar to that of many patients attending GP rooms.

In towns where GPs don't bulk bill, people use emergency departments around 60 per cent more than those in towns where GPs do bulk bill. For example, in one town where bulk-billing is available, people visit the local hospital emergency department less than once very year. In another town, where GPs do not bulk bill, people visit their local hospital emergency department around four times a year [Source: NSW Department of Health].

There was a 25 per cent increase in the number of nursing home patients being treated in public hospital emergency departments between 1998 and 2001. Lack of 24-hour GP services is also a likely reason for this increase, along with financial disincentives under the MBS for doctors to attend multiple patients in a residential care setting.

Overall, between 1999/00 and 2001/02, emergency department activity increased by 6.2 per cent (or 56,000 services), resulting in increasing costs for NSW Health. The cost of providing GP-like services in emergency departments in NSW is estimated to be around \$110 million a year. This means NSW Health must redirect this amount from essential acute services to fund these services. In contrast, the provision of these services under the MBS would cost around \$30 million.⁹

⁸ The Australasian College of Emergency Medicine (ACEM) has defined five triage categories used in NSW and other State and Territory hospital emergency departments. Triage 4 and 5 are defined as follows:
Triage 4: These people need to have treatment within one hour—they are potentially serious patients. People in this group would probably have less severe symptoms or injuries with something like a foreign body in the eye, sprained ankle, migraine or earache.
Triage 5: These people need to have treatment within two hours—they are less urgent patients. People in this group probably have minor illnesses or symptoms that may have been present for more than a week, like rashes or minor aches and pains.

⁹ Source: NSW Department of Health.

2.2.4 Initiatives at the interface between acute care and aged care

A shortage and/or inappropriate location of residential and community aged care services is also putting pressure on public hospitals, as they must accommodate older patients who are ready for discharge but are waiting for placement in an aged care service.

According to a survey undertaken by the Commonwealth, States and Territories, 2000 older people nationally were inappropriately waiting in public hospitals for Commonwealth-funded aged care.¹⁰ In NSW alone, 547 older people were waiting for residential aged care and 146 were waiting for Commonwealth-funded community care. The average length of stay in hospital for older people who need to be discharged into residential aged care was 27 days, compared to the average length of stay for acute care of just 3.3 days.

One reason for this situation is the time-lag between when the Commonwealth approves residential aged care places in NSW and when these beds become operational. As at December 2002, an estimated 7,209 residential aged care places, or 12 per cent of total places, allocated to the State were not operating. This represents a loss of \$147 million per year in Commonwealth aged care subsidies for the older people of NSW. The cost to the NSW health system of caring for older people who are in public hospitals while waiting for aged care places is around \$87.3 million per annum. Providing the equivalent services in residential aged care settings would cost just \$15–20 million per annum.

Australia's health ministers have agreed on the need for solutions at the acute/aged care interface, and placed this issue on their reform agenda. However, the progress of the joint development of strategies to improve care for older people has been disappointing.

As a specific measure, NSW proposed, subject to the Commonwealth making available funding under the nursing home subsidies, using some non-operational beds on a temporary basis to try to relieve the pressure on public hospitals. This proposal was not accepted. Instead, the Commonwealth offered to pilot 500 flexible places nationally in 2001/02 to trial innovation at the acute/aged care interface. The Commonwealth offered another 550 places for 2002/03, but the places available to NSW were for pilots at the disability/aged care interface. This is a high-priority area where a more permanent policy response is required.

NSW Health would like the flexibility to work with the private sector to provide transitional care arrangements that fit into the hospital/residential aged care facility/community continuum. It has already trialled one model of transitional care at Newcastle hospital with joint Commonwealth–State funding. This trial found that transitional care improves health outcomes for patients. Compared to those cared for in hospitals, aged patients who move into transitional care after discharge from hospital:

- improved their functional status
- were placed in a facility of their choice
- required a lower level of residential care than initially anticipated

¹⁰ 2002 data shows that on any given day nationally 56 per cent of people waiting for non-acute care in acute public hospitals are waiting for residential aged care, and only 26 per cent are waiting for rehabilitation, geriatric evaluation and management or palliative care. (Source: NSW Department of Health.)

- were more likely to be discharged home
- were less likely to die.

The Commonwealth has expressed interest in such transitional care arrangements.

2.3 The way forward—a new and integrated partnership

Recent inquiries into health care systems in other countries have concluded that a healthy community means a stronger economy, which in turn enables more to be spent on the health of the community. The Romanow Report¹¹ to the Canadian Government found that health care expenditure contributes positively to the economy. Investment in health care ‘leads to longer and more productive working lives on an individual basis’. This report also indicated that in all countries, an individual’s spending on health increases in line with income, and that this becomes more pronounced in line with the country’s level of development. That is, the wealthier the society is, the more it will choose, collectively and individually, to spend on health. In the United Kingdom, the Wanless Report¹² identified similar social and economic benefits of having a high-quality health service, including longer life expectancy and reduced absence from work which contribute to economic growth.

In Australia, we have not engaged in a national review of health care to agree on overall directions for reform. Instead, we have identified a number of specific priorities to progress reform. These include cancer, pharmaceuticals and ageing of the population and are based in part on the work of national clinical groups. They are designed to provide sustainable reforms to the system, both from a patient and funding perspective, over the medium term.

However, this approach lacks two vital elements:

- First, it does not have the endorsement and support of Australia’s heads of government. To be successful, a program to reform the national health system needs to be supported at this level, through which it can gain support at the ministerial and bureaucratic levels. While IPART understands that NSW has already had health listed on the COAG agenda, it believes it will take more than an important discussion at this level to address the needs of the health system. The challenges involved require greater commitment to and support for genuine reform.
- Second, the individual components of the system and their reform are not being developed in the context of an integrated framework or strategic plan. Successful reform of the health system requires that the roles and responsibilities of each level of government are clarified and rationalised. Then the funding and reporting arrangements of each level can be redefined in the context of overall health budgets, including those matters that are not within the AHCA.

¹¹ Roy J Romanow, QC, Commissioner, *Building on Values: The Future of Health Care in Canada*, Final Report, November 2002.

¹² Derek Wanless, *Securing our Future Health: Taking a Long-Term View*, Final Report, April 2002.

To move forward, IPART proposes a national inquiry into the future directions of the Australian health system. This inquiry should address the following core areas for reform:

- Medium- to longer-term planning priorities
- models of service delivery
- standards and quality of care
- governance structures, including roles, responsibilities and funding
- equity of access for different groups within the population and geographic locations
- other barriers to a better health system.

The inquiry should be under the auspices of COAG so that it reports to heads of Government. It should report within one year and be able to release progress reports to COAG.

There are some excellent precedents where an independent inquiry has delivered major social or economic reforms that involved reforming Commonwealth–State relations. Two examples are the Hilmer inquiry into competition policy and the Wallis inquiry into the Australian financial system. The latter, which built on two pace-setting reports from the Campbell and Martin Committees, resulted in the States handing over certain regulatory powers to the Commonwealth to enable a nationally regulated and integrated financial system to operate.

There is a need for an intensive review to develop a road map for the future of the national health system, to deliver more to the patient, the community and the economy. This is an issue of such significance that it must be dealt with at the highest levels of government.

Recommendations

- 1 A national inquiry into the future directions of the Australian health system should be established under the auspices of COAG and completed within 12 months, to especially progress collaborative service delivery and more unified funding.
- 2 Pending more substantial reform following the proposed national inquiry, NSW should continue to work with the Commonwealth Government to progress innovative and joint service delivery models that deliver better health outcomes for patients and the community.

3 State of Health in NSW: Implications for the future

To help identify opportunities for NSW Health to further enhance the effective, efficient and equitable allocation and use of available health resources, IPART first sought to understand the current state of the NSW health system and the implications this has for the future shape and focus of the system. In particular, it looked at what reforms have been achieved since its 1998 review, the current health status of the NSW community, current spending on health, and the key factors driving increased spending on health.

This analysis indicates that:

- NSW Health has implemented significant reforms since 1998, which have contributed to better patient care and provided a strong base for further reforms.
- Health outcomes for the NSW community compare well with those for other states and countries. But changes in the demographic and illness profile of the NSW community indicate that greater focus is needed on meeting patient and community needs, overcoming inequalities in health outcomes for some groups, particularly indigenous people, and addressing health promotion and mental health needs.
- Although health spending is a large part of the NSW budget, health expenditure per capita is similar to that in other states and countries, and expenditure growth appears to have been more controlled.
- The main factors driving expenditure growth are the increasing demand for health services (largely due to population growth and ageing) and growth in the costs of providing health services (largely due to rises in employee-related costs, as well as increases in the average cost of treatment). The impact of the ageing population on health costs will increase in the coming years, and will rise significantly from around 2020, when the first of the 'baby boomers' reach 75 years.

Overall, the analysis suggests that by many measures, the NSW health system is performing well and has improved its performance in recent years. However, it highlights several areas that could be improved. More importantly, it indicates that pressures on the health system, especially rising costs, will continue to increase, and will rise more quickly from around 2020. It is vital that the performance of the health system—in terms of NSW Health's four stated goals of healthier people, quality health care, fairer access and better value—is improved to meet this challenge and ensure the long-term sustainability of the system.

3.1 What has been achieved since 1998?

In 1998–2000, NSW Health was the focus of four major reviews. IPART's first review identified seven key opportunities:¹³

- increase budget certainty
- improve accountability and benchmarking

¹³ IPART, *A Review of NSW Health: Report to the NSW Treasurer and the Minister for Health*, November 1998.

- develop a metropolitan hospital strategy
- establish a more rigorous approach to asset management including the introduction of capital charging
- improve flexibility for staff, increase staff accountability and develop more appropriate pay structures
- devolve increased responsibilities to AHSs for some functions
- establish clear contractual relationships with all service providers.

Following this, the NSW Health Council's review developed strategies to improve health service delivery, better manage costs and improve health outcomes of people across NSW;¹⁴ and the Committee on Health Services in Smaller Towns review advised the Minister on better models for delivering health services for rural communities.¹⁵ Another review provided a framework for managing the quality of health services in NSW.¹⁶

In response to these reports, the Minister for Health announced the Government Action Plan for Health (GAP) in 2000. Over the last three years, many of the initiatives in the GAP have been implemented. The most important achievements under the GAP include:

- greater clinician involvement in developing and implementing the Department's reform agenda and formulating its metropolitan hospital strategy, and more effective community involvement in planning local health services
- greater budget certainty, through the introduction of three-year budgets from 2000–01. This has enabled better planning and an ongoing commitment to programs to improve health outcomes
- additional growth funding of 6.8 per cent (in real terms) over the first three-year budget, which helped reinforce the benefits of budget certainty and enabled a range of service enhancements. It also allowed NSW Health to increase the budgets of historically underfunded AHSs without adversely affecting other areas.

NSW Health also established a range of new structures within the health system, in response to recommendations from the various reviews. These include:

- the Clinical Council, the peak clinical group for the Director-General of NSW Health and the Minister, which has led the clinical reform process
- clinical implementation coordination groups for each area of change; acute chronic and intensive care; and emergency departments
- enabling groups to advise on issues such as IT management, funding issues and teaching and research
- the Greater Metropolitan Services Implementation Group (GMSIG) to develop a metropolitan hospital strategy
- the Greater Metropolitan Transition Taskforce (GMITT) to implement the GMSIG plan aided by a separate allocation of funds

¹⁴ NSW Health Council, *Report of the NSW Health Council—a better health system for NSW*, NSW Government, 2000.

¹⁵ NSW Ministerial Advisory Committee on Health Services in Smaller Towns, *A Framework for change: Report to the NSW Minister for Health*, NSW Government, 2000.

¹⁶ NSW Department of Health, *A framework for managing the quality of health services in New South Wales*, 1999.

State of Health in NSW: Implications for the future

- the Rural Health Implementation Taskforce to implement the recommendations of the NSW Rural Health Report
- the Institute for Clinical Excellence (ICE) to enhance clinical standards and patient safety through education and training.

The GAP has achieved measurable results that have led to sustained improvements in patient care in a number of areas. For example, there has been a marked increase in day-of-surgery admissions and day-only surgery. Between July 2000 and September 2002, day-of-surgery admissions increased from 72.3 per cent to 84.7 per cent of admissions and day-only admissions increased from 54.4 per cent to 58.3 per cent. This has increased system capacity by 14,500 bed days, or the equivalent of an extra 2,900 admissions per year.

Over 16,000 patients with cardiovascular disease, chronic respiratory disease and cancer have benefited from 60 local programs introduced in AHSs through the Chronic Care Group. For example, in 2001/2002 there was:

- a reduction of 10 per cent in the unplanned admission rates and a reduction of 4 per cent in the unplanned readmission rates for patients with heart failure, or 9,000 fewer days in hospital
- a reduction of 3 per cent in the unplanned admission rates, with patients with chronic obstructive pulmonary disease (COPD) spending 4,500 fewer days in hospital
- an introduction of a 24-hour contact service under which 12,000 patients with chronic illnesses were provided with a 24-hour telephone number to provide support and continuity of care.

The Emergency Care Group has integrated numerous (139) emergency departments into 17 area emergency department networks to better meet patient needs and enable the sharing of protocols, policy and expertise. A blueprint of where and how specialty services will be provided in the Sydney, Hunter, Central Coast, and Illawarra Area Health Services has been developed. This has seen the establishment of a number of new units such as new cardiac catheter laboratories and 18 stroke units.

Rural areas have also benefited. The NSW Institute of Rural Clinical Services and Teaching has been established, together with additional procedural training posts for general practitioners and anaesthetists. A Rural Clinical Network Program has been developed to link rural hospitals with metropolitan hospitals to ensure high quality care. Regional radiotherapy centres and four cardiac catheterisation laboratories have been established. Additional funding has been provided for joint replacements, renal dialysis, critical care services and podiatry services in rural areas.

Overall, the reforms achieved since 1998 provide an important base on which NSW Health can build, as it undertakes the next wave of reforms. However, one critical issue identified in IPART's 1998 report still needs to be addressed. That report found that the respective roles of the Department and AHSs were not clearly defined and delineated, and that this was a significant barrier to better outcomes. Little has been done to clarify these roles.

In addition, although most of the new structures established make good sense when assessed individually, too many separate bodies and overlapping planning and funding responsibilities can dissipate resources and result in conflicting priorities. Further, too much energy can be dissipated through sequential reviews covering similar ground.

3.2 What is the health status of the people of NSW?

Overall health outcomes for the NSW community have improved consistently over time. Over the last 10 years average life expectancy at birth has increased by 2.4 years to 82.6 years for females, and by 3.5 years to 77.2 years for males.¹⁷ This is reflected in the marked decline in death rates for all socioeconomic groups over this period.

Of course, many factors play a role in improving health outcomes. As well as improvements in health care services, these factors include increasing wealth, better education, environmental improvements and changing lifestyles. While it is difficult to disentangle the relative impacts of these various factors, one approach has been to analyse causes of death to identify those causes that could be prevented by either primary, secondary or tertiary interventions within the health care system.¹⁸

The analysis shows that around a half of the reductions in mortality rates relate to conditions preventable from primary prevention strategies. Around 25 per cent of the fall in mortality rates relate to conditions preventable through secondary strategies, while a further 25 per cent of the fall relate to conditions preventable through tertiary strategies. In other words hospital services have played, and continue to play, an important role in reducing mortality.

In addition, while the big-picture view is important, several other dimensions need to be considered to understand how well the NSW health system is performing and how it can be improved. These include health outcomes in NSW compared with those in other states and countries, the equity of outcomes for different groups within the community, and the main causes of ill health in the community.

3.2.1 How do NSW health outcomes compare with other states and countries?

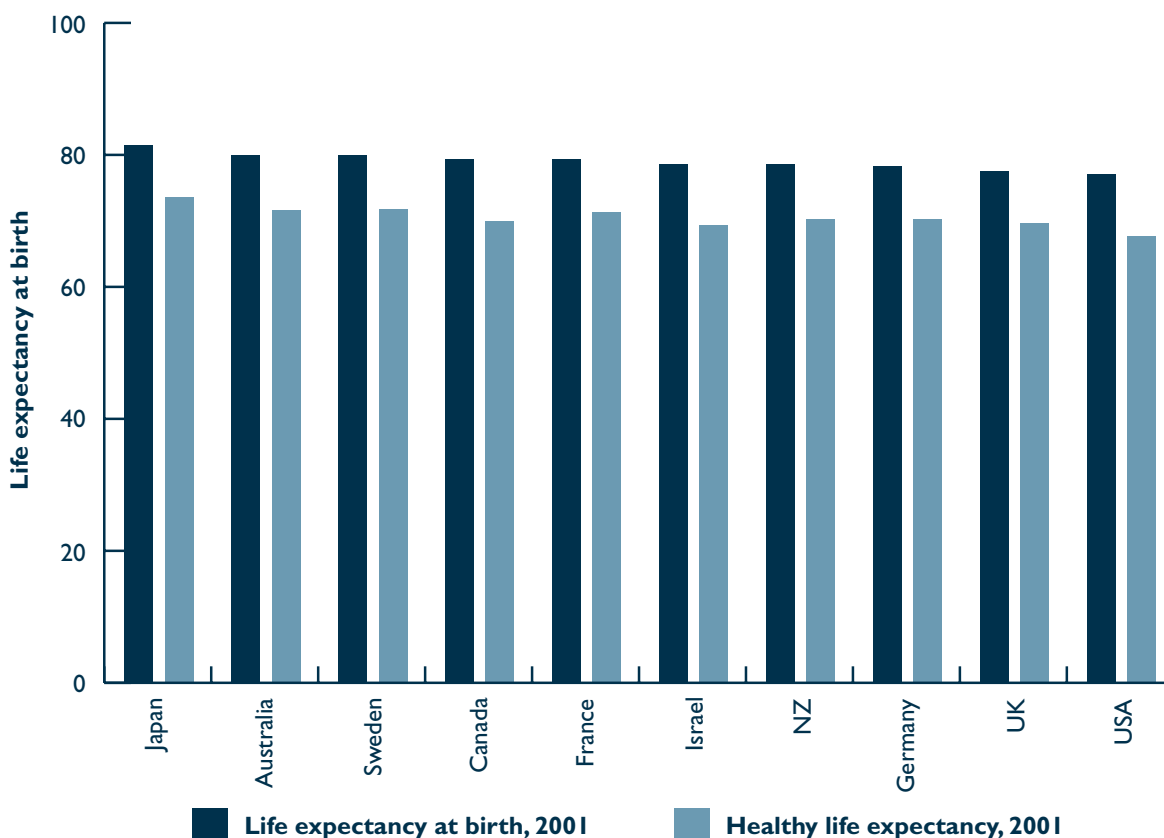
Health outcomes in NSW compare favourably with those for Australia as a whole and other countries. The life expectancy at birth in NSW is marginally lower than the national average (eg female life expectancy in 2000 was 82.6 years for NSW and 82.8 for the nation). Male and female life expectancies in Australia are only 1 and 2 years (respectively) lower than in Japan—the highest-ranked country for this measure—and are equal to or longer than life expectancies in other comparable countries (Figure 3.1).

On other measures, such as years of healthy life lost, infant mortality and adult mortality, outcomes for NSW and for Australia are similar to those for other comparable countries.

¹⁷ NSW Department of Health, *The health of the people of New South Wales: Report of the Chief Health Officer*, 2002, p 61.

¹⁸ Primary level interventions are those interventions that can prevent a condition from developing, such as healthy lifestyles, and, at the population level, legislation to protect the public from health hazards. Secondary level interventions are those that can prevent worsening of conditions such as the screening for and treatment of the diseases in early stages. Tertiary level interventions are those that can cure diseases or extend life through medical treatments and procedures.

Figure 3.1 International comparison of health outcomes: expected life and healthy life expectancy



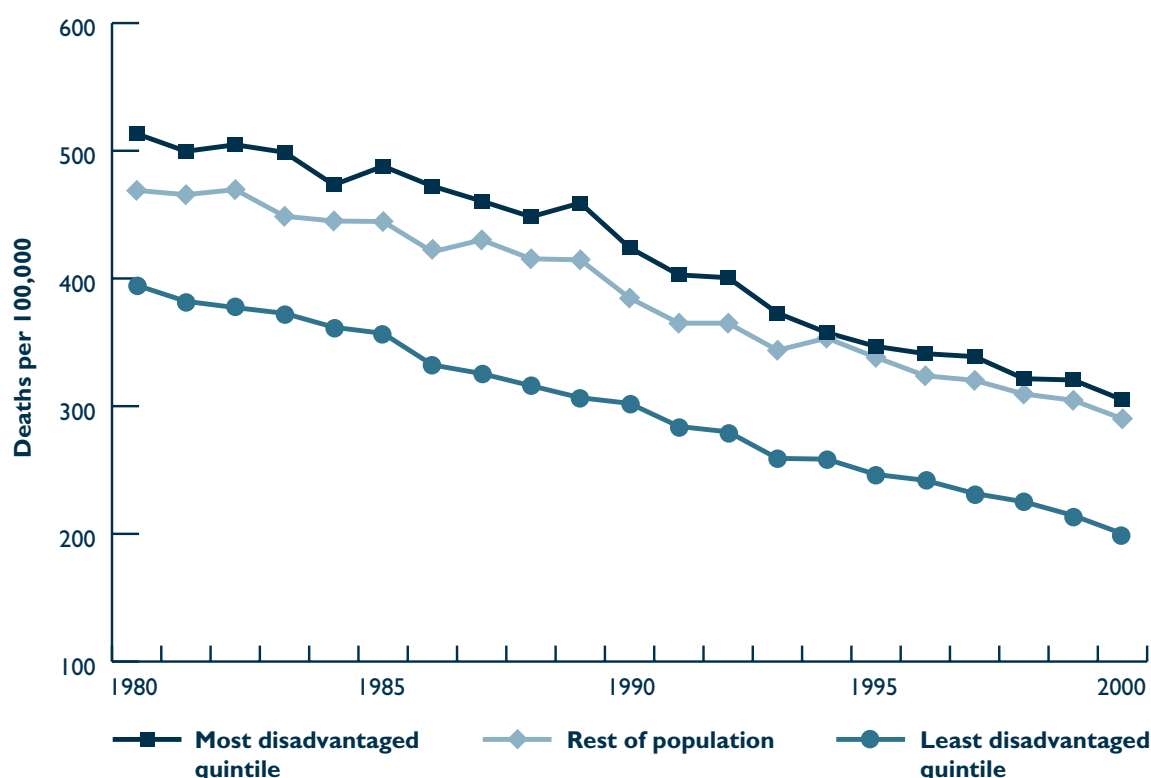
Source: WHO, *World Health Report 2002*

3.2.2 Are health outcomes for different groups within NSW equitable?

Although some health outcomes have become more equitable, people from low socioeconomic groups, indigenous people, and people from rural and remote areas generally have worse outcomes than other people in NSW.

The gap between the death rates for the lowest socioeconomic group and the rest of the community has narrowed over the last 10 years. However, the lowest socioeconomic group still has a significantly higher death rate (1.5 times) than the highest socioeconomic groups, and this has not changed over the 10-year period. This pattern of better health outcomes for higher socioeconomic groups is repeated across a wide range of measures, including hospitalisation, ambulatory care and teenage pregnancies. Socioeconomic differences in health outcomes are also much greater for males than for females.

Figure 3.2 All deaths by socioeconomic group for persons aged less than 75 years NSW 1980/2000



Source: NSW Health, *Annual Report*; various years

However, the gap between the health status of indigenous and non-indigenous people is even more marked. Life expectancies of indigenous males and females (56.3 and 63.6 years respectively) are 20 years shorter than for the general population. Rates for low birth weight and premature babies are 1.8 and 1.6 times those for the general population. Hospital separation rates are 1.4 times those for the general population rate.¹⁹

There is also a significant gap between the health outcomes for people living in rural and remote areas in NSW and those for people in metropolitan areas, as there is in other states. People living in remote areas can expect to live for five years less than the general population. Poorer access to health services in remote areas is a significant issue. Because there are relatively fewer GPs and private hospitals in these areas, their residents are less likely to visit GPs or be admitted to private hospitals, and more likely to visit emergency departments and public hospitals. If hospitalised, they are likely to stay longer.

3.2.3 What are the main causes of illness in NSW?

There are many dimensions to illness and its impacts. Of illnesses leading to death, cardiovascular disease and cancer are the main causes, accounting for around 40 per cent and 25 per cent of all deaths in NSW respectively. As cancer victims are often younger, this disease accounts for around 30 per cent of years of life lost due to premature death.

Another dimension of illnesses is the number of years lived with a disability. The leading cause of this is mental illness (accounting for 27 per cent of total years lived with a disability), followed by nervous system diseases (16 per cent of total years lived with a disability).

¹⁹ Data for health status of indigenous people is not as reliable as that for the population as a whole. Due to these problems, the reported data is likely to underestimate the actual difference in health status for indigenous and non-indigenous people.

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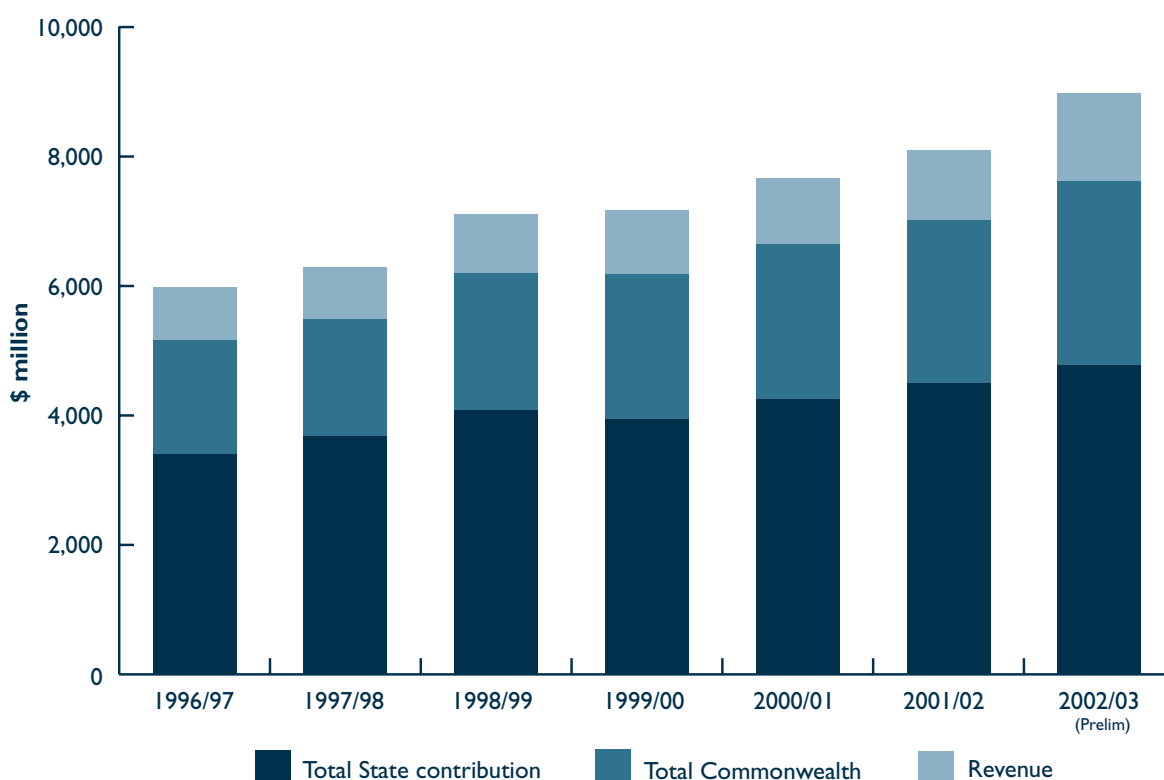
In terms of the underlying causes of illness, tobacco smoking is the leading preventable cause of disease and death. Hospitalisation rates associated with smoking-related illness continue to rise. However, deaths attributable to long-term smoking have declined by 34 per cent over the last 10 years.²⁰ Other behaviours, such as poor nutrition and exercise levels, and drug and alcohol abuse are also increasingly affecting the health of the community.

These main causes of illness in NSW suggest that public health programs, such as anti-smoking, diet and exercise programs, and community care, should be an increasingly important focus for NSW Health. In addition, the significance of mental illness presents a major challenge for the health system. Mental illness is a complex problem that requires strategies encompassing the full range of health services. It also has complex interactions with other health problems, such as drug abuse, and has substantial impacts on other community services.

3.3 What are we spending on health?

Health is the largest portfolio within the NSW State Government budget. In 2002/03, total budgeted spending by NSW Health was \$8.9 billion of which \$4.9 billion was funded by the State Government and \$2.7 billion by the Commonwealth Government. This represents around 26 per cent of total State budget spending for that year. The next largest portfolio, Education and Training, represents around 24 per cent of total State budget spending.

Figure 3.3 NSW Health—total expenses and sources



Source: NSW Health, *Annual Report*; various years

²⁰ NSW Department of Health, *The health of the people of New South Wales: Report of the Chief Health Officer, 2002*, p 46. Figures are the decline in age-adjusted death rates due to diseases attributable to smoking.

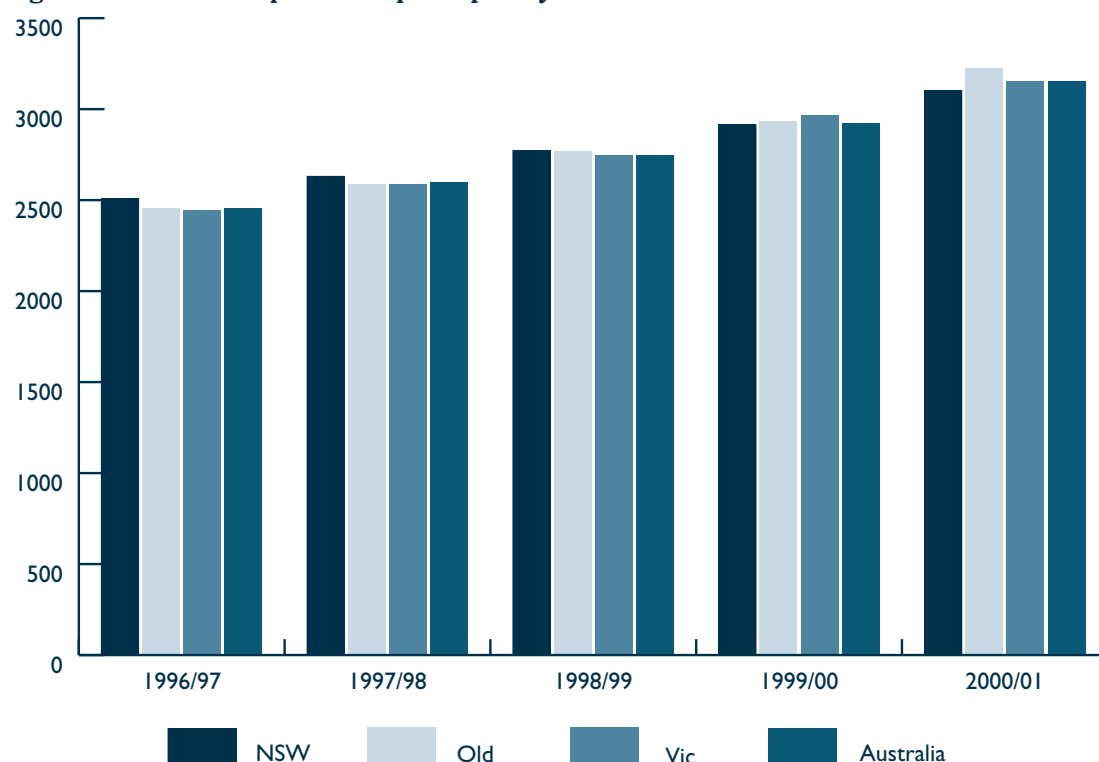
Health is also a growing part of the budget. Over the last five years, State Government funding for the health system increased by 13 per cent in real terms. NSW Health's expenditures increased by 16 per cent in real terms over the five years to 2002/03. Over the five-year period, hospital admissions and non-admitted patient services increased by only 9 per cent and 7 per cent respectively, which suggests that the average cost of treating patients has also increased.

Comparisons with spending on health in other states and developed countries suggest that the level of expenditure in NSW is in step with that in many comparable economies, and growth in this expenditure has been more controlled.

3.3.1 NSW health spending compared with other states

NSW Health's expenditure is similar to health spending in Queensland and Victoria, and growth in this expenditure appears to have been more controlled in NSW than in other states in recent years. In 1996/97, health expenditure (as an average per head of population) was higher in NSW than in Queensland and Victoria. Lower growth in expenditure to 2000/01 means that in 2000/01 expenditure in NSW was lower than in both other states (Figure 3.4). However, the higher growth in expenditures over the last two years may have reduced the gap.

Figure 3.4 Health expenditure per capita by state—all sources 1996/97 to 2000/01



Source: AIHW 2002

To be as meaningful as possible, we should also compare health expenditures to a comprehensive range of health outcome measures, to assess whether NSW is getting 'good value' for its health spending. This is a difficult task which IPART was not able to undertake for this review. However, it was able to compare the relative utilisation of hospital services to expenditures across States.

This comparison shows that the relative utilisation of all hospital services,²¹ as measured by admissions adjusted for differences in population profiles, is lower in NSW than in Victoria and

²¹ That is, public and private hospital services.

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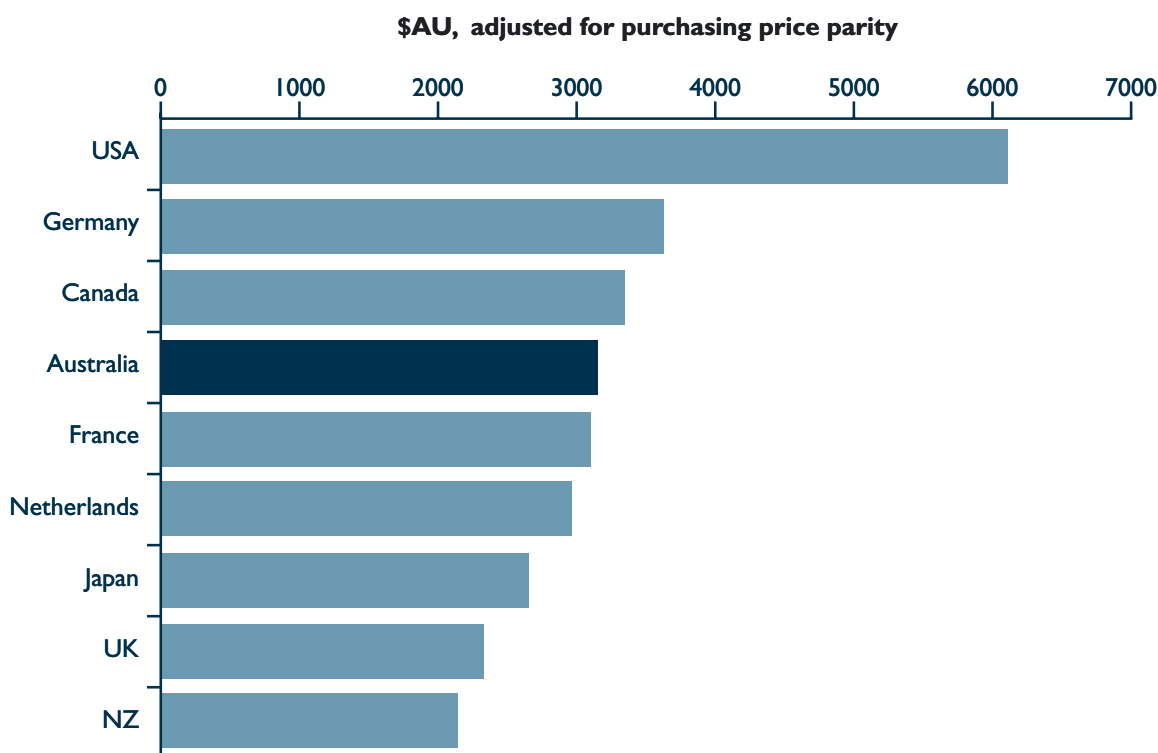
Queensland, which suggest that activity levels in NSW are lower than in the other states. The difference is most marked for private hospitals, with utilisation in NSW being 18 per cent lower than in Victoria, and 37 per cent lower than in Queensland. For public hospitals, total utilisation in NSW is similar to that in Queensland, but 4 per cent lower than in Victoria. (See Attachment 5 for a more detailed discussion of this analysis.)

One of the reasons for these differences is that patients in both Victoria and Queensland make greater use of day-only admissions than NSW. This may reflect a more cautious approach to discretionary procedures in NSW, some of which may have unclear health benefits. Alternatively, it may indicate that there is greater scope for same-day admission for non-discretionary services. Victoria and Queensland also have slightly lower average length of stay in hospital than in NSW (5.1 days in NSW compared to 5.0 and 4.8 in Victoria and Queensland respectively).

3.3.2 Australian health spending compared with other countries

International comparisons suggest that total health expenditure in Australia is comparable to that in most other developed countries. Of the selected countries shown below, only Japan, the UK and NZ have significantly lower expenditure on Health. Per capita expenditure in the USA is almost double that in Australia.

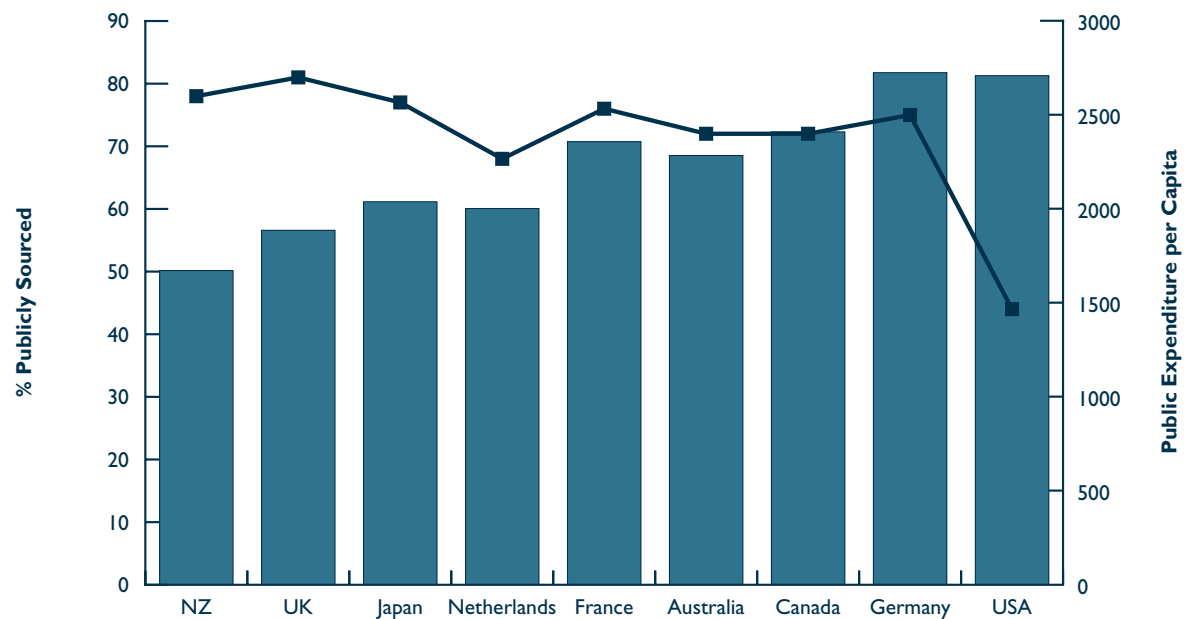
Figure 3.5 Expenditure per capita by country, 2000



Source: AIHW 2002

Governments fund just over 70 per cent of health expenditures in Australia, which is comparable to most other countries. The USA, where only 45 per cent of expenditures are funded by government, is the exception. New Zealand, the UK and Japan, which have lower total expenditures, have higher proportions of government funding. As a result there is a much smaller spread between countries in the net per capita government spending on health.

Figure 3.6 Percentage of health expenditure from public sources and public expenditures per capita, 2000



Source: AIHW 2002, *WHO World Health Report 2002*, Public Expenditure per Capita expressed as \$Australian, adjusted for Purchasing Price Parities

3.4 What is driving increasing spending on health?

In simple terms, there are two factors driving increasing health spending in NSW (and in other states). The first is the increasing demand for hospital services, which is being driven by demographic changes and the availability of new treatments. As new technologies, procedures and medicines make new treatments possible, there is an expectation among clinicians and the community that these should be made available through the public health system. The second factor is the increasing cost of providing health services. This factor is also being driven by the availability of new, more expensive treatments, but increases in employee-related costs are the major driver.

3.4.1 Increasing demand for hospital services

Managing the rising demand for hospital services is critical to the long-term sustainability of the public health system in NSW. To do this, we need a better understanding of the factors that are driving the rising demand. These are:

- growth in the total population of NSW
- ageing of the population
- growth in underlying admission rates, due to the availability of new technologies, new procedures and additional resources.

IPART commissioned a consultant (Hardes and Associates) to provide a detailed analysis of hospital admission trends to assess the relative impact of these factors, the first two of which are outside NSW Health's control. This analysis found that over the five years to 2001/02, total

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hospital admissions (public and private) in NSW increased by 144,000²² or 9.7 per cent. More than half of this growth was due to population growth, and only 15 per cent was due to the growth in underlying admission rates.²³

However, there were marked differences in the pattern of growth in admissions for private and public hospitals. Most of the growth in admissions to private hospitals was due to the growth in underlying admissions rates (per capita). In contrast, growth in admissions to public hospitals due to population growth (+6 per cent) and ageing of the population (+1.9 per cent) was offset by a decline in admissions of 5.7 per cent due to changes in underlying admission rates. One of the possible conclusions we can draw from this is that the growth in underlying admissions—that is, the controllable growth in demand for hospital services—has been largely for discretionary or non-urgent procedures that are given lower priority in public hospitals. The data suggests that a factor in the growth in private hospitals has been a shift in discretionary and non-urgent procedures from the public sector to the private sector.²⁴

The Hardes analysis also found that the cost-weighted demands individuals place on the hospital system vary significantly according to their age. The cost-weighted admissions for the 75 plus age group are double those for people aged 39 years or less. This suggests that the pressures on the NSW health system due to the State's ageing population will increase significantly from around 2020, when the 'baby boomers' start turning 75.

Obviously, these additional pressures will not appear overnight; they will gradually increase as the 'baby boomers' age and move into the high health expenditure years. But IPART believes strongly that unless the performance of the NSW health system—measured in terms of quality of care, equity of access, and value for money spent—is improved now, and proper long-term planning is undertaken, it is almost inevitable that patient care will deteriorate as these pressures intensify. The Hardes analysis is discussed in more detail in Attachment 5.

3.4.2 Increasing cost of providing hospital services

As noted in section 3.3, while NSW Health's expenditures increased by 16 per cent in real terms over the five years to 2002/03, hospital admissions and non-admitted patient services increased by only 9 per cent and 7 per cent respectively. This suggests that the average cost of treating patients increased over this period. The increase in average treatment costs is due to several factors, including new, more costly treatments made available by new technologies and procedures, and the movement to private hospitals of simpler, cheaper procedures.

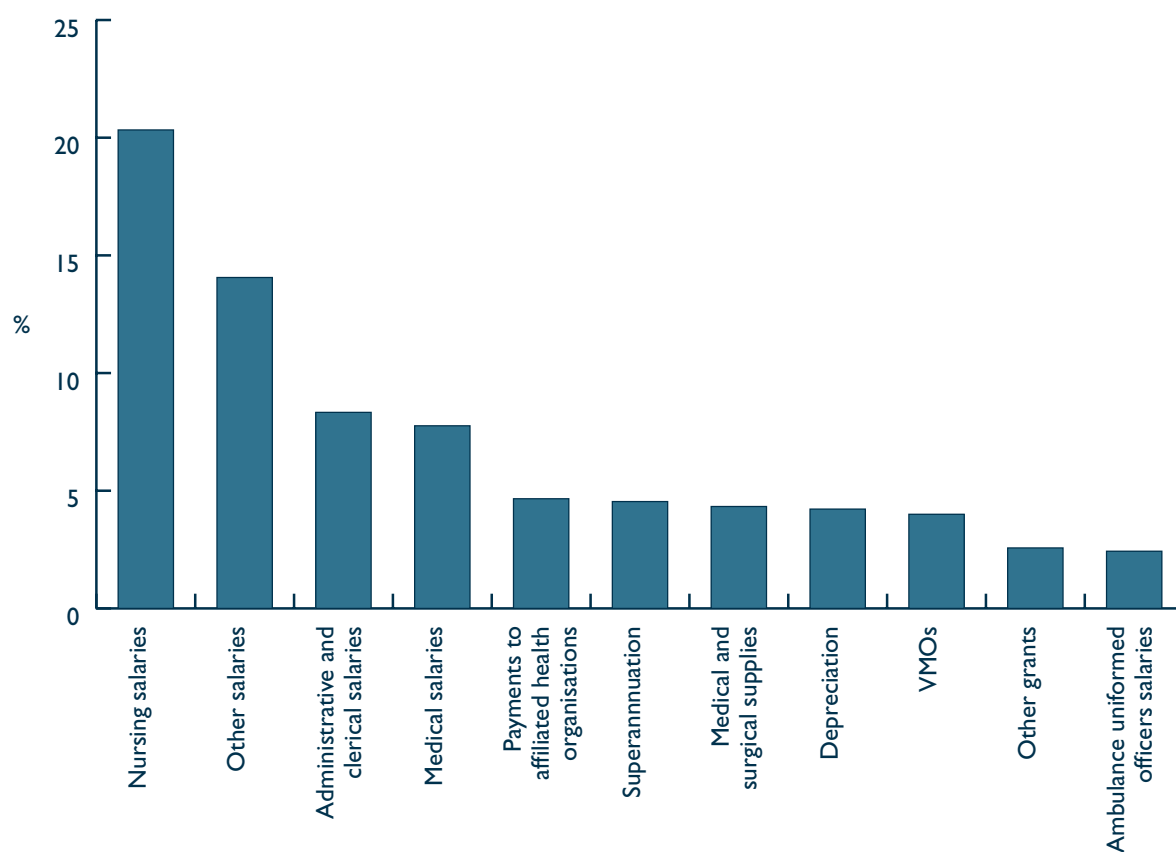
²² This does not include patients previously treated as admitted patients who are now managed on an outpatient basis.

²³ In the current study by Hardes and Associates, the relative contribution of changes in underlying admission rates to increased demand was found to be lower than it was in the study Hardes undertook for IPART in 1999. IPART understands that this is because more disaggregated age data was available for the present study. This highlights the potential sensitivity of the estimates to changes in data and estimation procedures.

²⁴ The growth in procedures relative to growth in private insurance coverage suggests that those who are insured are 'using' their insurance more and/or there are more private uninsured patients in private hospitals (either paying the costs directly or covered by non-health insurance such as workers compensation).

However, employee-related costs are still the largest category of costs, accounting for 65 per cent²⁵ of the total expenditure by NSW Health (Figure 3.7). Nursing salaries are the largest single cost category, and account for around 20 per cent of total expenditure. This suggests that managing these costs—for example through more efficient and effective utilisation of employees—will be critical for achieving the goal of better value.

Figure 3.7 Summary of NSW Health expenditure by cost category (2001/02)



Note: Expenditure including depreciation expenses.

Although other cost categories have increased more rapidly, employee-related costs also accounted for just over half (51 per cent) of the total increase in hospital costs over the five years to 2001/02 (Table 3.1). These cost increases were due to increases in average salaries (which rose by 29 per cent) and increases in staff numbers (which rose by 4.5 per cent on a full-time equivalent basis). Total administrative and clerical salaries increased the most (56 per cent) and nursing salaries increased the least (20 per cent). Nurses' salaries have subsequently increased by 15 per cent in January–July. The extent to which administrative costs have increased in excess of salary increases requires closer examination. Insurance costs increased by 189 per cent, and operating lease expenses increased by 337 per cent. Uncontrolled growth in these costs may significantly affect overall costs in future years.

A number of comparatively small cost items increased rapidly over the period. Nursing agency costs, which represent 2 per cent of total costs, increased almost four-fold in the five years.

²⁵ If VMO and agency nurse costs are included. It is 60 per cent if these are excluded.

Table 3.1 The 10 major cost drivers for NSW Health (1996/97–2001/02, real costs)²⁶

Real cost	Contribution to total increase, \$m	% Contribution to total increase
Nursing salaries	277.0	14%
Administrative and clerical salaries	238.9	12%
Other salaries	215.5	11%
Medical salaries	197.4	10%
Medical and surgical supplies	117.5	6%
Superannuation	111.1	5%
Insurance	90.4	4%
Drugs	85.5	4%
Other grants	85.4	4%
Payments to affiliated health organisations	76.6	4%
Total share of increase of top 10 cost categories	1,495.3	73%
Total staff-related	1,039.9	51%

3.5 What does this mean for the future direction of NSW Health?

IPART's review of the current 'health of the health system' indicates that the NSW health system is *not* in crisis—health expenditure is under control, and health outcomes are relatively good. But it also suggests that pressures on the system will continue to increase in the coming years. In particular, upward pressure on health expenditure will intensify—due to growth in the population, ageing of the population, availability of new treatments, and increasing community expectations as we become a wealthier and more educated society. Further, these pressures will step up significantly from around 2020, when the baby-boom generation starts to enter the high health expenditure age group of 75 plus.

²⁶ The increases in salaries are a combination of increases in average salaries paid as well as increases in numbers of staff employed.

4 Planning to focus on patient needs

As part of its review, IPART examined the high-level strategies, policies and planning that set the overall directions and priorities for the NSW health system. In particular, it looked closely at NSW Health's *Strategic Directions for Health 2000–2005*, which sets out its vision and key strategic objectives, and at its planning framework and priorities for resource allocation.

IPART found that although the current vision and strategic direction has many merits, it also has some major weaknesses. The four stated strategic objectives—healthier people, fairer access, quality health care and better value—appear to be centred on the patient and the community, but the vision is more focused on the system itself.

In addition, the vision is not sufficiently long-term, providing a five-year planning horizon only, which now has only two more years to run. Nor is it based on a robust review of the potential impacts that emerging trends in technology, demographics and patterns of illness could have on the system and demand for its services.

Further, priorities for allocating resources do not appear to reflect emerging community needs. In recent years, NSW Health has directed most of its growth funding towards improving the efficiency and effectiveness of acute care services. While these reforms have been important, the changing demographic and illness profile of the NSW community suggests that there should be an increased role for population and community health programs.

IPART believes NSW Health has a significant opportunity to improve its effectiveness, efficiency and equity and increase the long-term sustainability of the health system by strengthening its ability to meet patient and community needs—now and into the future. Specifically, it believes NSW Health should:

- sharpen the focus on patient care and the health of the community in its vision and strategic direction, and enhance its structures, processes and priorities to better support a more patient-focused health system and deliver more patient-centred health services
- develop a vision for the system in 5–20 years time, together with a medium- to long-term State health plan that is based on robust scenario planning and provides the basis for area- and service-level planning
- adjust its funding priorities to reflect the vital role that community health and population health programs can play in achieving a healthier community, and establish mechanisms to ensure accountability against these priorities.

4.1 Sharpen the focus on patient care and the health of the community

In its *Strategic Directions for NSW 2000–2005*, NSW Health set out a vision for the health system in 2005. This document drew on earlier reviews, including the Health Council (Menadue) and Health Services in Smaller Towns (Sinclair) reviews, and provided a framework for the initiatives that followed them. It focuses on four key objectives—healthier people, fairer access, quality health care and better value—and the system attributes required to achieve these objectives. It also specifies a number of strategies expected to be implemented by 2005, and compliance with many of these is testable.

However, IPART's review suggests that this critical document is not fulfilling its purpose. There is a surprising lack of awareness of *Strategic Directions* among senior executives within the health system. And although the agreed objectives are ostensibly based on the community and patients, the vision and strategic direction focus more on the health system itself. The document does not draw out the community- and patient-focus implicit in these objectives, partly due to poor integration between the objectives and the system attributes it sets out.

The importance of focusing on patient care and the health of the community is not a new idea. It is at the core of the day-to-day relationship between clinicians and their patients and other community members that is the foundation of the health system. In addition, many of NSW Health's recent reforms contribute to better patient care and a healthier community.

In some cases, this patient focus is quite explicit. A good example is the work of the Chronic and Complex Care Group. The group's 'blueprint for change' had a strong focus on the needs of patients and the problems they face as they move through the health system, seeing different clinicians at different institutions. Its guiding principles put the patient at the centre. This blueprint guided the development of subsequent clinical service frameworks, such as the framework for optimising cancer care (described in Box 4.1).

Box 4.1 Clinical service framework for optimising cancer care in NSW

This extract from the *Clinical service framework for optimising cancer care in NSW* (May 2003, p 11), is a good example of what is meant by 'putting patients at the centre' of health care.

Satisfaction of care has two dimensions. One has to do with clinical excellence—the skill and competence of professionals and the ability of equipment, procedures and systems to accomplish what they are meant to accomplish, reliably and effectively.

The other 'soft' dimension relates to subjective experience—the patient's perception of illness or well-being and their interactions with the health care system. In health care it is the quality of care provided in this subjective dimension that patients experience most directly.

Any health system must address both the technical excellence and quality of care to achieve legitimacy in the eyes of those it serves. This can be expressed as 'patient-centred care'.

Key Objectives:

- to ensure that cancer patients and their carers have access to the level of information and support that they require to assist them through their cancer journey
- to ensure that cancer patients receive care that is coordinated throughout the continuum of care
- to minimise the physical and psychological impact of cancer on patients
- to provide care that is tailored to meet specific physical and psychological issues nominated by individual cancer patients and their carers through a process of routine assessment.

Other initiatives show how redesigning systems and processes around the patient can have quite fundamental effects on the way in which services are delivered, including the physical infrastructure involved. The new approach to service delivery currently being rolled out in the Hunter AHS is a good example (see Box 4.2).

However, IPART believes a strong focus on patient care and the health of the community is required throughout the NSW health system—from its highest level strategies down to the service delivery level. To achieve this focus, it believes NSW Health needs to:

- clarify and prioritise its key strategic objectives, so that the primary goal is to achieve a healthier community, and the system attributes required to meet each subsidiary goal are clear
- enhance its structures and processes to better support patient-centred care.

Box 4.2 Maggie's Journey: A new approach to delivering services in the Hunter Area

Hunter AHS recognised that many of the frustrations felt by both staff and patients were the result of fragmented and complex care processes that lead to unnecessary delays and communication breakdowns. To address these frustrations, it embarked on a program to redesign the way it delivers health care. It decided to adopt an approach that focuses on the patient journey, labelled 'Maggie's Journey'.

This approach aims to manage the whole patient journey through the system to avoid disruption and improve communication. Its key attributes include:

- focus on patient needs
- team approach, that includes good information-sharing and trust between health care providers and cooperation beyond professional boundaries
- coordinated hospital systems.

The approach was first applied to the Emergency Department (ED) in John Hunter Hospital. ED systems and processes were redesigned around an understanding of patients' journeys through the Department. Consultants were commissioned to help reach this understanding and coordinate the redesign processes, but staff and consumers were included in the project team and working parties.

The new systems and processes are now being implemented. Some aspects were implemented immediately (such as providing name tags for all ED staff), while others had a lead time of several months (for example, making imaging services available 24 hours a day within ED). The performance of the new approach is being monitored to evaluate the effectiveness. The most important performance priorities are:

- no ambulance delay
- no access block
- patient satisfaction equal to or better than the State mean within 12 months, then continuously improving
- staff satisfaction continuously improving.

4.1.1 Clarify and prioritise objectives

IPART believes NSW Health should clarify and prioritise its key strategic objectives so that the primary goal is a healthier community, and the system attributes required to meet each objective are clearly stated. The other existing objectives—fairer access, quality health care and better value—are important subsidiary objectives, or components, of a healthier community. A strong focus on patients and their needs is an important system attribute for each of these objectives.

For example, to achieve a healthier community, we need to:

- Improve outcomes and access to health services for those groups that currently have poorer outcomes and access than the community as a whole (fairer access). One of the ways we might do this is by better understanding the health needs of people within these groups, and finding more effective ways to meet these needs.

- Provide the best health care services we can afford (quality health care). As the cancer care framework described in Box 4.1 points out, this requires focusing on patients and their individual physical and psychological needs as well as on achieving clinical excellence.
- Use available health resources as efficiently and effectively as possible (better value). One of the ways we might do this is to find new models for delivering health care services that meet patient needs, but require fewer resources.

In many ways, sharpening the focus on patients and the community requires NSW Health to reassess many aspects of the health system to ensure that they are designed to meet the full range of patient and community needs in the most efficient and effective way, rather than simply reflecting traditional or historical models of care. This direction needs to be clear in its highest-level strategy document.

4.1.2 Framework supporting patient-focused services

A patient-focused health system and healthier community will need to be built on:

- better structures and processes to deliver patient-focused services
- better prioritisation of programs and use of resources, especially the highly skilled and committed workforce.

Enhance structures and processes to support patient-centred care

To ensure that the strong focus on patient care and the health of the community is reflected throughout the health system, NSW Health needs to enhance its structures and processes so they better support patient-centred care. In particular, it should improve the mechanisms that support and influence the relationship between health care service providers and patients and other community members.

The Department does not provide health care services directly except for some population health, mental health and child protection programs, and critical care networks. The key service providers are the AHSs, which run the hospitals, community care facilities and population health programs, and the clinicians who provide the services through these facilities and programs.

However, the Department is responsible for developing, in consultation with AHSs, clinicians and the community, the framework within which the direct service providers operate. Three key structures within this framework can help strengthen the focus on patient care, and better align services with the objectives of healthier people, fairer access, quality care and better value. These include:

- **Quality patient care** through establishment of service guidelines (or standards and modes of delivery) and monitoring/reporting systems to ensure compliance with these standards. This is often referred to as ‘clinical governance’.
- **Clinician and community involvement** in decision-making. It is essential that clinicians have effective means to contribute to development of the policies and frameworks that guide service delivery. Clinicians have the most direct understanding of the patient’s need and it is essential that clinicians have confidence in the policies and frameworks. It is equally

important that the community have an effective voice if the focus is to be on the patient. This can be referred to as ‘community governance’.

- **Accountability of services providers** for efficient use of resources in delivering services and programs. This can be referred to as ‘corporate governance’.

IPART believes the Department can increase the focus on patient care by strengthening each of these three legs of governance and improving the balance between them. To date, the emphasis has been mainly on corporate governance, and as a consequence this is the strongest leg. However, it can be strengthened further by clarifying roles and accountabilities within the health system. For example, IPART believes AHSs should be given greater management responsibility and be more accountable for health outcomes and service provision in their communities (see Chapter 9). This should lead to a stronger focus on patient care and community needs.

Recent reforms have strengthened clinical and community involvement, although it is still not as strong as corporate governance. IPART believes it needs to be further enhanced. The leadership role of clinicians needs to be embedded in the decision-making process. Community members need to have effective means to contribute to the development of the policies and frameworks that guide service delivery (see Chapter 7). This will help to increase the focus on both patient needs and community needs. Clinicians have the more direct understanding of patient needs, and community members can help ensure the patient’s perspective and community priorities are built into the decision-making process.

Clinical governance is the least developed of the three legs of governance, and needs to be enhanced. In particular, IPART believes the key body within the clinical governance structure should focus specifically on promoting patient care—including the ‘softer’ dimension of care—and have a stronger role in ensuring quality of care and patient safety (see Chapter 5).

Prioritisation and better use of resources

The Department of Health must embark on scenario planning to provide the foundation for prioritisation of programs and better resource use (see section 4.2 below). The allocation of resources between population health programs, community care and hospital services is an important element in using the available resources better.

Public health encompasses programs such as nutrition advice, immunisation and anti-smoking. There is a strong presumption within NSW Health and by many clinicians that public health programs, primary health care and community care should be given a greater priority. Evidence suggests investment in health programs such as these can be more cost-effective in improving health outcomes. Evidence-based decision making should apply equally to acute care, community care and public health programs and the prioritisation between these areas.

A fair allocation of funds between AHSs that reflects the community’s needs is also an important part of the better prioritisation of resources to achieve the objectives of the health system.

Box 4.3 Emerging health care priorities

Changes in the demographic and illness profile of the NSW community are shifting the burden of disease. The most significant changes are the ageing population, the prevalence and cost of behaviour-related illness, and the rising incidence of mental disorders. In addition, community expectations of the health system are increasing. Each of these factors, and their implications for patient care and the health system, are discussed below.

Ageing population

The care of older people at the interface between acute care and home or residential aged care services is one of the most significant issues facing the NSW health system. Older people are already the major users of the NSW health system. They will become even greater users as the State's population becomes progressively older, as the 'baby boomers' reach old age and people live longer than before.

Generally, we will see an increasing proportion of the population living a long time. Many will age well, remaining relatively healthy and continuing to live in the community. However, as more people survive events that previously had high mortality rates—such as heart failure, renal failure and cancer—they will live for a longer time with disabilities.

We will also see an increase in dementia. By 2016, it is forecast to be the largest cause of disease burden in women (all ages) and the fifth-largest cause in men (all ages). And we will see an increase in neuro-degenerative diseases, leaving some older people frailer, much slower, with greater loss of balance, vision and memory.

To respond to the ageing of the population, the health care system needs to achieve the right balance in service delivery—so that healthy people remain independent, living at home with minimal support, while the more vulnerable older people with chronic and complex needs get the specialised services they require. Appropriate models of care for older but otherwise healthy people with dementia may require more people-intensive, low-technology solutions. For those in hospital, better care may require more flexible approaches and changes to our views on the roles of nurses and other health care service providers.

The general expectation is that older people in the last year of life will use health services about six times more intensively than other people of the same age. One view is that longer lifetimes simply defer this period of more intensive medical support.²⁷ This appears to be the most common planning assumption. However, if longer lifetimes result in a more drawn-out period of intensive health support, the demands on the health system could increase substantially.

Behaviour-related illness²⁸

Illness related to behaviours such as smoking, poor diet and exercise habits, and drug and alcohol abuse are placing increasing demands on the NSW health system, especially on acute care in hospitals.

- Although adult smoking rates have declined over the past 10 years, it is still the largest cause of illness in NSW and results in more than 6,500 deaths and more than 50,000 hospitalisations each year.
- The level of obesity in Australia has doubled over the last 20 years. At least half of men and one-third of women in NSW are overweight or obese, and only two-thirds of men and less than two-thirds of women report adequate levels of physical exercise. This has implications for heart disease, diabetes, high blood pressure and cancer.

²⁷ The contention is that increasing years of life may not lead to a corresponding rise in years of poor health and may even reduce the time between failing morbidity and death (Fries J, Aging, natural death and compression of morbidity. *New England Journal of Medicine* 1980; 303: 130–5)

²⁸ Source: NSW Department of Health, *The health of the people of New South Wales: Report of the NSW Health Chief Health Officer, 2002*, p xiii.

- Harmful use of alcohol causes around 1,500 deaths and more than 27,000 hospitalisations each year in NSW.
- Use of illicit drugs causes more than 300 deaths (mainly from heroin overdose) and 6,000 hospitalisations each year in NSW, although deaths from heroin overdose and the number of ambulance attendances for overdose declined in 2000.

Health promotion programs aimed at changing illness-related behaviours can be very effective in reducing future demands on the health system. NSW Health has an active health promotion strategy for the key areas outlined above, and has participated in cross-government action such as the Drug Summit and NSW Obesity Summit, and the planned Alcohol Summit. However, one of its key challenges is to increase the priority and effectiveness of population health programs while maintaining the efforts to continue to improve acute care.

Mental disorders

Mental disorders are becoming a more important cause of disease in NSW, with widespread implications for the demands on the health system:

- mental disorders (including substance-use disorders) are already the leading cause of disability burden in Australia, and account for about 30 per cent of the total years lost due to disability
- unipolar major depression is currently the fourth leading cause of disease burden but, by 2020, it will be second only to heart disease
- the National Survey of Mental Health and Wellbeing (Child and Adolescent Section) showed significant levels of depression, conduct disorder, and attention deficit hyperactivity disorder affecting a total of 14.5 per cent of children and young people
- the suicide rate in males in general, and young males in particular, has been relatively high for the past 15 years.

In NSW, mental health care is estimated to cost \$1.6 billion per annum.

An effective response to mental disorders requires programs that span public health and health promotion, community care and hospital-based care. Government growth funds have been directed at providing additional mental health beds and supported accommodation for people with chronic mental disorders. Additional services (beds and community-based) will be required in forensic mental health, intensive care and emergency services (for protection of the individual and the community), and child and adolescent services. A sustained effort in suicide prevention is also required, such as the whole-of-government, whole-of-community strategy currently being implemented across the State.

Increasing community expectations

The community's expectations of health care continue to rise with improvements in medical technologies and increasing access to medical information. The media regularly report on the latest wonder drug or new procedure, and consumers can now access health information that a decade ago was only provided by health clinicians to patients.

One of the benefits of this is that people increasingly understand the role they can and should play in their own health and well-being. Public health and health promotion can play a crucial role in keeping the community well advised on the most effective approaches to maintaining good health. Not all expectations can be afforded; some may have to be moderated. There cannot be tertiary health services in every district hospital. The community is increasingly coming to accept this view.

4.2 Develop long-term vision and State health plan based on robust scenario planning

The NSW health system is subject to major pressures, including increasing costs and demand for services, due to changes in the demographic and illness profile of the community, new and more costly treatment, and rising community expectations. The impact of these pressures is already significant, and will continue to increase. To ensure that it can continue to meet patient and community needs in the medium- to long-term future, NSW Health needs a long-term planning framework that is based on the best available evidence, draws on the latest techniques and technology, is developed by experts and is understood and accepted by the community. A scenario-planning approach is needed. It should seek to identify a number of alternative views for the future, and draw out the policy implications. Most importantly it needs to examine not only how the health system can most efficiently meet the requirements under any of these views for the future. It also needs to focus on how the system can adjust as the different patterns of pressures emerge.

NSW Health does not currently have such a planning framework. Its *Strategic Directions for Health 2000–2005* document is not long-term. It provides only a five-year planning horizon, which is too short for a complex system like health. Nor is it based on robust, policy-oriented scenario planning. In addition, while NSW Health has a number of specific plans and policies—such as Healthy People 2005, NSW Aboriginal Health Strategic Plan, the NSW Quality Framework and Strengthening Health Care in the Community—it does not have an integrated, long-term, State-wide plan.

IPART believes the NSW health system needs to take a much more strategic approach to planning. It should develop a vision for the system in 5–20 years, and undertake long-term scenario planning to develop an overarching, State-wide strategic health plan. A proposed scenario planning framework, together with suggested roles for the Department and AHSs, and processes for involving clinicians and the community in developing this long-term planning, are outlined below.

Box 4.4 Proposed scenario planning in NSW Health

NSW Health's proposed scenario planning process will describe the impact on the NSW health system of trends in the external environment, project these trends for the next 5 to 10 years, identify a limited number of future scenarios, identify issues of strategic importance to NSW Health and, testing these issues and opportunities against the future scenarios, identify key decision points.

The project will consider a range of key issues, which are likely to include the following:

- patterns of morbidity and changes in the burden of disease, including the effects of demographic change and the impact of chronic conditions
- effects of new health care technology
- trends in consumer expectations (including issues of access, equity, and health ethics), and emerging whole-of-government approaches to community distress and health
- how these issues play out in a number of key case studies
- changing roles of major institutions (such as hospitals), the health workforce, and the evolution of models of patient care
- health financing trends (such as private insurance) and trends in funding approaches.

4.2.1 Proposed framework for scenario planning

NSW Health has already begun to work on long-term planning by establishing a process for scenario planning (see Box 4.4). It needs to ensure this yields a fully integrated strategic approach to long-term planning and allocating planning responsibilities. Its current multi-tiered planning hierarchy can support this approach, which should encompass a high-level, long-term scenario plan that sets the strategic direction for the State. This State health plan should then be cascaded down to detailed, shorter-term plans and policies for AHS business plans and specific service plans.

Once developed, the State health plan should also be a dynamic document. IPART suggests it should be subject to regular evaluation and revision—for example, every three years.

The new planning framework should:

- encompass long-term (up to 20 years) strategic plans and shorter-term (1–5 years) operational plans that are cross-linked and consistent
- link these strategic and operational plans to strategic directions that clearly specify the objectives and priorities for the health system
- ensure the plans are policy-focused and recognise the inherent uncertainties as to the future demands on the health system
- provide for strong clinician and community involvement in the development of the plans
- ensure consistency between the plans prepared by the Department and those prepared by AHSs.

The development of these strategic and operational plans must be closely integrated with the development of the clinical services standards or frameworks (see Chapter 5). These plans should also form the basis for more detailed planning in particular areas—such as resource planning (eg workforce and capital expenditure planning)—and cross-AHS regional planning (eg metropolitan and rural hospital strategies). And together with clinical services standards or frameworks, they should form the basis for developing clinical service plans.

4.2.2 Suggested roles for the Department and AHSs

Under IPART's proposed planning framework, the Department's role would be to set strategic directions and provide policy and planning frameworks for key issues (such as mental health and Aboriginal health). It would also provide the State-wide context for all planning, to ensure a consistent approach to achieving specific corporate objectives. The scenario plan developed in consultation with stakeholders and AHSs would set the framework for more detailed shorter-term plans.

In addition, the Department would provide guidelines, information and tools to facilitate local health service planning (eg clinical best-practice guidelines, patient flow guidelines, data and analytical software, episode costing benchmarks, software for supply modelling and demand projections). And it would continue to undertake system-wide planning for highly specialised services and technologies, such as radiation oncology and genetics services.

AHSs' role would be to develop an Area Strategic Plan that is consistent with the Department's State-wide policies, planning guidelines and overall priorities, and responsive to their local population requirements.

Good communication between AHSs, and between AHSs and the Department, is also essential, as all parties must understand their respective roles, and the processes and their outcomes, for this integrated approach to planning to succeed.

4.2.3 Processes for community and clinician involvement

Close involvement of clinicians and community members in NSW Health's long-term planning is essential. IPART considers that a sound process to facilitate this involvement would include the following elements:

- input from revamped groups of clinical specialists in relation to both service development and clinical practice guidelines (through the clinical governance structures outlined in Chapter 5)
- linkages to, and input from, the new Health Care Advisory Council (see Chapter 7)
- a community summit on the future directions for health, modelled on the successful 1999 Drugs Summit
- awareness programs and a public process to ensure the community has the opportunity to both participate in the planning process and to be informed by media reporting of the proceedings
- cooperative engagement with the Commonwealth in State health planning and related processes
- a review of demand drivers in the system and how best to manage this within overall financial parameters.

4.3 Adjust funding priorities to reflect the vital role of primary health care

The NSW health system provides four broad types of clinical services—early intervention, acute care, critical and emergency care, and chronic and complex care. These services are provided in a number of settings, from community health centres through to intensive care units in hospitals.

To manage increasing demand and escalating costs, NSW Health has focused mainly on changing models of care in acute-care services. It has directed most of the growth funds in recent years towards increasing acute-care hospital-based services.

For example, increased use of less invasive medical and surgical procedures has enabled a shift away from in-patient care to day-only and outpatient care in hospitals. Reduced average time spent in hospital has enabled hospitals to treat more patients. Better coordination of care for people with chronic disease has decreased the demand for hospitalisation and improved the quality of care for the patient. Networking arrangements for AHSs and clinical specialties have improved access to, and reduced duplication of, costly clinical services.

However, there appears to have been no increase in primary, post-acute care, community health or home and community services. Indeed, non-acute health programs, including population and community health, represent a very small part of the overall State budget for health. For example, estimates indicate that in 1999/2000, NSW spent \$196.4 million on core public health activities, predominantly in the areas of communicable disease control, immunisation, breast cancer screening and selected health promotion. This represented only 2.7 per cent of the total NSW Health budget—a similar proportion to the previous year.

IPART believes the long-term planning process described above will show that these funding priorities are not sustainable, given the changing demographic and illness profile of the people NSW (see Box 4.3), and the evidence of the effectiveness of non-acute care and population health programs (see Box 4.5). Many of the stakeholders it spoke to during its consultations—including NSW Health staff and clinicians—also strongly believe public health programs and community care should be given a greater priority.

Box 4.5 Effectiveness of primary health care programs

Strong evidence suggests that population and community health programs can have significant benefits. For example, the Commonwealth Department of Health and Ageing recently published a report on the return on investment in public health.²⁹ This report focused on the public health issues of smoking-related illness, coronary heart disease, HIV/AIDS, measles and Hib disease, and road safety and road trauma.

For smoking-related illness alone, it estimated the total benefit of health improvements in 1998 due to lower tobacco use since 1970 to be \$9.6 billion. It also identified improved health status gains of \$2.2 billion and lower health care costs of \$500 million.

The benefits of public health programs can also be quite immediate. During IPART's consultation process, it was told by one rural AHS that its public health efforts with the Aboriginal communities, focusing on immunisation and mothers and babies, had delivered obvious improvements within one to two years. For example, the latter programs resulted in higher birth weights and increased breast feeding, both of which have been shown to deliver long-term benefits.

Public health and community health programs should be seen as a major partner to acute care hospital services. With their emphasis on early intervention and prevention and post-acute services and community care, these programs have the ability to reduce pressures on acute services and hence costs. But above all, they can improve the health status and hence the quality of life for individuals and the whole community. A diversion of funds away from public health and community health to general services—at any level in the health system—is short-sighted.

For these reasons, IPART believes NSW Health should increase the priority of public health and community health within the State health plan and establish mechanisms to ensure that funds intended for public health are not diverted into general services.

²⁹ *Returns on investment in public health: An epidemiological and economic analysis*, prepared for the Department of Health and Ageing, 2003.

4.3.1 Increase the priority of primary health care within the State plan

The NSW Government has established a Cancer Institute with funding of \$205 million over four years. It has also announced its intention to hold an Alcohol Summit, following the successful summits on drugs and obesity. These initiatives are important, but more needs to be done. IPART believes NSW Health's new State health plan should include a strong emphasis on population health, particularly early intervention and prevention strategies. The major priority areas include:

- reducing tobacco use
- improving diet (both to improve nutrition and reduce obesity and diabetes)
- improving exercise levels
- improving mental health
- preventing falls
- increasing immunisation rates
- preventing violence (especially sexual assault)
- improving asthma management
- more intensive early-childhood home-nursing visits
- improving dental or oral health.

These priorities need to be particularly focused on the disadvantaged in the community—such as low-income earners, migrants, indigenous people, outer suburban populations and residents of rural and remote areas. While there may be considerable time before the health returns of these investments are evident, the key issue is that the longer population health programs are delayed the longer the benefits to the individual and the community will take to be realised in a sustainable manner.

4.3.2 Establish mechanisms to ensure primary health care funds are not diverted

The pressures related to increasing demand for acute care services are immediate and highly visible. NSW Health needs clear priorities, goals and accountabilities in relation to population health to ensure that funds intended for this important priority are not diverted to acute care.

The Department should include appropriate outcomes and targets related to population health in its performance agreements with AHSs, and back these up with proper monitoring and inspection systems. It should also include population health performance in its annual performance agreements with AHS CEOs.

AHSs should prepare sub-plans within their area plans for each of the priority public health areas. They should back these up with improved information systems and workforce training, especially for first-line managers.

In addition, the important role of Community Health Centres (CHCs) should be reinforced by ensuring their attachment to hospitals for funding purposes does not weaken their performance. Appropriate funding bases should be established by each AHS, even if it means re-allocating a small proportion of hospital budgets to the CHCs. Their vital work for patients in the community can reap enormous benefits to hospitals themselves.

Recommendations

- 3 NSW Health should undertake a fundamental review of strategic directions to ensure that they are clearly focused on the patient and the health of the community, developed in conjunction with policy-oriented scenario planning, and provide a vision of the health system in 5 and 20 years' time.
- 4 NSW Health should develop a State health plan. The plan should include specific scenarios for models of care and the major causes of ill health and death, taking into account major cost drivers in the system, and be used to guide plans for metropolitan and rural NSW, for regions and for areas.
- 5 The NSW Government should conduct a Summit on the Future Directions in Health to assist NSW Health's long-term planning process and engage the community in this process.
- 6 In developing the new State health plan, the Department should actively involve the Health Care Advisory Council (HCAC), the new Institute for Clinical Excellence and Patient Care (ICE-PC), Health Priority Taskforces and the Health Participation Council.
- 7 The role of primary health care, including public and community health, in disease prevention and health promotion should be a major priority in the planning process and consequent funding decisions.
- 8 AHSs must develop strategic health plans that cover the medium term and must be consistent with the State health plan, clinical service guidelines, the AHS's four-year budget and approved capital expenditure programs.
- 9 The Department must take responsibility for the development of metropolitan and rural Area plans, and any other cross-Area plans in consultation with the HCAC, AHSs and other stakeholders. These plans should be guided by the State health plan.
- 10 AHSs need to ensure there are specific plans for population health, and report outcomes against these plans. The AHSs should put systems in place with the Department to ensure funding is not diverted into general services.

5 Better quality care and patient safety

A commitment to quality care and patient safety is fundamental if the health system is to deliver effective care for patients and the community. Patients should expect and receive treatment that results in their leaving facilities in better health, as far as their condition permits, than when they entered.

Of course, some human error is inevitable and breaches of standards and guidelines will occur. However, health systems should aim for zero tolerance of these events. Aiming for perfection should lead to achieving close to it. Anything less means the system is failing patients and the community.

Achieving this focus on quality care requires strong clinical governance systems that support clinicians in a way that reduces the risk of individual errors, and the consequence of such errors. Clinical governance systems focus on promoting quality in the health care system by developing and implementing guidelines for clinical care, and monitoring and reporting on clinical care performance. As well as having major implications for patients and their care, they also influence the health system's resource needs by setting standards for treatment.

Many health systems around the world are working on improving their clinical governance systems. In recent years, for example, both the United Kingdom and Scotland have revamped their clinical governance structures to ensure that quality of care is a central concern of their respective health systems (see Attachment 7). The World Health Organization has also signalled that it needs to take a greater leadership to advance patient safety.

NSW Health has made significant advances in clinical governance since IPART's 1998 review. It has made quality a higher priority and improved its system to ensure quality. However, the roll-out of new tools, systems and procedures appears to be slow, and not all participants are giving the promotion of quality the weight it deserves and that patients expect.

IPART believes NSW Health needs to strengthen its clinical governance structures and systems further, to ensure that quality, including patient safety, is regarded as a central theme at all levels of the system. Among other changes, it recommends that the Institute of Clinical Excellence be transformed into the Institute of Clinical Excellence and Patient Care (ICE-PC), and be given primary responsibility for developing clinical guidelines and advising the Department on processes and systems to support higher quality care.

The sections below describe the key components of systems to ensure quality care, provide an overview of the current clinical governance structures in NSW, and explain in more detail IPART's proposals to strengthen these structures.

5.1 What are systems to ensure quality care?

Clinical governance systems, which aim to ensure the quality of patient care, usually comprise two broad strands—developing and implementing guidelines (or frameworks) for care and systems to support quality care; and monitoring and reporting clinical care performance, including mechanisms to examine complaints and instances of individual error or system

failures. The establishment or enhancement of these systems is a sensitive issue, and can have important implications for clinicians and the costs of health care. Each of these aspects of clinical governance is discussed below.

5.1.1 Developing and implementing guidelines and support systems

Developing guidelines for care sets standards or expectations for care. Many questions need to be answered in considering the design of the process for developing these guidelines. Firstly, how should the development of guidelines be prioritised and should different processes be used, depending on the priority? Secondly, how flexible should the guidelines be? Should they go beyond guidance, or recognise a need for appropriate clinician discretion?

Developing systems to support quality care aims to ensure best practice in accordance with the guidelines, and reduce the risks and consequences of human error. Individual clinical guidelines may specify elements of quality systems. However, quality systems need to be implemented across facilities and areas as a whole, and can have far-reaching effects. In seeking to reduce the risk of error, quality systems can encompass many elements, including the design of a facility, record-keeping systems, staff rostering and information exchange, and internal peer review systems.

5.1.2 Monitoring and reporting clinical care performance

Monitoring and reporting care outcomes is essential to compare performance over time, across the system and with best practice, to ensure the quality of care is maintained or improved. Where guidelines exist, care outcomes can be monitored and reported against the standards or expectations established in these guidelines. This can be done at the State, AHS and facility level.

Reporting performance down to the facility level enables comparison within and across areas and facilities. How such data is then used is a key issue in the design of quality systems. At the least, significant variations in performance are likely to lead to further questions so that clinicians and others can better understand the factors that lead to variations in performance—either high or low.

Establishing mechanisms for investigating individual complaints or instances of failure also aims to ensure the quality of care is maintained or improved. These mechanisms can be separate from the general monitoring and review function. However, where individual failures highlight problems of a systemic nature they may be referred to those responsible for the overall monitoring and reporting and the development of guidelines for care and quality systems.

5.1.3 Implications for clinicians

The relationship between the individual clinician and patient, and the duty of care that the clinician owes to the patient, is the fundamental relationship for quality of care. The health superstructure should be seen as a means of supporting that relationship to ensure that the care received is high quality and appropriate. However, clinicians may be concerned that there could be a tension between their responsibility to do the best for each individual patient before them and the rigid application of prescriptive standards of care.

Guidelines or frameworks should provide expectations of care—and quality systems are likely to result in greater monitoring and reporting of outcomes of care. It is important that the guidelines are developed by leading clinicians and be subject to peer review, to ensure that they reflect agreed best practice. It is also important that clinicians are closely involved in the development and implementation of quality systems.

5.1.4 Implications for the cost of health care

Specifying guidelines for clinical practice and establishing systems to ensure quality care can have important implications for health care costs and demands on the State budget. Given that the overall funds available for health are limited, additional spending in one area will reduce the resources available in another. Hence, it is important that the development of clinical guidelines and systems have regard to their cost.

It is often the case that more could be done if funds were unlimited. Clinical guidelines could specify higher levels of care or access to particular treatments. For example, guidelines could set finer screening of patients presenting with physiological problems for mental disorders. Or they could specify the use of drug-emitting stents and implantable defibrillators for cardiac problems. This would result in much more extensive take-up of these technologies, which would add to costs. Similarly, more extensive processes to insure against individual or system errors are likely to require additional resources.

However, it should also be noted that a lack of guidance can also increase costs of health care. One response is to require all guidelines to be based on sound evidence of the benefits for patients of the specified treatments—that is, ‘evidence-based medicine’. Discussions of evidence-based medicine suggest that if rigorously adopted, it would result in lower use of some common existing practices. Hence, it may yield savings as well as additional expenditures.

A second response is to ensure that while guidelines are developed by those expert in the field, they are also subject to review by clinicians that have broader interests and responsibilities, including managing the overall health budget.

5.2 Current clinical governance structures and initiatives in NSW

A wide range of bodies are involved in clinical governance of the NSW health system. Within NSW Health, these include the Department, the relatively new Institute of Clinical Excellence, the AHSs and statutory corporations and their facilities. It also includes the independent statutory body, the Health Care Complaints Commission, and the NSW Therapeutic Assessment Group, the professional colleges and Commonwealth agencies.

Within the Department, the Quality Branch is mainly responsible for policy development. Its key initiatives in recent years include developing *A Framework for Managing the Quality of Health Services in New South Wales* in 2000, which sets out six dimensions of quality, and a framework for measuring and managing them. It also developed the *Clinician’s Toolkit for Improving Patient Care* in 2001. IPART understands that these have been deployed in varying degrees across the health system. In addition, most AHSs and hospitals have set up quality councils or committees to improve quality throughout their jurisdictions.

The Institute of Clinical Excellence (ICE) was established to develop and implement guidelines and improve systems to support quality care. It is currently working with the Department to roll out State-wide training programs. These programs include the Clinical Practice Improvement Program, the Safety Improvement Program (which focuses on root-cause analysis) and human factors training and skill development.

One of ICE's key initiatives has been to mandate the use of root-cause analysis to guide systems redesigns in response to system failures. This management tool involves tracking back through systems and processes to identify gaps that were the cause of particular system failures. It is to be deployed within areas by the new patient safety officers AHSs are in the process of recruiting. Through this approach, ICE aims to improve the quality of patient care by improving systems and processes, rather than focusing on faults at the facility or individual level.

Another of ICE's initiatives has been to adopt the Towards a Safer Culture (TASC) approach. Initially, ICE worked with the College of Physicians to produce guidelines for the coronary clinical stream. These guidelines will be gradually deployed across AHSs. ICE intends to collaborate with appropriate experts to develop guidelines for other clinical streams, including red blood cell transfusions, patient flows and safety, chronic care patients and emergency management of acute coronary syndromes and strokes.

The Department, through the Chronic and Complex Care Program, has recently developed three NSW Clinical Service Frameworks:

- Optimising Cancer Care
- Heart Failure
- Chronic Respiratory Disease.

IPART believes these recent initiatives have many strengths. For example, ICE's focus on systems to support quality is important, and it is engaged in some highly innovative work.

However, the development of systems and guidelines to ensure quality care needs to be given greater priority and integrated with the planning process and clinical performance reporting. Clinical performance should be monitored, reviewed and reported against clinical guidelines in a manner that helps drive continuing quality improvement and public awareness.

5.3 Proposals to strengthen clinical governance

While important progress has been made on clinical governance, the quality of patient care needs to be the focal point for all participants in the health system. It requires a framework that will give it greater priority and establish more effective review of performance against expectations. IPART believes it should create this framework by:

- **transforming ICE into the Institute of Clinical Excellence and Patient Care (ICE-PC) and enhancing its role and resources.** The ICE-PC's role would be to ensure the timely development of an effective system of clinical standards and guidelines, promote safety and quality and promote best practice in the health system. In addition, it would be a vehicle for change management. The ICE-PC's funding levels should be reviewed to ensure it can properly fulfil all aspects of this role and roll out its initiatives in a timely manner.

- **streamlining the existing specialist clinical groups to form 11 Health Priority Taskforces** (HPTs), and integrating the operation of these taskforces into the ICE–PC and the proposed Health Care Advisory Council (HCAC). As part of their role, the HPTs would help the Department approve and communicate the final form of clinical guidelines. (IPART’s proposal to streamline the specialist clinical groups and create the HCAC is outlined in Chapter 7.)

Within this framework, the ICE–PC, HCAC and the Department would need to work together to integrate the development of clinical guidelines with the overall planning and priorities of the health system. The AHSs would be responsible for implementing the guidelines, with help and support from the ICE–PC. The Department would be responsible for monitoring, auditing and reporting. Both the Department and the ICE–PC will be involved in evaluating clinical performance.

The proposed framework for clinical governance, and these roles and responsibilities are explained in more detail below.

5.3.1 Developing and implementing guidelines and support systems

Developing guidelines for care

Currently, the development of clinical guidelines is not coordinated through a process that is integrated with overall health priorities and planning. For patients with a specific health condition and their clinicians, the clinical guideline for that condition is of utmost importance. However, from a system perspective, some guidelines are more important than others because of the current or expected prevalence of the illness, the complexity of the illness and the resources required. The long-term planning for the system should be informed by these clinical guidelines. Conversely, NSW Health’s State plan and expected resources will also influence the guidelines.

For these reasons, it is important that the prioritisation of the development of guidelines and their subsequent endorsement be integrated with overall health planning. To achieve this:

- The Department should identify State-wide priorities for the development of clinical frameworks, in close consultation with the HCAC. The ICE–PC should then submit three-year plans for the development of clinical frameworks to HCAC and the Department.
- The ICE–PC should be represented on the Health Priority Taskforces.
- The Director-General should be a member of the board of ICE–PC, and the chair of this board should be a member of the Health Care Advisory Council. This will help integrate the strategies of the ICE–PC with the advisory role of the HCAC and the planning role of the Department.

The ICE–PC, assisted by clinicians and the HCAC, would be responsible for developing guidelines for each of the State-wide clinical priorities. The HCAC would assist with determining trade-offs in the different policy choices. Guidelines outside the State-wide priorities may also be developed by the ICE–PC or the professional colleges. Guidelines developed by the ICE–PC would be referred to the HCAC for consideration and review, and then submitted to the Department for endorsement and State-wide application.

In overseeing the development of guidelines, the ICE–PC would work closely with the HPTs and other relevant bodies such as the colleges. The HPTs would have two functions—to assist in the development of service strategies (including networking), and to develop clinical practice guidelines.

Although guidelines would be mandated across the system, they should allow the AHSs flexibility in the delivery of outcomes. AHSs or facilities that have not established or operated a fully functioning clinical governance structure, such as quality councils or committees, should be obliged to do so.

Implementation and system development

Once the Department has endorsed the guidelines, AHSs will be responsible for implementing them. They will also be responsible for developing systems to ensure compliance with the guidelines and minimise the risks and consequences of errors. To do this effectively, they may need to improve many of their existing systems and practices. For example, they will probably need to enhance their information technology and provide better education and training to their workforce. They may also need to promote particular attitudes and practices within their workforce—such as a team approach or cohesion within health facilities—to advance quality care.

The ICE–PC will be responsible for working with AHSs, facilities and clinicians to implement the guidelines and develop quality of care systems—and this aspect of its role should be seen as being as important as developing the guidelines. As discussed in section 5.2, ICE has placed priority on developing quality systems and processes for analysing problems from a system perspective. The ICE–PC will need to continue this important and innovative work. However, IPART believes it should review ICE’s current sequential application of the TASC approach, which it believes has the potential to slow down the realisation of improvements resulting from the approach.

AHSs and the ICE–PC will need to develop close and effective working relationships. The ICE–PC will need to provide practical advice to AHSs and facilities, and work collaboratively on reviews of systemic problems. AHSs need to be confident that requesting such assistance would not prejudice the assessment of their performance. Separating the performance-monitoring function from the implementation and system development function will help (see below).

5.3.2 Monitoring and reporting clinical care performance

The Department should have primary responsibility for monitoring, auditing and reporting on the clinical care performance of the NSW health system, as it does for other aspects of the health system. However, strong clinician involvement in developing the monitoring and reporting systems will be important for their credibility. In addition, the Health Priority Taskforces should assist the Department in monitoring performance in the clinical streams they represent.

In reaching this view, IPART carefully considered whether the monitoring, auditing and reporting role should be formalised at all, and if so, in what form. It also considered the degree to which the process of benchmarking performance should be transparent, and indeed the degree to which benchmarking should be adopted.

Better quality care and patient safety

Under the current clinical governance structure, ICE has adopted a ‘no-blame’ approach that would seem to imply little role for a central system of monitoring and auditing. This is not because it believes incidents should be covered up, but because it genuinely believes that quality is better advanced by improving systems, not by exposing incidents, individuals and hospitals that make mistakes.

However, some stakeholders believe greater transparency is required, so that the public and other stakeholders can be properly informed about the performance of the health system, and of particular facilities. To achieve this transparency, an extensive monitoring, auditing and reporting function would be required. The UK health system has taken this approach, and gives individual hospitals ‘star’ ratings to both inform the public of their performance against clinical care standards and provide incentives for them to improve their performance. Others put the view that this kind of rating system could potentially create incentives for facilities to manipulate their data to avoid a ‘bad’ rating, and thus could actually impede the advance of quality.

On balance, IPART believes that a strong monitoring, auditing and reporting function is a key component of an effective clinical governance system, and that the Department should perform this function. It also believes that transparency is important, both to inform patients and create incentives for facilities to continue to aim for a higher standard of care. It believes the Department should publish data annually on the key indicators of quality for each facility, but this data should not be ranked to provide a form of rating system. It does not believe a standard rating system is appropriate, though it may be necessary to reconsider this view in the future.

IPART does not consider that its proposed approach is inconsistent with the existing ‘no-blame’ environment. It is possible to have strong and independent performance-monitoring, inspection and reporting of facilities, including some public reporting, while primarily focusing on systemic improvements rather than finding faults with individual facilities or clinicians.

Finally, IPART believes the existing Health Care Complaints Commission, registration board and police procedures should continue to apply where there are serious breaches of care by an individual. However, the HCCC’s operations, legislation and funding should be reviewed to ensure it effectively performs its functions, especially its investigation and prosecutorial roles.

Box 5.1 National service frameworks in the United Kingdom

The UK has developed five National Service Frameworks to guide the delivery of services in the key areas of cancer, renal, mental health, diabetes and coronary heart disease. The frameworks serve two purposes. They are a policy outline as well as guiding clinical practice. They integrate the planning and also clinical governance functions to guide funding and service delivery. The frameworks outline the national standards for each field, their aims, means of development and delivery as well as performance monitoring.

The standards are evidence-based, assisted by external reference groups who were involved in the development of the framework. The range of evidence is graded according to different systems and drawn into each framework. Each field includes a number of standards. For example, the mental health framework has seven standards covering five areas. In this framework, each standard consists of aims, rationale, interventions and evidence base, service models and examples of good practice. This framework also includes local implementation guidelines, assessing performance including national milestones, research and development, support systems and an information strategy.

Recommendations

- 11 The Institute for Clinical Excellence (ICE) should be transformed into the Institute for Clinical Excellence and Patient Care (ICE-PC) and have its role expanded to include leading the development of clinical frameworks and guidelines, assisting with their implementation and improving quality and safety systems and processes throughout the NSW health sector.
- 12 The Department, in close consultation with the HCAC, should identify State-wide priorities for the development of clinical guidelines by the ICE-PC to ensure that the work of the ICE-PC is integrated with the strategic directions and State health plan.
- 13 Clinical guidelines developed by the ICE-PC should be referred to the HCAC for review and comment prior to submission to the Department for endorsement and State-wide application.
- 14 The Health Priority Taskforces proposed in recommendation 26 should support the ICE-PC to realign the operation of the health system to improve the quality of patient care.
- 15 The ICE-PC's funding base should be reviewed to ensure it can fully and effectively perform its roles.
- 16 The Department should have a strong monitoring, auditing and reporting role to enforce the promotion of quality across the health system.
- 17 Consistent with national and international trends, the Department should publish annually, in a consolidated form, the key indicators of quality for every public hospital and facility in the NSW health system.
- 18 Every AHS and health facility should be obliged to have in place an effective clinical governance structure to achieve improved quality and patient care outcomes.
- 19 The Health Care Complaints Commission's operations, legislation and funding should be reviewed to ensure it effectively performs its functions, especially its investigation and prosecutorial functions.

6 More integrated service delivery

There is increasing recognition that factors such as education, employment and housing can affect a person's health as significantly as their access to quality health care. Poor health outcomes can also increase demands on other community service agencies. Integrating—or at least coordinating—the delivery of human services by government agencies can play an important role in improving the health status of the NSW community and the quality of life for many of its members. It can also provide better value from government's limited resources.

For example, more effective, coordinated mental health strategies can improve outcomes for people with mental health problems, allowing them to be more independent, fulfilled members of the community and reducing harmful behaviours. This is likely to have flow-on benefits for other human and community service agencies, such as fewer demands on justice, community support, housing and educational services.

In recent years, many governments in OECD countries have focused on integrating government service delivery as part of their efforts to improve the outcomes from these services. Initiatives include the Blair Government's 'Joined-Up Government', the Clinton–Gore 'Reinventing Government' and subsequent reforms, and Canada's 'Getting Government Right', which involved clustering services around citizens' needs.

In Australia, more coordinated and cohesive human service delivery is being pursued in several jurisdictions. For example, in Queensland, the 'Managing for Outcomes' initiative aims to coordinate outcomes and outputs across departmental boundaries. It operates under a whole-of-government strategic plan to integrate policy development, planning, implementation and evaluation, and is supported through the Office of Financial Management. In Victoria, the responsibility for most human services delivery has been brought together in one large department, which drives the integration of these services through its policy, planning and resource allocation process. In Western Australia, the number of agencies involved in human services has been reduced, cabinet committees on social policy and other related issues have been established, and a State-wide strategic plan has been developed.

NSW has encouraged agencies to work together and provided guidelines for making this happen. It has focused on a number of key social health issues, such as child protection, Aboriginal health and well-being, illicit drugs through the Drug Summit, development of local communities through Community Solutions, sexual assault, domestic violence, and early intervention through Families First.

As part of its review, IPART examined the existing mechanisms for collaboration and integration between providers of human services in NSW. It has identified a range of ways in which these mechanisms could be strengthened—including:

- improving integration and coordination mechanisms at the regional level by piloting regional human services action plans in three regions, and potentially establishing regional human services boards

- improving integration and coordination at higher levels of government by promoting strategic health reform through the relevant Cabinet Committee, to ensure whole-of-government support for coordinated services that deliver better health outcomes
- focusing integration and coordination efforts on high-priority issues, including developing effective, whole-of-government responses to mental health problems, improving transport access to health services, and better coordinating community health and post-acute care services across government agencies
- reviewing the Department's regulatory role for nursing homes to determine whether there should be a collaborative approach with the Commonwealth or whether the function better sits with the Department of Ageing, Disability and Home Care.

6.1 Improve coordination at the regional level by piloting human services action plans

At the service delivery level, better integrating and coordinating human services is most likely to achieve improved client outcomes where:

- the current service system offers ineffective or limited support (eg people fall into gaps created by eligibility requirements; people with complex needs receive services from multiple agencies that are not well coordinated; the resources of individual agencies in rural areas are so small that services are restricted)
- there is evidence that prevention and early intervention strategies have positive results over a person's lifetime (eg early intervention with young families as in Families First; children with learning difficulties)
- people are involved in a life transition stage that involves a change in the nature of support services provided (eg young people leaving school and early school-leavers)
- people live in geographic areas where a large proportion of the community has low socioeconomic status and community capacity is limited (eg those targeted in Priority Regional Communities; new growth areas; rural and regional areas with poor health status).

Currently, NSW Health participates in various collaborative or partnership mechanisms involving other human service agencies. At the regional level, it belongs to the Regional Coordination Management Groups established under the authority of the Premier's Department. Within areas, many AHSs collaborate with other agencies, especially for whole-of-government programs including the response to the Drug Summit, Families First and Community Solutions.

However, while these arrangements appear to be working reasonably well, IPART believes the integration and coordination of services could be enhanced by developing regional human services action plans, and potentially establishing regional human services boards and trialling pooled funding for these services.

IPART proposes that human services action plans should be trialled in selected AHSs—for example, one rural AHS, one Sydney Metropolitan AHS, and one of the Hunter, Central Coast or the Illawarra AHSs. The action plans should be developed by regional human services groups, established with help from the local Premier's Department Regional Coordinator. The groups should comprise the local senior executives of human services agencies, including the AHS, Corrections Health Service (where applicable), transport and planning administrations, and the

Departments of Housing, Community Services, Ageing, Disability and Home Care, Police, Aboriginal Affairs and Juvenile Justice. They should also include representatives of local councils and non-government organisations.

Although considerable informal collaboration already occurs through the goodwill and commonsense of frontline staff, the development of human services action plans should enhance these staff's ability to work usefully together in delivering better service. The plans should be approved at the regional level or, if the required initiatives exceed regional delegations, by the human services CEOs.

Additional means of improving the coordination of human services include establishing formal regional human services boards and trialling the pooling of a component of agencies' funding for services and initiatives under the human services action plans. This may require the delegation of authority to this level. It would also require appropriate integration of such services with each agency's local plans.

6.2 Improve coordination at higher levels of government

Improved integration at the regional level must be supported by greater integration at the departmental and Ministerial level. At the departmental level, various CEO forums already exist, including one for Human Services. IPART believes this forum should oversee the establishment of the proposed regional human services boards outlined above.

At the Ministerial level, there is a range of Cabinet Committees that deal with human service policy areas, including Social Justice, Drugs, Community Solutions and Aboriginal Affairs. However, because health issues traverse a range of policy areas, IPART believes the most appropriate vehicle to progress strategic reform and service linkages would be an umbrella committee of Cabinet. IPART suggests that it is important that the State health plan be referred to the relevant umbrella committee of Cabinet for endorsement.

In relation to broader Government advisory committees, the principal body is the Social Justice Reference Group. IPART suggests that a member of the proposed Health Care Advisory Council should also be a member of this Reference Group, to better integrate health issues into discussions and planning on social issues generally.

6.3 Focus integration and coordination efforts on high-priority issues

IPART's review indicates that integration and coordination efforts in NSW should focus on three high-priority areas. These include developing an effective, whole-of-government response to mental health problems, improving transport access to health services, and better coordinating community health and post-acute care services across government agencies.

6.3.1 Whole-of-government response to mental health problems

Developing effective responses to the growing burden of disease related to the earlier onset and increasing prevalence of mental health problems and disorders is a responsibility for all of government and society. Meeting the many needs of the individuals concerned and their families requires collaboration within and across all government service sectors. A wide range of interventions is required, including prevention strategies (such as the promotion of mental health and well-being), early intervention strategies, treatment and rehabilitation services, and recovery or continuing care for those people with persistent problems.

There are many examples of NSW Health and other government agencies already working together at policy and operational levels on mental health issues. These include:

- the ongoing suicide prevention strategy which involves Police, and the Departments of Community Services, Education and Training, Housing and Corrective Services
- the Joint Guarantee of Service with the Department of Housing, which was recently expanded to involve additional agencies, including the Department of Community Services, Supported Accommodation Assistance Program and services, Office of Community Housing within the Department of Housing, the Aboriginal Housing Office and the Aboriginal Health and Medical Research Council
- the ongoing Memorandum of Understanding with the Police Department
- the School-Link partnership with the Department of Education and Training, which targets depression in young people.

Memoranda of understanding have been key instruments in establishing principles and broad frameworks for providing mental health services. Other successful approaches include developing protocols and pathways to care for providing mental health services that are adopted locally and adapted to local and regional needs and circumstances. The development of strong local management is also important. In the School-Link program, joint training between mental health and education staff was a key component in strengthening understanding and collaboration. These provide good examples for other efforts at collaboration at a local level.

Of particular concern is the increase in violent behaviour among people with mental disorders. In these instances, the police are often called in as the first response, and the Department of Community Services is required to intervene in particularly complex family situations. Carers are also taking much more responsibility for the direct care of people with acute and chronic mental health problems. IPART believes that in the future, the organisation and delivery of mental health services will require more formalised recognition and funding of these service providers.

6.3.2 Need for better integration and provision of transport services

During its consultations with stakeholders, IPART heard a consistent message from consumers and AHSs that transport access to health services, particularly in rural and regional areas, is critical and needs to be improved.³⁰ Many locations are not serviced by regular transport services, and there are not enough special services provided for patients without ready access to

³⁰ Both the Menadue and Sinclair reports also emphasised the importance of transport access.

transport. For example, IPART was told of elderly patients being transferred from their local hospital to another, significantly further from their home, with no provision for their return when they were discharged.

NSW Health recognises that improving non-emergency health transport services is a priority. It has allocated increased funding to transport services, and AHSs are developing innovative approaches to improving transport (see Box 6.1). However, better health-related transport services should be part of a broader approach to providing for all community transport needs. This requires funding and commitment from all related agencies including those within the transport services portfolio.

The impetus now needs to be maintained, and must be State-wide and across agencies. Bringing the human services CEOs together with the transport administration CEOs to develop regional human services action plans (see section 6.1) is a potential mechanism for delivering more and better coordinated transport services.

Box 6.1 Recent transport initiatives in NSW Health

In 2001, the Rural Health Implementation Coordination Group commissioned a discussion paper on Non-Emergency Health-Related Transport.³¹ This paper identified the key issues affecting people's ability to get to and from health facilities and roughly estimated the level of unmet demand for transport access.

As part of the Government's responses to the paper, the Minister for Health announced in December 2002 the distribution of \$2.5 million to boost health-related transport services in regional and rural AHSs. This funding is linked to the provision of an additional 20,000 passenger trips every year for people travelling to and from hospital and outpatient appointments.

AHSs that received this funding are required establish a health-related transport unit. This approach was modelled on the very successful approach used in the Illawarra AHS. However, for some areas, it may be less appropriate. For example, Far West AHS received \$160,000 in funding. If it were to establish a health-related transport unit, more than half this amount would be used to pay salary and on-costs for the unit.

Some AHSs are already exploring collaborative approaches. One rural AHS wants to establish a regular transport route along its major highways. It would prefer to pool all the money it spends on transport, including the government's most recent grant, with that spent by other agencies in the area in an effort to provide a coordinated and efficient local service.

Hunter AHS supports public transport projects that better integrate transport in the Newcastle region. This improves the viability of running shuttle bus services between public transport junctions and the AHS's major hospitals. Shuttle services could be provided by the private sector or run by the AHS itself. Ideally, these services should link with rural transport funding from the Ministry of Transport.

³¹ *Non-Emergency Health-Related Transport—Facilitating Access to Health Services in NSW*. Discussion paper prepared by Transport Planning and Management and Applied Economics for the Rural Health Implementation Coordination Group of the NSW Government Action Plan for Health.

6.3.3 Coordinate delivery of health care services across agencies

A range of agencies provides community health and post-acute care services—including Commonwealth and State Government-funded agencies, non-government organisations and private sector organisations. Anecdotal evidence suggests access to these services often depends on good fortune rather than good planning, and that the number of different agencies involved in service provision creates confusion for both patients and health professionals. One of the most common complaints is that the lack of coordination of these services means patients are subjected to multiple assessments to meet each agency's requirements, resulting in unnecessary duplication and a disrupted patient journey.

Many health systems around the world are struggling with this problem. In the United Kingdom, for example, there are plans to penalise the social service system if there is not adequate post-acute care available for an elderly patient who is ready for discharge. The aim is to create stronger incentives for adequate resourcing and coordination of community services. However, IPART notes that it is easier to apply this kind of incentive-based approach in the UK because there are fewer separate organisations providing the services.

In NSW, the Models of Care clinicians group established under GAP has made discharge planning a major focus. Discharge planning involves developing an individual plan for each patient about to be discharged from hospital. Discharge planning can improve the experience of individual patients and their health outcomes. They can also improve the efficiency of the health system by preventing readmissions and reducing duplication of patient assessments.

The Models of Care group has developed a draft framework for discharge planning in NSW Health, which is currently being implemented across AHSs through the Institute of Clinical Effectiveness. The framework now needs to be supported, by improving the accessibility and coordination of community health services.

AHSs need to work collaboratively with community health service providers operating within their boundaries to promote awareness of the available services and to facilitate coordinated services. Some have already begun to do so, and their success shows the benefits of facilitating community involvement and of community-driven initiatives (see Box 6.2).

For other AHSs, the first step might be to facilitate a high-level audit of local community and post-acute care services to determine what services are available and identify gaps. Collaboration between the service providers could help each provider define its role and develop agreements with others to ensure coordinated care. The proposed regional human services action plans could be an effective mechanism for this work.

Ultimately, there should be fundamental reform of the sector to reduce the number of separate bodies providing services and to improve equity of access. This should be considered as part of the national inquiry into the future of health care in Australia, outlined in Chapter 2.

Box 6.2 Community-driven initiatives in post-acute care

Mid North Coast

Representatives of the Mid North Coast Consumer and Community Health Forums told IPART how individuals on the forum had improved patient support and discharge planning by involving volunteers in this process. For example, Meals on Wheels now provides breakfast packs to patients discharged late in the day and who don't have the capacity to shop and prepare food when they return home. It also provides regular meal services to the patient in their home from the following day until they are better able to care for themselves. The local Legacy group for war widows has also taken an active role in coordinating support services for its members when they are discharged from hospitals, but it doesn't have the resources to provide the services to a wider group.

Darlinghurst Community Health Centre post-acute care team

Darlinghurst Community Health Centre has established a small post-acute care team, whose focus is to provide short-term post-acute care to patients while they recover or until longer-term access to other services, such as Home and Community Care (HACC), for which there are often waiting lists, can be arranged.

Team members visit the ED of St Vincent's hospital each day and identify patients likely to need support following discharge. Social workers and others at the local hospitals also refer cases to the team. It is not uncommon for patient discharge to be delayed because the small team doesn't have the capacity to provide additional services.

The team believes that operating from a community health centre rather than the hospital enables them to better coordinate with other community health services and maintain a broad range of skills at the centre.

6.4 Review the Department's involvement in the regulation of aged care services

The Department retains a regulatory role in aged care. There is some sense in this, as the interface between aged care facilities and hospitals is important, and close relationships between them supports the provision of a continuum of care. However, no other state has maintained this function, since the Commonwealth has primary responsibility for funding and regulating nursing homes.

IPART believes the Department's role in regulating aged care facilities should be reviewed, to ensure that it is not duplicating the role of the Commonwealth. If the function is retained, a collaborative arrangement with the Commonwealth should be brokered that ensures that the State role adds value. Consideration should also be given to whether this function is more appropriately located in the Department of Ageing, Disability and Home Care.

Recommendations

- 20 The coordinated human service approach should be strengthened through the trialling and subsequent evaluation of regional Human Services Action Plans developed through Regional Services Boards in three AHSs. This could be further progressed by other mechanisms developed through Regional Services Boards such as a pooled regional funding approach.
- 21 NSW Health should progress strategic reform of the health system and stronger linkages with other government objectives through the relevant committee of Cabinet.
- 22 A CEOs group of Premier's, The Cabinet Office, Health, Community Services, Police, Corrective Services, Juvenile Justice, and Disability, Ageing and Home Care and other relevant agencies should oversee the development of a cross-departmental strategy for mental health.
- 23 NSW Health should review its regulatory function in aged care with the purpose of minimising duplication of the Commonwealth's role. If the function is to be retained, NSW Health should consider whether it is more appropriately located within the Department of Ageing, Disability and Home Care.

7 Stronger structures for clinician and community participation

One of the great strengths of NSW Health's reform process since 1999, and in particular the implementation of the Government Action Plan for Health (GAP), has been the participation of clinicians and consumers in the reform agenda. NSW Health established structures that brought together doctors, nurses and allied health professionals across AHS boundaries, to influence clinical practice at the point of care. Many AHSs also established effective structures to facilitate community consultation.

Almost all the stakeholders IPART consulted observed that this was a substantial change from the recent past, when the Department was seen as not consulting with or listening to active clinicians or the community. It is important that this change be reinforced and built into the culture and structures of the NSW health system.

However, it is also important to recognise and address the weaknesses of the current structures for clinician participation and community governance. For example, many stakeholders believe the peak clinical advisory group, the Clinical Council, has too narrow a role and is not sufficiently integrated with NSW Health's policy process to properly guide future directions in health care in NSW. In addition, many are concerned that the structures created to provide clinician input and leadership to the improvement of acute specialty services in the Sydney region have resulted in parallel planning and funding processes. This confuses accountabilities for the performance of services and their funding, and impacts on budgets and priorities.

Further, there are concerns about the balance between community and clinician input. Consumers and community representatives feel that the current structures are biased towards medical clinicians, while some clinicians are not convinced of the benefits of consumer involvement. Several community organisations also argue that in many respects the changes implemented over the past three years have remained too focused on acute care services, and continue to reflect the traditional organisation of health services around speciality and sub-speciality disciplines.

IPART believes the success of the ongoing reform agenda for the health system depends on the involvement of clinicians, the community and NSW Health managers—working together effectively to lead and implement change. As discussed in Chapters 3 and 4, the system is under mounting pressure—especially from rising costs due to changes in the demographic and illness profile of the community, advances in medical technology, and rising community expectations. This pressure means that health care services will almost certainly need to change in the medium to longer term.

IPART envisages that over the medium to long term major structural change will be required to the role of hospitals, private health providers, community services and support for the aged. Hospitals will increasingly become centres for high dependency care and specialisation and there will be a pronounced shift from acute hospital care to community and domiciliary services and improved interfaces between acute and residential aged care. Further, the health system will need to be reorganised to provide coordinated health care programs designed around patient care needs, and not according to the traditions or preferences of clinicians and administrators.

This change process must be led by clinicians with the active participation of the broader community, to ensure that patient and community interests are properly understood and remain the focus of reforms. If it is not, the changes that are essential for a sustainable and quality-based health care system may be misunderstood by the community—or even rejected.

NSW Health needs to build on the existing structures for clinician and community involvement, to better integrate and embed the role of clinicians and the community into the system. In particular, IPART believes it should:

- establish a new peak advisory body, the Health Care Advisory Council (HCAC), to replace the Clinical Council. The HCAC should have a wider role and be more integrated with policy processes and other key groups within NSW Health
- strengthen and streamline the other structures for clinician input to and leadership of planning and related processes, by replacing the current specialist clinical and other groups with eleven Health Priority Taskforces. The clinical co-chairs of these groups should also be part-time members of the Department and members of the new HCAC
- supplement the community input provided through the HCAC with new community consultative mechanisms at the Area level, supported by better community participation processes.

7.1 Establish new Health Care Advisory Council with a wider, more integrated role

As part of the process for implementing the GAP, NSW Health established the Clinical Council as the peak advisory group for the Director-General. This council includes representatives from clinicians (doctors, nurses and allied health professionals), the community and the Department. Its primary roles are to:

- coordinate and monitor implementation of the GAP
- oversee the work of the clinical implementation and community participation groups
- foster collaboration between clinicians, consumers, health managers and the Department.

IPART believes that this key body for clinician and community involvement should be re-invigorated and strengthened by replacing it with a new Health Care Advisory Council (HCAC). The HCAC should have a wider role than the Clinical Council and be more closely integrated with NSW Health's policy development processes and with other key advisory groups, such as the proposed Institute to Promote Patient Care (ICE-PC, see Chapter 5).

The HCAC's role would be to:

- assist and advise the Department in the development and ongoing refinement of its long-term health plan
- advise the Department and the Minister on clinical and health issues including innovative service delivery models, health care standards and the results of performance measurement and reporting
- review and provide advice on the proposals on quality of care guidelines and systems developed by the ICE-PC

Stronger structures for clinician and community participation

- initiate and evaluate policy ideas for the Department to consider including in the overall plans it submits to the Minister for approval and Department funding.

The HCAC should provide an annual report to the Minister. The HCAC's membership should include a wide representation of stakeholders—covering community and patient representatives and providing expertise in quality. For example, it should include the Chair of the proposed ICE-PC; senior practising clinicians including all the clinical co-chairs of the proposed Health Priority Taskforces (see section 7.2); public health experts covering both population and community health; GPs; some AHS CEOs and board chairs, and the chairs of the key advisory groups such as the Health Participation Council. IPART envisages that this will make the new HCAC roughly the same size as the current Clinical Council.

The HCAC should have one independent Chair, with two Deputy Chairs (one of whom is an active clinician and the other a community representative). The Chair should be a part-time member of the Department on an ex-officio basis.

7.2 Establish 11 Health Priority Taskforces, to strengthen and streamline other structures for clinician input

In addition to the Clinical Council, NSW Health established a range of groups to provide clinician input to and leadership of the change process. These include:

- Implementation Coordination Groups (ICGs) that focus on particular areas of care—including aged care, chronic care, intensive care, emergency departments and mental health—and are represented on the Clinical Council.
- Groups that work across clinical streams and focus on particular issues, including models of care, consumer and community participation, information management, greater metropolitan services, rural services, funding models and teaching and research.
- The Greater Metropolitan Transition Taskforce (GMTT), which provides leadership on the implementation of the report of the Greater Metropolitan Services Implementation Group.

Most stakeholders agree that these groups have been successful in facilitating the involvement and leadership of clinicians in the reform agenda. They have also enabled much greater interaction between clinicians and the NSW Health administration, at both Departmental and AHS levels. For example, the ICGs have delivered clinical leadership and brought together clinicians across AHS boundaries to influence clinical practice at the point of care. This could never have been achieved by the Department or AHS administrations alone. A number of clinical co-chairs have taken up part-time appointments with the Department and are providing up-to-date advice on key clinical areas.

However, most stakeholders also see these groups as a stepping stone towards improved structures and a more mature environment for clinician involvement into the future. Based on its review, IPART believes that NSW Health can create a stronger and more mature environment by replacing the current specialist clinical and other groups (including the GMTT) with 11 Health Priority Taskforces (HPTs).

These HPTs will be the vanguard for the development and implementation of new policy directions and service delivery improvements in each of the high priority areas for the NSW health system, including:

- workforce development
- aged and continuing care (care of older people, chronic care, community health, primary health care and post-acute care)
- indigenous health
- public health
- maternity and child health
- rural health
- acute medical and surgical services
- critical care services (intensive care, emergency and trauma)
- cancer (through the NSW Cancer Institute)
- mental health
- information management and technology.

Together with the HCAC, these taskforces will provide a valuable channel for the thoughts and opinions of the community and clinicians on the ground—an essential touchstone for the Minister, Director-General and the Department of Health. They should be established and report through the HCAC. They should include community representatives, clinicians, AHS CEOs and Departmental staff. The clinician co-chair for each HPT should be a member of the HCAC.

The number and focus of the HPTs will not necessarily remain static—the Department should continue to work with the community, clinicians, and AHS managers and staff to identify the key health priority areas. Its role should also be to champion the interests of patients and communities across the State by providing policy development, logistics and secretariat support to the work of the HCAC and the HPTs. This may involve a reorganisation of sections of the Department to provide greater focus on key priority areas.

In addition, the Department should continue to appoint senior practising clinicians and community representatives to its staff, to provide direction and leadership in the formulation of priorities and policy at a State-wide level. These staff should work alongside policy makers and executive staff to set priorities for improving the NSW health care system.

Further, the Department should look for ways to help spread best practices identified by the HPTs across NSW Health. Currently this spread is often slow and ad hoc. To achieve rapid, effective service improvement, targeted expert support is needed to spread best practice and stimulate change locally. Clear guidance on the best treatments and interventions will ensure a faster, more uniform uptake of treatments that work best for patients.

7.3 Create new, Area-level community consultative mechanisms and improve community participation processes

All members of the community have a right to be involved in decisions about changes to their health care system. As taxpayers, they provide much of the money that funds the system. Individuals and community organisations also play major roles that complement and supplement the system—for example, as carers, participants in self-help groups, home care service providers, volunteers in the hospital and community settings, and transport providers.

Furthermore, NSW Health needs the community to understand why change is necessary and have a say in decision-making. While consultation may appear to be time consuming, it offers important, longer-term benefits. These include a greater degree of community ownership of the system, increased likelihood that difficult service changes will be successfully implemented and accepted by the community, and the potential to avoid certain costs.

For example, one of the major challenges for NSW Health is to work with the community to set reasonable expectations for health care services, and determine how to pay for them. Some existing expectations may have to be moderated. The Rural Health Report, for instance, has demonstrated that changes in acute care service delivery mean that NSW cannot afford to provide the range of services to each country town that were available a decade ago.

Effective community participation and consultation requires an environment that enables a more informed community discussion about what the health system can realistically achieve. This includes discussing the balance between promotion of health and treatment of illness, and the balance between hospital-based and community-based care. It also requires permanent structures for community involvement, and openness about planning and budgeting processes. This provides the certainty and information base necessary. Finally, communities must be appropriately resourced to participate effectively.

As part of its review, IPART examined the adequacy of current arrangements for consumer and community participation. It looked at the level of information available to individual consumers about local priorities, services and treatment options, and the degree to which local communities have been involved in planning and decision-making about the distribution of services. It also looked at the degree to which the broader community has been involved in the debate at the state level about setting health care priorities.

It found that while some structures have been put in place to facilitate community consultation and participation, the extent and effectiveness of these structures varies widely. In addition, community participation structures seem to be more effective in rural and regional AHSs than in the Sydney metropolitan AHSs. This possibly reflects the different characteristics of these populations and the strength of community values in rural and regional AHSs.

Some of the existing structures are very effective. For example, IPART met with members of the Health Forums established by the Mid North Coast AHS. These representatives convincingly demonstrated the benefits of community involvement and the success of the structures that have been established (see Box 7.1). Other AHSs have broadened community involvement in the development of its area health plan. For example, Illawarra AHS called for interested persons to commit to approximately three months to assist in that task.

However, the challenge now is to ensure that the most effective models are used consistently across the State. In particular, IPART believes:

- each AHS should ensure it has effective consultative arrangements to inform its board and management in developing local health priorities, especially for local health plans. These plans would include clinical and public health components
- these arrangements need to be supported by a well-resourced communications system. This should be based on a best-practice model and include a facility that enables patients and the community to offer suggestions or ideas to improve the performance of the health system
- consumers should be involved throughout the process as early as is practicable to do so, not as an afterthought or in a token manner.

The NSW Health Participation Council (HPC) was established in 2002 to advise the Minister for Health on consumer and community participation and ensure the community has an effective input to decision-making. This is an important role that should continue to be filled by the HPC.

The HPC is currently monitoring the establishment of a consistent State-wide infrastructure to ensure the development of local participation models. It is also reviewing the various existing structures and communication issues, and examining better ways to gain public input into complex policy decisions. It has already taken a number of steps, such as requiring AHSs to identify a position responsible for coordinating participation activities at the local level, and developing a training program to assist consumers and community representatives to actively participate in local and State-wide activities.

Box 7.1 Consumer and community health forums, Mid North Coast AHS

Mid North Coast AHS, in consultation with community representatives, has developed a new structure for community consultation that led to the establishment of three geographically based Consumer and Community Health Forums in 2001. Membership of the forums is open to all residents and they are self-managing, democratic and community-based. Representatives are elected by the forums and participate on all of the AHS Board sub-committees.

Some of the functions of the groups are to:

- promote public awareness of the forums, so that the members of the community can tell them their concerns
- coordinate community meetings on health concerns—for example, meetings have been held on mental health and renal issues that were widely advertised and well attended
- meet with the AHS Board four times a year to provide direct community input.

Members of the forums recognise they don't have a governance role but that they provide advice on the needs and preferences of the community.

The forums' activities can be linked directly to a range of positive outcomes, including the:

- successful lobbying of local bus companies to stop outside a hospital
- allocation of AHS resources to fund drought counsellors located at saleyards
- modifications to plans for new hospital wards
- changes to the job description for a mental health worker.

The groups are supported by a Community Liaison Officer and are provided with some funds from the AHS. Group members also have access to training opportunities including training in public speaking and interacting with the media.

Group members were positive about their contribution and appreciative of the support and opportunities provided by the AHS and led by the CEO.

Stronger structures for clinician and community participation

Recommendations

- 24 A new peak advisory body, the Health Care Advisory Council (HCAC), should be established to replace the Clinical Council.
- 25 The HCAC's key roles should be to guide the Department in the development of the State health plan and clinical guidelines, and advise the Department and the Minister on clinical and health issues. The HCAC should also be able to initiate policy ideas for consideration by the Department and the Minister.
- 26 The current specialist clinical and other groups established under the GAP process (including the GMTT) should be replaced by 11 Health Priority Taskforces (HPTs) to streamline and reinforce clinician and community input to, and leadership of, the change process commenced under GAP. The HPTs should be focused on:
 - Workforce Development
 - Aged and Continuing Care (Care of Older People, Chronic Care, Community Health, Primary Health Care and Post-acute Care)
 - Indigenous Health
 - Public Health Forum
 - Maternity and Child Health
 - Rural Health
 - Acute Medical and Surgical Services
 - Mental Health
 - Critical Care Services (Intensive Care, Emergency and Trauma)
 - Cancer (through the NSW Cancer Institute)
 - Information Management and Technology.
- 27 The clinical co-chairs of the HPTs should be part-time members of the Department and members of the HCAC.
- 28 The HPTs should report through the ICE-PC for quality issues and the HCAC for other issues.
- 29 The Department should provide support to champion the work of the HCAC and HPTs by providing policy development, logistics and secretariat support.
- 30 Each AHS should establish permanent, effective community participation arrangements to ensure the role of the community is embedded in the planning, decision-making and performance-monitoring processes within the AHS.
- 31 These arrangements should include best-practice models of community participation and communication, and AHSs should ensure they are adequately supported and resourced.

8 More equitable health outcomes and more effective funding arrangements

People living in NSW enjoy good health and have access to high standards of health care. Over the past decades, advances in care and essential services have led to increases in life expectancy and improvements in population health (see Chapter 3). However, evidence suggests that these health gains have not been equally shared across the population.

There is still a significant health gap between the people with the best health in NSW and those with the poorest health. These differences are related to socioeconomic status and level of disadvantage. For example, people from the most disadvantaged groups within our community have the highest rates of exposure to risk factors such as smoking, substance abuse, physical inactivity and poor nutrition. They also make the most use of primary and secondary health services but the least use of prevention and health promotion services. And they experience higher rates of illness and disability, and are much more likely to die prematurely than people from the least disadvantaged groups.

Three groups with lower health outcomes in NSW are indigenous people, people resident in rural and remote areas, and people with lower socioeconomic status. The link between socioeconomic status and health is discussed in Box 8.1. The difference between health outcomes for indigenous and non-indigenous people is discussed in Box 8.2.

The funding arrangements for AHSs are complex and involve a number of tools including multi-year budgets, the Resource Distribution Formula (RDF), episode funding and limited budget holding. Presently there is insufficient budget certainty as the budget periods are not adjusting for the forward years each year. The RDF is dated, which disadvantages underfunded areas. The application of episode funding is mixed and limited to only three areas of care. The trial system of intra-State budget holding is extremely complex and narrow.

IPART recognises that removing all the underlying causes of inequitable health outcomes is beyond the scope of NSW Health. However, it can strengthen its current efforts to achieve more equitable outcomes—and also help the health system achieve better value—in two important ways:

- by developing more specific strategies within its Health and Equity Statement that are more directly related to the groups with lower health outcomes in NSW
- by reforming funding arrangements to ensure the allocation of funds to AHSs is fair and reflects community needs in each area, and to improve the efficiency of the system.

IPART proposes a number of improvements to existing funding arrangements to improve equity and efficiency of the system: four-year rolling budgets; a more equitable RDF; the extended use of episode costing as a management tool; and the application of capital charging. In short, a system that delivers a better deal for patients.

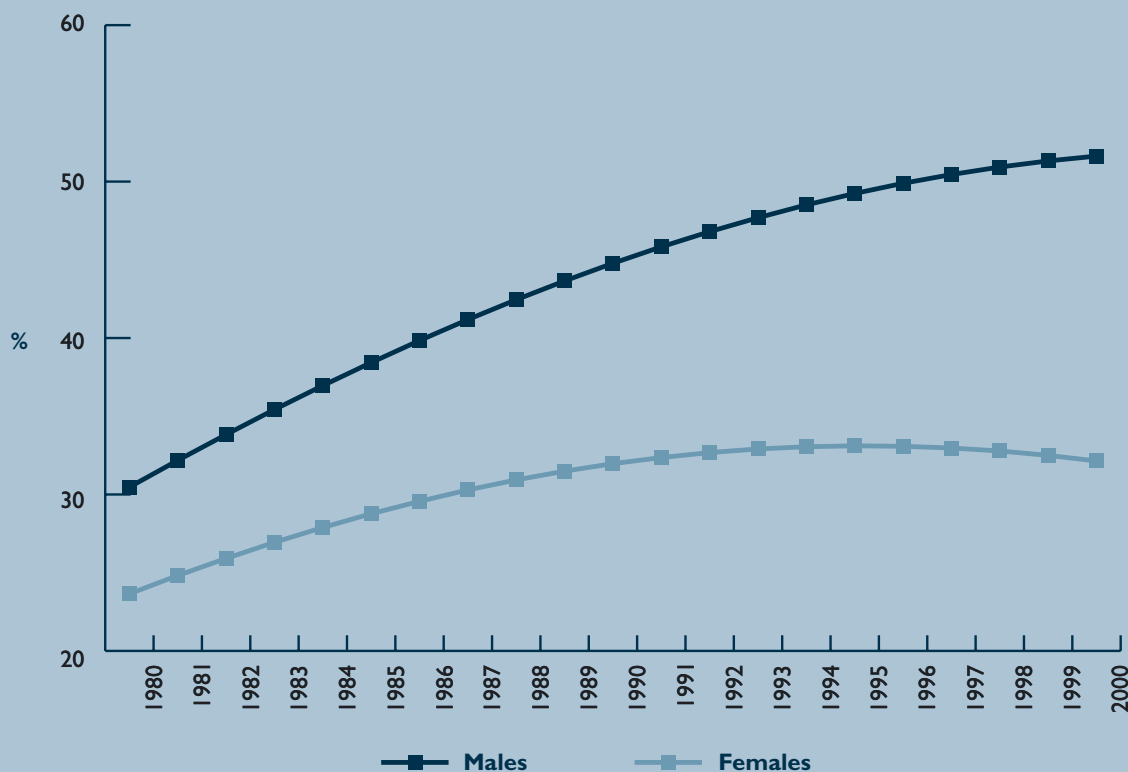
Box 8.1 Socioeconomic status and health

Socioeconomic status (SES) is a major indicator of health outcomes in all societies across the world. People from lower SES groups consistently have the worst overall health, and health status significantly improves as SES increases.

The Report of the NSW Chief Health Officer (2002) suggests that over the last two decades, the rate of health gain in NSW has been considerably greater for people in the highest SES group than for those in the lowest SES group, and for the rest of the population.

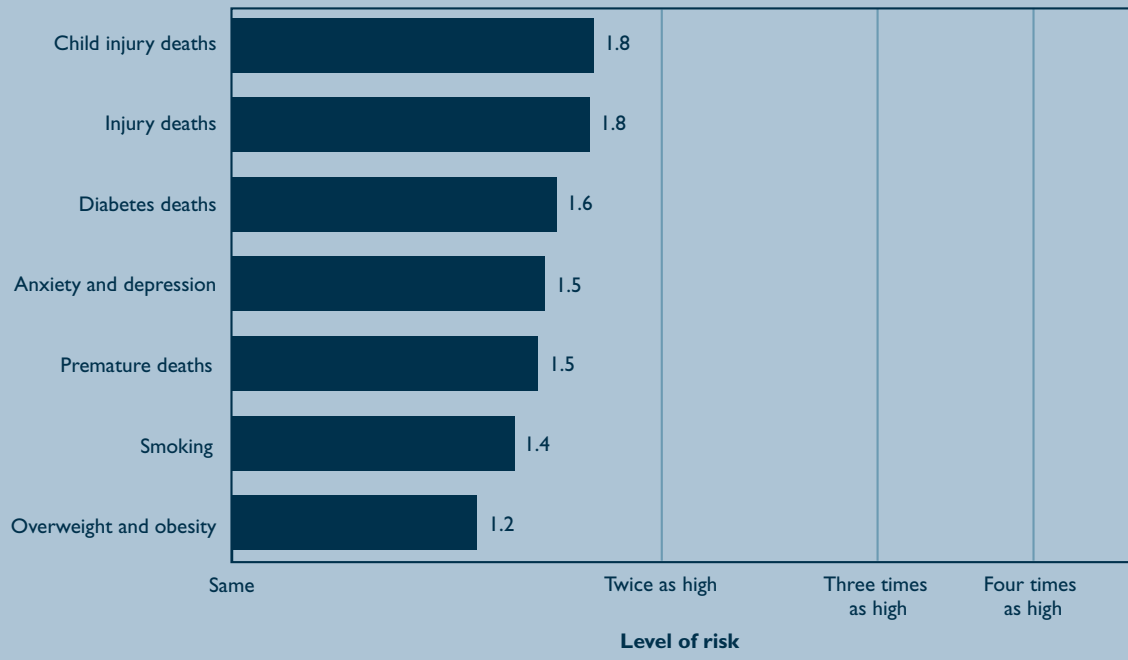
Between 1980 and 2000, the percentage difference in premature death rates for the highest and the lowest SES groups increased for both males and females (Figure 8.1). The gap for males has increased more than the gap for females. In 1980, the premature death rate in the lowest SES group was 24 per cent higher for females and 30 per cent higher for males than in the highest SES group. By 2000, these rates had increased to 32 per cent higher for females and 52 per cent higher for males.

Figure 8.1 Premature deaths: percentage difference between lowest and highest socioeconomic groups, NSW 1980–2000



Similarly, people in the lowest SES group have a higher prevalence of health risk factors (such as smoking and obesity) and poorer health outcomes (such as anxiety and depression) than people in the highest SES group (Figure 8.2).

Figure 8.2 Health disadvantage of lowest socioeconomic group compared with the highest for selected indicators between 1997 and 2000, NSW

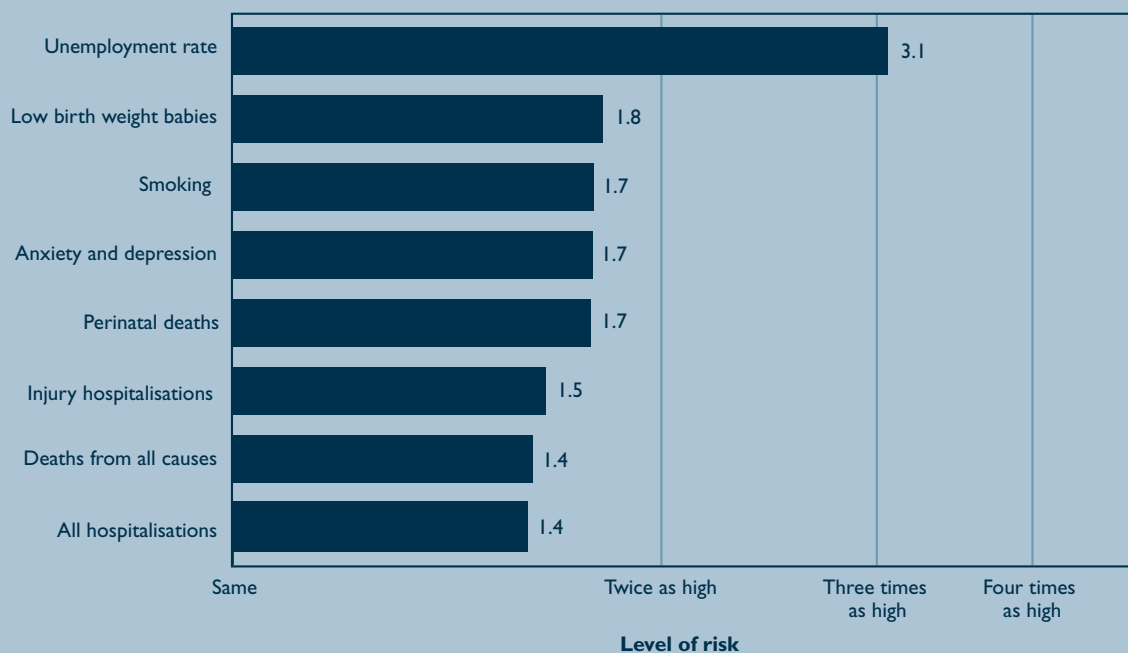


Box 8.2 Health outcomes for indigenous people

The differences in health status between indigenous and non-indigenous Australians provides the most extreme example of inequity in health outcomes across the country and within each state. Life expectancy for Aboriginal people is roughly 20 years less than for non-Aboriginal people. In 1998/99 an Aboriginal boy could expect to live on average to 56 years and an Aboriginal girl to 64 years. These figures are comparable with life expectancies experienced by the non-Aboriginal population in the early 1900s.

Indigenous people in NSW have a much higher prevalence of health risk factors (such as smoking, unemployment) and worse health outcomes (such as anxiety and depression, hospitalisation, and low birth-weight babies) than non-Aboriginal people (Figure 8.3).

Figure 8.3 Indigenous health disadvantage compared with non-indigenous, NSW, 1996–2000



8.1 Develop more specific strategies for health and equity priorities

Equity has been a guiding principle within the NSW health system for a number of years, and is currently one of its four key strategic objectives. NSW Health has developed and implemented many policies and principles aimed at reducing inequalities across a range of health issues and population groups. More recently, it has developed a Health and Equity Statement that sets out six priorities for action:

- securing good health outcomes for children at birth and throughout their lifespan, by concentrating on health care during the antenatal period and their first eight years of life by increasing the level of NSW Health's investment in the well-being of families with young children
- ensuring that people from all backgrounds can participate in decisions about their own health, and the development of health services
- developing a strong primary health care system so that everyone in NSW (including those people with the greatest needs) can easily access all parts of the health system and receive the care they require
- ensuring that the NSW health system finds better ways of working together with other Government and non-Government sectors, particularly at the regional level
- increasing the capacity of the NSW health system to address inequalities by improving systems and infrastructure, and through workforce development strategies
- ensuring that adequate resources are invested over realistic timeframes to reduce health inequalities.

IPART supports these priorities, and suggests that NSW Health further develop the Health and Equity Statement. Implementing many of the other recommendations in this report, such as those on community and clinician involvement, workforce development and integration of health services, will help to achieve its priorities. More equitable funding arrangements will also be critical. In addition, IPART believes that the Statement needs to be developed to provide specific strategies that are more directly related to specific areas of inequity, such as the health of indigenous people and remote communities. The planning process outlined in Chapter 4 should assist with this.

Of course, the goal of developing comprehensive and sustainable strategies to reduce the underlying causes of health inequalities cannot be achieved by NSW Health alone. It can only be achieved through partnership at all levels of the human service system with a range of interest groups, including local communities, other government departments and non-government organisations.

8.2 Reform funding arrangements

The NSW health system will not be able to deliver quality health care that delivers the best possible outcomes for all groups within the community unless the AHSs are funded fairly and these funds are used efficiently and effectively. At the moment, the arrangements for allocating funds to AHSs are complex, and several weaknesses make it difficult for these funds to be used as effectively as they could be.

More equitable health outcomes and more effective funding arrangements

For example, while recent reforms have increased budget certainty, the current three-year budget period still provides insufficient certainty. The Resource Distribution Formula (RDF), which provides a basis for redistributing health resources across areas to better match the projected needs of the population, is based on outdated data, which disadvantages underfunded areas. The trial intra-state budget holding is extremely complex and narrow. And the application of episode funding is mixed and limited to only three areas of care.

IPART believes NSW Health can use available health resources more efficiently, effectively and equitably by further reforming funding arrangements. In particular, it believes NSW Health should:

- increase budget certainty for AHSs by introducing four-year rolling budgets
- ensure a more equitable allocation of funds across AHSs by revising the RDF, phasing in the Department's updated version over a maximum of four years, and then updating the formula every year with new data
- allow funding to 'follow the patient' by proceeding with the Department's proposed further roll-out of an improved budget holding system
- help AHSs to better manage their services and budgets by adopting episode costing across the health system
- strengthen incentives for AHSs to seek capital efficiency by implementing the Department's policy for capital charging and exploring alternative financing tools
- address other funding issues, related to State-wide and specialty services, contingency and innovation funding, and publication of AHS budgets and outcomes.

8.2.1 Introduce four-year rolling budgets

Many of the stakeholders IPART spoke with during its consultations for this review cited the introduction of three-year budgets for the period 2000/01 to 2002/03 as one of the most important reforms NSW Health has achieved since 1999. The benefits of the greater budget certainty this change delivered were further enhanced by the availability of predictable growth funding during this period.

In combination, these benefits enabled many AHSs to develop a more rigorous and integrated approach to planning, and improved their capacity to commit to new programs and trial new ideas. For example:

- Mid North Coast AHS made mental health services the number one priority in its Area Strategic Plan 2001–2005, and used allocated growth funds to increase beds from 23 in early 2001 to a total of 70 by the end of 2002³²
- Hunter AHS redesigned its approach to delivering health care (see Box 4.2 in chapter 4).

IPART strongly supports the move to three-year budgets, which it sees as an important first step. However, two key changes are required to strengthen its application. First, the budget periods should be extended to four years. This would provide greater fiscal certainty for AHS management and planning to improve service delivery. IPART understands that the Department is pursuing this with the Treasury.

³² *Mid North Coast Area Health Service Annual Report, 2001–2002.*

Second, the static or fixed-period approach should be replaced by a rolling one. At present AHS budgets are set for a fixed three-year period, at the end of which a new three-year budget is set. Under the rolling budget approach, the budget is updated for the current year and the forward years, each year. This is similar to the present budget procedures applied by Treasury to the Department, whereby the Department receives its current-year budget and forward estimates for the following three years. Both these changes should be implemented for the 2003/04 budget year.

In addition, NSW Health should reinforce the benefits of greater budget certainty by removing financial disincentives or unexpected shocks to the system as much as possible. For example, AHSs expressed concern at three issues they believe have reduced their certainty:

- the Department's decision to set higher revenue targets in 2002/03
- the Department decision to retain some of the savings from salary packaging
- the absence of CPI indexation for AHS budgets in 2002/03.

IPART acknowledges these concerns, but also notes that the Department had reasons for each change which took into account its State-wide responsibilities. IPART accepts that budget certainty cannot be absolute—changes in budgets will inevitably be made from time to time. However, it is important that the frequency and magnitude of these changes are limited as far as possible, and that changes are made with as much consultation and notice as possible.

The Department and AHSs also need to improve the level of communication between them, so they have a better understanding of each other's position. The new Senior Executive Advisory Board should provide a vehicle for this. IPART's recommended changes to streamline the performance agreements between the Department and AHSs, and clarify their respective roles will also help (see Chapter 9). Where the Department wishes to achieve progress in specific areas, it should focus on performance and outputs/outcomes, not financial inputs.

8.2.2 Revise the Resource Distribution Formula

In NSW, the Resource Distribution Formula (RDF)³³ has guided the redistribution of health resources to better match the projected needs of the population. Its primary objective is to achieve an equitable distribution of resources that reflects the needs of each Area's population.

The RDF attempts to quantify known influences on the utilisation of health services within each Area. For example, it incorporates age/sex adjustments and several indices of health needs to reflect the impact of age, sex, mortality, socioeconomic, geographic and other factors on the use of health services and costs of providing health services. Aboriginal populations and utilisation of private hospitals are also taken into account.³⁴

In its 1998 report, IPART noted that current allocations to AHSs did not fully correspond with the RDF. IPART recommended a progressive transition toward 'live' RDF-based budget allocations. In 2000, the NSW Government committed to ensure that funding for any AHS was not below the RDF target by more than 2 per cent following three years of growth funding from 2000/01 to 2002/03.

³³ And its predecessor, the Resource Allocation Formula.

³⁴ Other issues not considered in the RDF also have an important effect on service utilisation, including funding for reform of health services, the recurrent requirements of capital works to be commissioned, and issues that may be relevant to a special project.

More equitable health outcomes and more effective funding arrangements

Over time there has been a significant improvement in the disparity between AHS allocations and the RDF, particularly for AHSs that historically received less than their fair funding share. In 2001/02, the mean distance of Areas from their RDF targets was 2.3 per cent, compared with 16.4 per cent in 1989/90.

However, this result is based on the current RDF, which is now four years old.³⁵ IPART understands the Department has recently reviewed the RDF, and has updated the basic data underlying the formula and made some other adjustments (see Box 8.3). When the updated formula is introduced, the disparity between existing funding and the new RDF targets may be greater.

IPART supports the changes proposed as a result of this review, and endorses their implementation. They are important to ensure that the recent progress is continued so that AHSs eventually receive their correct funding under the RDF. It also recognises that the new RDF may need to be phased in, to avoid sudden changes in funding in some areas. However, the phasing-in period should be no longer than four years, depending on the availability of growth funding towards transition arrangements.

In addition, it believes a number of further changes to the formula and the process through which it is applied are required. In particular:

- All information relating to the RDF should be transparent.
- The RDF should be updated each year and take into account actual and prospective flow reversals (including from capital developments).
- The Department should consider establishing a separate pool of funds to fund new services in growth and rural areas or the relocation of services from established areas. AHSs would bid for these services as advocates for their populations. The delivery of these services from the new funds would be built into an AHS's performance agreement through the setting of appropriate targets. In subsequent years, this discrete funding should be built into an Area's funding base.
- The Department should phase out the 2 per cent leeway around the RDF target, and ensure that AHSs receive their precise RDF allocation. The only exception should be for those smaller Areas already allowed to remain above their RDF target.³⁶
- The Department should continue its recent practice of subjecting the RDF to a more fundamental review—for example, every four or five years.
- The RDF for mental health should be finalised as soon as possible.

A final issue is the proposed RDF for capital. Capital allocations have generally been made on a more arbitrary basis having less regard for equity issues. This has meant some Areas have not received a fair share of funding for capital works. Allocation of capital funds based on a formula taking into account the sort of objective factors incorporated in the RDF has merit, especially for historically underfunded AHSs. However, in moving towards a capital RDF, there would need to be adjustments to the formula for historical levels of funding and for major projects that are already in progress. The Department would still approve major capital works.

³⁵ Whilst aspects of the RDF were updated internally to take account of new data, the implications of new data were not implemented in terms of funding allocations, largely because this would have compromised the commitment to budget certainty over the three years from 2000/01.

³⁶ This would be subject to smoothing to provide budget certainty.

Box 8.3 Department's review of RDF

The Department has recently completed a review of the RDF. This review has resulted in several changes. First, changes have been made to basic data underlying the formula. These include changes to population estimates and projections for each of the Area Health Services, reflecting the results of the 2001 Census, changes in patient flows between Areas, growth in the use of private hospitals by residents of the Area, changed utilisation for various age/sex groups, the impact of additional funding, particularly funding targeted at Government priorities and shifts in expenditure patterns between program areas.

Second, new methods for estimating the relative impact of existing factors considered in the RDF have been introduced. The most important of these is a revised Acute Health Need Index. Others include the methods for assessing substitutable private sector activity, taking into account inter-State patient flows, and assessing the impact of patients eligible for residential aged care.

Third, new factors incorporated into the RDF. These include a factor for small hospitals and new approaches for dealing with eligible veterans.

8.2.3 Proceed with proposed further roll-out of improved budget holding system

Patients often receive treatment outside the Areas in which they live. Such 'patient flows' are a significant part of the system. For example, in 2001/02, around 44,000 residents in the Illawarra, Central Coast, South Western Sydney and Wentworth Areas received secondary health services outside their Area. Similarly, 29,500 rural residents were treated outside of their Area. These patient flows arise for a number of reasons. For example, the hospital in another Area may be the closest hospital or their Area may not have the necessary specialist or facilities. Referral patterns of doctors are a major factor in patient flows.

The funds for treating these out-of-area patients are currently paid directly to the treating AHSs through flow adjustments in the RDF. In contrast, under a budget holding system, AHSs would be funded for all patients living within their Area. They would hold funds for services provided to patients by other AHSs, and transfer these funds to the other AHSs periodically.³⁷

The widespread adoption of budget holding would mean that funding dollars 'follow the patient' rather than the service. AHSs would be allocated funds to meet the needs of their population base, without having these funds adjusted to reflect the flow of patients to other AHSs. They could therefore focus on meeting these needs in the most efficient way—either by providing services within their Area, or 'purchasing' services from other AHSs.

One of the expectations is that budget holding would allow AHSs that currently have significant patient flows to other Areas to develop the capacity to provide more services locally and thereby reverse those flows. However, that would not necessarily occur. The ability of an AHS to provide services locally depends on more than who holds the funds—clinician referral patterns and the availability of capital facilities and workforce skills will also be factors. Adjustments to Area boundaries could reduce patient flows.

³⁷ Budget holding involves two types of funds—those related to the flow of patients to other States, and those to the flow of patients to other areas within the State. NSW Health has already devolved responsibility to AHSs for managing funds related to inter-State flows. This discussion focuses on budget holding for intra-State flows.

More equitable health outcomes and more effective funding arrangements

NSW Health has recently trialled a limited form of budget holding. This trial focused on a small number of services, worth around \$2 million of funding resources per annum. It has had limited success. One was intended to enable AHSs to develop the capacity to provide services locally, thus reversing intra-State patient flows. However, in the first year, only around 9 per cent of the targeted intra-State flow was reversed and around 50 per cent of the resources were transferred. The results improved in the second year, with 78 per cent of targeted flows projected to be reversed and 73 per cent of resources transferred.

Several weaknesses in the trialled approach to budget holding were evident. These include very complex processes for transferring funds between AHSs, with disproportionately high transaction costs, and long negotiating times.

IPART understands that the Department has developed a revised approach to budget holding, which it proposes to roll out for a wider range of services over the next five years. Under the revised approach:

- **Retrospective adjustments for most patient flows.** The RDF and Area funding will be adjusted each year to take account of changes in patient flows that occurred in the most recent period.
- **Prospective adjustments for major service change.** When significant changes in patient flows are expected—due to a major capital development, or priority issues that require a fundamental change in service delivery patterns—funding adjustments may need to occur prospectively. In these cases, Areas will need to reach agreement with flow partners and the Department on the expected number and scope of flows to be included in the prospective adjustments. Agreed flow changes were then to be built into three-year budgets for Areas, and reflected in the RDF. Actual flow changes arising from these developments will be monitored to ensure they have occurred. In addition, there will be no double counting of the impact of these developments in the retrospective adjustments proposed above.

In principle, the introduction of a purer version of budget holding and over a shorter period may provide stronger incentives to reduce flows where services can be provided locally, more efficiently and with better patient outcomes. However, there are important practical limits. As noted above, the reallocation of service provision will not be easy, even if funds are reallocated. Furthermore, the net impact on AHS budgets could be substantial. Nevertheless, IPART endorses the Department's revised approach, providing it takes every step possible to ensure the weaknesses identified in the previous trial are addressed.

8.2.4 Adopt episode costing as a management tool

With episode funding, a standard cost can be assigned to categories of procedures and related diagnostic groups across the whole health system. In the context of the NSW health system episode funding is a tool for allocation of funds received by AHS to their hospitals and other facilities. This would link the funding for an AHS's facilities to their activity levels. That is, if the facilities cost more to operate than the standard 'benchmark' cost, the AHS would provide fewer services from its allocated funding. Conversely, if the facilities perform better than the benchmark, the AHS would retain these efficiency savings and could potentially provide more services. Episode funding is difficult to apply to non-hospital services.

NSW Health introduced the concept of episode funding from July 2000, as part of the reforms flowing from the Health Council's Review. The Department issued guidelines for Areas to apply episode funding separately to acute care, emergency and intensive care procedures (except where they are provided by small hospitals). Funding consists of an activity component that is measured in case-weighted separations, an infrastructure component and an incentive component. Funds are also adjusted through transition and justification grants to smooth out the base for AHSs that might have uniquely higher cost levels.

The Department required AHSs to report on their use of the episode funding. Some AHSs are fully utilising it to fund their facilities and hold activity levels to those allowed under episode funding. Others did not report their progress to the Department, which suggests they are not using this tool. One of the non-reporting AHSs claimed it had moved to a higher-level model than episode funding.

In principle, the Department's episode funding model is very similar to case-mix funding that has been used in Victoria, South Australia and Western Australia for some time. In Victoria, the use of the casemix approach was initially tainted in the public's perception as it was introduced at the same time as significant budget cuts were imposed on the Victorian health system. However, it is now well entrenched, and is applied centrally from the Department of Human Services to the facility. It also includes a system of bonuses and penalties in relation to activity targets. It should be noted that Victoria does not have an across-the-board capitation system of funding as NSW does with its RDF approach.

IPART believes the Department should make it compulsory for all AHSs to adopt the episode costing approach as a management tool to monitor activity levels and costs in their facilities. Its main use would be to allow benchmarking between hospitals, not to determine the level of funding for these facilities. It would also be used to inform decision-making in relation to trade-offs between clinical decisions in the strategic plan. The Department should ensure a consistent costing methodology is adopted across the AHSs.

Hospital benchmarking is important to identify cost-drivers in the system. The results should be reported to the Department to enable it to monitor system-wide performance. To enforce this, the use of the episode costing approach and its reporting should be included in CEO performance agreements.

In addition, IPART believes the coverage and reliability of episode costing should be enhanced by:

- Extending episode costing and benchmarking to cover other programs. This would ensure that all program areas are being monitored. An important priority should be to extend episode costing to ambulatory services previously classified as admitted-patient services. AHSs and hospitals would need to extend the collection of patient level data.
- Improving the system-wide capacity to undertake product costing, both through information infrastructure for costing and skills development. A key priority is the selection of a clinical costing application and its implementation in order to leverage the potential to the Health Information Exchange.
- Ensuring benchmarking information is available at the clinical-unit level. While it may not always be possible, the current benchmarks produced by the Department should also be available at a clinical-unit level, to enable Areas/hospitals to benchmark at this level.

8.2.5 Capital charging and other capital funding issues

Under the current approach for funding capital projects, there is a notional zero cost of capital that effectively applies to agencies that receive contributions from the NSW Government Consolidated Fund. The Department has undertaken a pioneering role within the NSW government sector, in exploring an alternative approach based on the concept of capital charging. Under a capital charging approach, agencies would incur a charge for their capital assets. This charge would apply to land, buildings and building services, but not plant and equipment, and would be set at the Treasury 10-year bond rate.

The Department proposes to introduce the capital charging approach for AHSs, to create stronger incentives for them to seek better value in providing health care. For example, AHSs might respond by rationalising their assets to consolidate their holdings, thereby reducing their capital charge and ongoing property management issues such as maintenance. AHSs will require ongoing maintenance plans for assets they retain and will be subjected to benchmarking of maintenance expenditure. It will also impose greater financial scrutiny on AHSs' plans for new capital works.

The Department has revised its timetable for adopting its capital charging policy and is now shadowing it over the 2002/03 and 2003/04 financial years. The policy will be progressively implemented in 25 per cent increments. By 2007/08, all new capital works begun after 1 July 2001 will incur the full capital charge, while those that were begun before this date will incur 75 per cent of the capital charge.

IPART supports this approach, but suggests that the Department should further consider several implementation issues. These include:

- the need to ensure that the starting base for the policy will not unfairly penalise AHSs with a predominance of established assets that are less able to be rationalised
- the need to develop a capital RDF
- the applicability of the capital charge to third-schedule hospitals
- the incorporation of capital charging in episode costing.

In addition, IPART suggests that the health system should more fully explore using other financing tools such as Privately Financed Projects (PFP), in accordance with Government policy, which excludes clinical services from any proposal.

8.2.6 Address other funding issues

IPART has identified several other funding issues that it believes need to be addressed. These relate to State-wide and specialty services, contingency and innovation funding, and the publication of AHS budgets and outcomes.

State-wide and selected specialty services are a limited set of services that:

- provide access to populations across the State, through a single designated service or a small number of designated networked services
- provide diagnostic and treatment services of proven effectiveness

- need to achieve and maintain critical throughput thresholds, based on a demonstrated relationship between volume and patient outcomes
- involve high costs per patient.

Some but not all of these services have explicit funding arrangements. As a result, there has been inconsistent treatment of these services, relatively poor transparency in funding and limited accountability to the broader system.

NSW Health is in the process of finalising a funding policy for these services. The policy proposes to:

- create a clear process for identifying and agreeing to State-wide and selected specialty services in the Department's allocations to AHSs
- make the allocation of funding from the Department to AHSs and from AHSs to the designated services transparent
- develop service agreements for these services that specify agreed targets and address other issues.

IPART believes the Department should continue the system of State-wide program funding, but on a more restricted basis, limiting its application to a maximum of four years. It should also finalise its funding policy for these services, and progressively implement it from July 2003. In addition, service agreements should be output- or outcome-based, to ensure accountability.

IPART also has some suggestions on other aspects of funding to improve the efficiency, effectiveness and equity of these arrangements. These include that:

- The Department should retain a pool of contingency funding for the system, in a similar manner to the Treasurer's Advance for the State Budget to provide flexibility for changed circumstances.
- The Department should establish an innovation fund for trialling new ideas and rewarding performance. This could include a system of better-practice grants operating similarly to previous schemes. The thrust of this fund is to advance reforms to the system.
- The Government should continue to publish the budgets for AHSs in a comparable form, as it did in the 2003–2004 Budget Papers, and extend this approach by also publishing the AHSs' previous year's budget estimates, the budget outcome for that year and the coming year's budget estimates. This should also apply to the statutory corporations.

More equitable health outcomes and more effective funding arrangements

Recommendations

- 32 The current system of three-year budgets should be extended to four-year rolling budgets to give greater budget certainty to the AHSs.
- 33 The Department's recently revised Resource Distribution Formula (RDF) should be phased in over a period of four years or less, depending on the availability of growth funds for use as transition funding to ease the adjustment process.
- 34 The current 2 per cent allowance under the actual RDF share should be phased out so that underfunded AHSs receive their true RDF share.
- 35 The RDF should be updated each year, taking into account actual and prospective flow reversals.
- 36 The actual formula for the RDF, as opposed to data input, should be subjected to a fundamental review at least every four years.
- 37 The Department should consider providing a pool of growth funds to further enhance the provision of services closer to the patient to enable services to be established or relocated to growth and rural areas.
- 38 The mental health RDF should be implemented as soon as possible.
- 39 The Department's proposed further roll-out of budget holding should proceed, providing that the weaknesses in the initial phase are addressed, to achieve the desired outcome for the populations of each Area.
- 40 The episode costing system should be mandatory for all AHSs and be fully adopted across the health system for appropriate services as the means by which AHSs can manage their services and budgets.
- 41 The Department should implement its policy for capital charging in line with its proposed timetable.
- 42 NSW Health should fully explore the use of PFPs in funding and delivering their capital projects.
- 43 In relation to State-wide services, the Department should:
 - continue the system of State-wide program funding but on a restricted basis, limiting its application to a maximum of four years
 - finalise the State-wide and selected speciality funding policy, to be progressively implemented from July 2003. Funding under this policy should be transparent and be accompanied with output-based or outcome-based performance agreements to ensure accountability.
- 44 The Department should retain a pool of contingency funding each year similar to the Treasurer's Advance for the whole general government sector.
- 45 The Department should establish an Innovation Fund to advance clinical and corporate reforms to the system.
- 46 AHS and statutory corporation budgets and their outcomes should be published each year.

9 Better performance through clearer roles and accountabilities

IPART's 1998 review found that NSW Health's corporate governance suffered from a lack of clarity in the respective roles of the Department and the AHSs, and that this was a significant barrier to better health outcomes. The current review found that little has been done to clarify these roles, and action to do so is urgently required.

Nearly all the stakeholders consulted identified corporate governance as a key area needing reform. Many complained that the roles and responsibilities of each part of the NSW health system are not clearly delineated or, if they are, that the delineation is not clear to those 'on the ground'. For example, the Department is seen as infringing unnecessarily on the autonomy of AHSs, while some AHSs are seen as not complying with their obligations to the Department. The establishment of separate decision-making and funding processes has exacerbated this problem.

To address these issues, IPART believes that the corporate governance structures need to be strengthened by improving the existing AHS model.³⁸ Alternative approaches that involve dismantling the Area structure would be too disruptive, especially when the system is still undergoing major change as a consequence of the GAP. Further, overseas experience suggests that more radical change will not necessarily work, and the longer time required for implementation will slow progress on clinical and other reforms already underway.

IPART believes NSW Health needs to make four main changes to strengthen its corporate governance model, including:

- refocusing the Department's roles on strategic planning, policy setting and supra-Area responsibilities, so it can provide stronger overall leadership for the health system
- making AHSs more accountable for meeting the health needs of their Area, including introducing a system of incentives and sanctions tied to their performance under simpler and clearer performance agreements
- making the statutory corporations and other health entities more accountable
- improving procedures for Ambulance Service and better integrating ambulances and hospital emergency departments.

Each of these changes is discussed in more detail below. In many respects, they echo recommendations from IPART's 1998 review. While IPART understands that NSW Health has not acted on these earlier recommendations largely because of its focus on implementing GAP, it believes the changes now need to be implemented as a matter of urgency. NSW Health should begin implementing them immediately.

³⁸ IPART reached a similar conclusion in its 1998 review, when it recommended that, to improve corporate governance, the relationship between the Department and the AHSs be reformed and their roles more clearly defined. It identified a number of options for reforming this relationship, and recommended the AHS model be retained, but with a modified structure. Its reasons for preferring this option are summarised in Attachment 4.

9.1 Refocus the Department's role on strategic planning and policy setting

In the last three years, the Department has grown significantly, and its role has expanded to include operational aspects traditionally the responsibility of AHSs. IPART believes the Department's proper role is to provide leadership and set strategic directions for the components of NSW Health, not to operate them. It therefore needs to refocus its role on this high-level leadership.³⁹

On occasions, leadership will involve mandating frameworks—such as the recent guidelines on the use of drugs in cancer treatment, and the targets for day-of-surgery admission and day-only surgery. Many stakeholders consider these latter two examples to be good central management: they were appropriate matters for mandating, with the framework developed by the Department focused on establishing the outcomes to be achieved rather than prescribing how to do so. The AHSs were then able to develop their own approaches for achieving these outcomes and, in general, have succeeded in doing so in a relatively short time.

IPART endorses this approach, which could be termed 'flexible mandating'. It is not incompatible with more autonomous AHSs. The Department needs the power to mandate a State-wide approach to specific issues to improve the overall performance of the State's health system. However, it must use this power selectively, and ensure it does not lead to an ever-expanding role for the centre.

IPART envisages that in some cases, the Department will develop these frameworks in consultation with other stakeholders, and apply clear sunset or review provisions. In others, it may identify broad strategic directions only, which can then be cascaded down to metropolitan or rural plans, and Area plans.

Either way, the AHSs will be responsible for implementing the framework, preferably in the manner they determine to be most appropriate to their Area, to achieve the desired outcome. The Department will hold them accountable by monitoring their performance, and applying sanctions if the outcomes are not achieved. It is important this circular path is adhered to, as all components are integral to the effective delivery of policy.

To effectively perform the leadership role, the Department should focus on five key areas. These include: State-wide planning, direction-setting and guidance; State-wide health issues; strategic financial and asset management; industrial relations; and strategic performance measurement and monitoring. It also needs to restructure its organisation to reflect its sharper focus.

9.1.1 State-wide planning, direction-setting and guidance

Planning, direction-setting and guidance is a fundamental part of the Department's role. It includes undertaking high-level, State-wide scenario planning to develop a medium- to longer-term vision for the health system, and a State health plan that sets the strategic direction for all levels of the system, including funding and service development. (The framework and processes for this high-level planning are set out in Chapter 4.)

³⁹ The approach in this report is in line with the WHO's 2000 report and its discussion on stewardship. The role IPART recommends for the Department fits very well with the philosophy of 'row less and steer more'.

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In addition, it includes:

- developing greater metropolitan and rural plans within the State health plan
- ensuring a strong focus on public health within plans, especially early intervention and prevention strategies
- determining which services should be managed centrally as State-wide services, in the context of the State health plan and in consultation with AHSs and clinicians
- cross-referencing the overarching strategic plans with relevant resource plans, for example for assets, human resources and information technology
- promoting risk management across the system
- if requested, providing guidance and support to AHSs on significant management and implementation issues
- providing advice to the Minister on health policy and legislative issues, and advocating reform of health law.

Although the Department must be clearly responsible for and accountable for setting State-wide directions through planning, it must involve AHSs, clinicians and the community in its planning and policy development processes. This involvement must go beyond consultation to enable clinicians to provide guidance and leadership as appropriate. By actively engaging these groups, the Department can ensure that its policies and decisions draw on the different expertise and perspectives of key stakeholders, and that these stakeholders feel some ownership of policies and decisions. This will be particularly important where the Department adopts a flexible mandating approach.

To provide an effective mechanism for AHS involvement and input, IPART believes the Department should strengthen and reconfigure the Senior Executive Forum (SEF) as a Senior Executive Advisory Board. This non-statutory board would comprise the Director-General, the Deputy positions, the Chief Finance Officer, and the CEOs of the Areas and statutory corporations, and would enable a more cooperative management approach. It would focus on providing input into system-wide matters, as opposed to being a forum for discussion. Although the Department would ultimately make the higher-level decisions (subject to Ministerial approval where required), this board's deliberations would assist in formulating final decisions—for example, on policies related to information technology, industrial relations and budget scenarios.

In addition, the Department should establish a forum that includes the chairs of all Area boards (and statutory corporations), to meet regularly with the Department's executive and the Minister. This forum is properly a management concern for the Department and it should replace the current forum arranged by the Health Services Association.

The key mechanisms for clinician and community involvement in planning and direction-setting should be the new Health Care Advisory Council and Health Priority taskforces (outlined in Chapter 7).

IPART considered the extent to which the Department should be involved in approving AHS plans. This approval process can take a significant period of time, and delay the implementation of the Area plans. If the Department's performance agreements with AHSs are effective and based on agreed outcomes, and it monitors these outcomes, there is less need to approve local plans. However, it should approve any major capital works that underpin the plan.

The AHS should be required to prepare strategic Area health plans that must be consistent with:

- the Department's performance agreement with the Area
- the State health plan, clinical guidelines and State-wide or regional policies determined by the Department
- four-year rolling budgets and approved capital works programs.

These will set clear, firm limits on the AHS strategic plans. The Department will receive copies of the plans and review the plans for consistency with the requirements set out above. This would be undertaken to an agreed timetable and process. Where the Department identifies an inconsistency it must notify the AHS and require resubmission of a complying plan.

The Minister would retain the ability to direct an AHS (or the Department) in the case of potential serious issues with the planning or delivery of Health Services. However, the structures proposed in this report are aimed at reducing the need for such interventions and increasing the accountability of the Department and AHSs.

Where certain services are nominated as priority initiatives for central management and funding review a period of no more than four years should be specified. After this review, the AHS where the service is located may take over its management and its separate funding pool rolled into the AHS's funding base. This is designed to prevent the gradual expansion of the number of centrally-managed services.

9.1.2 State-wide primary health care issues

Another major part of the Department's role is leading the health system's response to State-wide public health issues. Primary health care includes population and community health, and encompasses a broad range of issues. For example, managing these issues includes limiting the spread of communicable diseases, such as SARS, as soon as a new outbreak occurs, and developing ongoing and long-term plans to contain their spread. It involves promoting better health practices by the community, such as improving nutrition and exercise levels, and reducing the use of tobacco, drugs and alcohol. And it includes providing care outside hospitals, such as in community health centres or by post-acute care teams visiting patients in their homes.

The Department should be responsible for:

- developing State-wide strategies, plans and processes for primary, public and community health
- delivering State-wide public health services, such as anti-smoking advertising, legislative responses to smoking and substance abuse
- ensuring AHSs develop plans for public and community health consistent with the overall State health plan

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- agreeing output/outcome-based targets for public and community health programs with the AHSs and monitoring performance against these targets.

These roles are consistent with the overall allocation of responsibilities between the Department and AHSs. The key difference is that, in relation to public health, the Department is directly responsible for delivering some health services.

9.1.3 Strategic financial and asset management

The Department's third major area of responsibility is strategic financial and asset management. This includes financial reporting and monitoring, the overall budget framework, funding mechanisms (such as the RDF, episode funding, budget holding and capital charging) and asset management.

The Department should be responsible for:

- developing funding mechanisms and allocations that are consistent with the overall strategic direction of the State plan, and that provide appropriate incentives and accountabilities for the AHSs and service providers
- establishing monitoring and reporting mechanisms to ensure AHSs and service providers are accountable for the efficient and effective use of those funds consistent with their responsibilities.

Based on its review, IPART has recommended a range of improvements to the funding mechanisms and arrangements, which are discussed in Chapter 8.

IPART believes the Department's asset-management role would be strengthened if it were more involved in the development of capital proposals in conjunction with the AHSs. As part of a review of functions with the establishment of shared services corporation the Department should consider the transfer of responsibility for negotiating Service and Resource Allocation Agreements (SRAAs) with Treasury from the information management and technology section to the finance and business management section. This will better link the resource allocation and outcomes functions.

Finally, from time to time the Department needs to establish specific priorities and new programs to address the varying pressures on the health system. To date, this has resulted in more detailed financial monitoring of individual programs, which has increased the cost and complexity of the Department's monitoring systems with little benefit. Instead, monitoring should be output- or outcome-based and there should be an expectation that special monitoring requirements will be only temporary.

9.1.4 Industrial relations and employment issues

As deemed employer of all staff within the public health system, the Department has an overarching industrial relations role within the system. This includes developing employee relations policies—such as those for sick leave, rehabilitation, code of conduct, discipline and harassment—which need to be consistent across the system.

However, the central agencies (Treasury and the Premier's Department) have the predominant role, especially in relation to wage negotiations. This is appropriate given the potential for wage decisions to have implications for other government sectors, and for the State budget. But IPART believes these agencies should more fully involve the Department when developing sector-wide wage strategies. In turn, the Department should engage the proposed Senior Executive Advisory Board when considering the implications of these strategies for the health system, to obtain input from AHSs. Ideally, there should be provision for some flexibility in the implementation of new agreements.

The Department's role also includes coordinating system-wide workforce strategies (including the priority issue of workforce planning), and promoting excellence and innovation and State-wide training and development programs. Currently, the responsibilities for workforce issues are dispersed across three key divisions (public health, operations and policy). These should be brought together by creating a strategic workforce planning unit (see Chapter 12).

IPART supports the need for AHSs to retain an industrial relations role, to enable them to deal with issues of workforce flexibility and local conditions. However, they will need to interact with the Department on these issues, as there could be State-wide implications.

9.1.5 Strategic performance measurement and monitoring

The Department's final key area of responsibility, strategic performance measurement and monitoring, is the critical lynchpin between the Department and AHSs and other entities. This role involves:

- benchmarking of key measures of performance across States, AHSs and facilities
- monitoring a dynamic set of key performance indicators that are linked to the State plan
- monitoring the implementation of operational and strategic plans and compliance with targets and outcomes (including quality)
- investigating performance when AHSs fail to achieve targets or agreed outcomes, to hold them properly accountable.

These monitoring and inspection roles should occur in a formalised manner and the level of monitoring and inspection may vary with performance. Those AHSs and entities that do not appear to meet their targets and outcomes for some months will incur an inspection, with a full audit set in place after a certain period of failed performance. For those AHSs that do meet their financial and health outcomes, the Department should be less interventionist, with fewer reports and inspections—that is, these AHSs should enjoy a form of earned autonomy.

A policy of varying the level of performance monitoring and inspection according to past performance is consistent with regulatory and administrative best practice. It provides rewards for those who perform well, while focusing compliance efforts on areas of greatest risk. IPART has adopted this approach in its own licence compliance activities.

Controls on expenditures, such as requirements for approval of capital expenditure or new equipment could be relaxed for AHSs that out-perform expectations. The UK Government recently incorporated this approach in proposals for earned autonomy for hospitals.

9.1.6 Future scope of the Department

Many of the stakeholders IPART consulted see the Department as being too large, previously resisting outside input, prone to ‘micro-management’, and having a confusing structure. While these perceptions may be flawed, they need to be addressed.

The Department has undergone a number of restructures in recent years. In August 2000, it had 633 staff, including corporate and executive support. In January 2003, staff numbers had risen to 790. After allowing for the transfer of CEIDA, this means a net increase of over 130 positions in less than two and a half years.

Some of this growth is due to the Department taking on the central management roles for emergency department performance and winter-beds, as well as initiatives under the GAP. However, IPART believes it should significantly sharpen its organisational focus and structure.

This will involve the abolition of some positions, and staff transfers to:

- the new Health Shared Services Corporation (see Chapter 10)
- the Areas and statutory corporations, as management functions are devolved back
- other Government agencies.

IPART’s recommendations in relation to improving clinical and community governance structures (see Chapters 5 and 7) will strengthen the involvement of clinicians and the community that has been a positive feature of recent reforms. As a further step, IPART suggests that the Department establish an Innovation Exchange, to promote the sharing of new ideas and methods, whether these are developed from within parts of the system or learnt from interstate or overseas. This initiative would complement the proposed Innovation Fund outlined in Chapter 8.

To address the perception about micro-management, the Department should conduct an intensive but short review of its committees, circulars, directions and procedures—the sheer number of which creates the impression, if not the reality, of micro-management. The aim of the review should be to minimise red tape, and ‘de-clutter’ the bureaucratic infrastructure. In addition, IPART believes all new circulars should have a sunset clause as standard practice. The central agencies should also review their reporting requirements for the health system, and very likely for all government agencies.

To create a more logical structure, the Department should ensure its future structure is more functionally aligned and focused on its core functions. For example, stakeholders cited the fact that oral health promotion sits within the policy area, not public health as seems logical.

9.2 Make Area Health Services more autonomous and more accountable

AHSs are significant entities in their own right—in terms of assets, budgets, staff and services. They have their own statutory boards, whose members are now remunerated. Their CEOs are directly responsible to the Director-General and to their boards, and they are also members of these boards.

IPART's proposed model for corporate governance and funding envisages that AHSs continue to have two roles with their communities: that of purchasers of services to care for their communities, and of operators of the hospitals and other facilities that provide this care. These roles are not conflicting, but AHSs need to consider them separately and independently.

IPART proposes four measures to better distinguish AHSs' role and responsibilities from the Department's, and to improve their performance:

- creating a framework of greater autonomy for the areas, balanced with improved accountability mechanisms backed by a system of incentives and sanctions
- focusing the roles of AHS boards on corporate governance and strategic leadership, and holding them to account through improved performance agreements based on key targets and outcomes arising from the State or Area plans
- aiming to achieve a high standard of board membership through selection on merit, improved training, diverse skill mix and fewer members on most boards
- clarifying the role and accountabilities of AHS CEOs.

Each of these measures is discussed below. IPART also considered the need to reduce the number of AHSs and review their boundaries. While there is an argument for this, it believes that given its other recommendations, it would be too disruptive for the system at this time, and impede progress on other reforms. This issue is discussed in section 9.2.5.

9.2.1 Create a framework for greater autonomy and accountability

IPART believes the performance of AHSs can be improved by granting them greater autonomy as part of a package that also includes increased responsibilities and sanctions for failing to meet these responsibilities.

Under this framework, the Department would establish State-wide strategic directions through the State health plan and other policies, and set out clear outcomes and targets for each AHS in its performance agreement. AHSs would:

- have more authority in developing their Area plan (in line with the State health plan)
- have more authority in determining how to achieve the outcomes and targets in the performance agreement
- have greater roles in decision-making forums like the proposed Senior Executive Advisory Board
- be subject to fewer performance indicators at the departmental level
- receive less scrutiny if they continue to meet their performance goals.

To balance this greater autonomy, AHSs would also be more effectively held accountable for meeting their outcomes and targets. They would be accountable to the Department through its strengthened monitoring systems and to the Minister, and subject to sanctions when they significantly or consistently fail to meet their outcomes and targets.

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These sanctions could escalate from the demotion of a CEO, the dismissal of a CEO, the dismissal of a board's Chair to the ultimate sanction of the dismissal of the board by the Minister and the CEO by the Director-General. In this instance, a new board and CEO would be appointed, either immediately, or after a period with an administrator, similar to the system that applies to local councils.

9.2.2 Focus the role of AHS boards on corporate governance and leadership

During its review, IPART saw evidence of considerable variation in the current role and performance of AHS boards, particularly in relation to the abilities of current board members and the degree of leadership they provide. It concluded that these boards should be retained, but they must be reformed.

Boards should be established on the basis that their key roles are to provide corporate governance, strategic leadership and high-level expertise that may not be available within the AHS management. They should not be involved in daily management issues. Nor should they be seen as a primary or significant source of community input. Board members may well be members of the local community, but IPART believes community input to AHSs must be sought through more open, participatory models (see Chapter 7).

Several other changes should also be made:

- Performance agreements between AHS boards and the Minister should be more focused, timely and functional. Their primary purpose should be to focus on outputs (eg occasions of service) and outcomes (eg improved response times) that are linked to the Area plan.
- The conduct of the boards should be based on a best-practice model of the existing boards, especially in relation to information flows. Board members should receive initial and ongoing training. Certain boards are already following this approach.
- AHS staff should only attend board meetings while the items they are involved in are being discussed, or at the invitation of the board. A representative of the Department should be invited to regularly attend board meetings as an observer.
- Boards should be assessed and audited by the Department and by themselves annually.

9.2.3 Aim to achieve a high standard of AHS board members

Arguably, the chair and members of an AHS's board are among the key factors that determine its success. IPART believes that to ensure these boards are as effective as possible, the size of some boards should be reduced, their members should be selected on merit, and the term of members should be limited to three years.

Currently, AHSs have up to 12 members. IPART considers that smaller boards are likely to be more effective, as there is a greater chance that members will all be of the high standard required and they are likely to be more manageable. However, larger boards may be desirable in rural areas because of their size and diversity.⁴⁰ For comparison, in Victoria, the boards of metropolitan health services range from six to nine members and those of rural hospitals range from eight to twelve members.

⁴⁰ This is not to say that the members of these boards should be focusing on their local community's interests—their role is to advance the AHS's interests as a whole.

IPART believes the boards of the greater metropolitan AHSs, including the Hunter, the Illawarra and the Central Coast, should be reduced to seven members, but those of the other regional and rural AHSs should not change. Given the number of sub-committees that boards include—for example, for finance, audit, quality, appointments, IT, planning and community input⁴¹—seven seems to be the minimum practical number.

The collective skills and experience of current AHS boards vary significantly. To fulfil their functions, these boards require a high standard and mix of skills among their members. This is a significant issue for all boards. For this reason, IPART believes board members should be selected on the basis of merit, and in all cases should include a senior practising clinician. Remuneration levels may need to be reviewed in light of the increased role and responsibilities of board members.

Some current boards include members who have served for 12 years. While not wishing to reflect in any way on the individuals concerned, IPART does not believe such long terms are desirable. New board members can inject freshness and vigour into boards. It believes that terms for individual board members should be limited to three years, and that members should serve no more than two terms. To maintain continuity, members' terms could be staggered, particularly for Chairs and Deputy Chairs.

IPART considered whether the changes outlined above should be made gradually. However, as the role of AHS boards is fundamental to the reform of the health system, it believes there should be a spill of existing greater metropolitan boards as soon as practicable. To maintain a degree of continuity, up to three of the existing members could be reappointed.

9.2.4 Clarify the role and accountabilities of AHS CEOs

Currently, the AHS CEOs are also members of AHS boards. During its review, IPART noted that the relationship between CEOs and their boards varied significantly. In some areas, this relationship was very strong, and strengthened the accountability and management of both the board and the AHS. However, there is a risk that a strong CEO can dominate a board to the detriment of good governance. This risk is heightened by the fact that AHS CEOs also have strong working relationships with the Director-General of Health and the other senior executives.

IPART believes AHS CEOs should not be members of the AHS board. They should attend board meetings but not as ex-officio board members. This is not a reflection on any of the existing CEOs. Rather it aims to ensure that the respective roles of the board and the CEO are properly distinguished. A similar system applies in the Victorian health system.

IPART suggests that the chair of each AHS board and the Director-General form the basis of selection panels for CEOs. Their performance targets and outputs would be set out in performance agreements with their boards and the Director-General.

The CEO's role would include reaching performance agreements with their own facility, sector or clinical stream managers. The clinical streaming approach applies across facilities on a clinical stream such as cardiology.

⁴¹ The membership of these committees would also include individuals from outside the board.

9.2.5 The number of AHSs and boundary issues

Many stakeholders IPART spoke to during its review raised the issue of AHS numbers and boundaries. For example, many people questioned why the New Children's Hospital was not part of the Western Sydney Area Health Service. Others suggested that the Western Sydney and Wentworth AHSs should be amalgamated. Others proposed more far-reaching models, including reducing the number of AHSs covering Sydney, Central Coast and Wollongong to four.

IPART notes that most other government services in NSW divide the state into fewer service areas or agencies than NSW Health does. For example, while the Sydney metropolitan area is served by seven AHSs, it only has one entity for rail, water and sewerage services, and two for electricity. Although health is a special type of service, seven does appear to be a high number.

IPART considered the pros and cons of Area amalgamations (see Box 9.1), and the need to review AHS boundaries. It concluded that although there are some potential benefits, it would not be wise to undertake a large-scale review of boundaries while the reforms it has recommended are being implemented.

The health system has already undergone significant change since 2000, and the reforms recommended by this review will result in further substantial change. Adding an extensive review of Area boundaries and program of Area amalgamations to the reform agenda is likely to be disruptive, and negate some of the gains to be made in other parts of the system. Indeed, a degree of certainty in the overall framework for the next five years is highly desirable.

IPART believes that the Department, in consultation with the new Health Care Advisory Council, should review the number and boundaries of the AHSs in the medium term. The Tribunal considers that there is not a strong case for a system-wide boundary review at present. However, this does not preclude NSW Health considering minor changes in boundaries. Nor does it preclude it considering any 'one-off' amalgamations, such as Western Sydney and Wentworth, should the specific circumstances arise and should these be able to be done without affecting other areas.

Box 9.1 Pros and cons of Area amalgamations

IPART identified a number of potential benefits and costs associated with amalgamating AHSs across NSW. The most significant of these include:

- **Reducing inter-Area flows, and thereby reducing the need for flow-reversal strategies.** This reduction would, at least initially, be cosmetic. Flows would be reduced simply because boundaries had been removed. There would be no substantive shift in services being provided closer to a patient's home. This may change over time as the new larger Area plans its future services. However, it may also reinforce the historical concentration of services in established Areas. Existing disadvantaged Areas subsumed by the new, larger Area's structure could potentially have a diminished voice unless counterbalancing actions are taken.
- **Streamlining management structures.** Reducing the number of AHS boards and CEOs reporting to the Director-General and Minister would help to streamline management structures and enhance the quality of the pool available for these positions. However, these benefits need to be balanced against the challenge of managing a highly complex system on a larger scale for a more diverse population. There is a risk that management will be too far removed from the population to adequately address all of its needs. Particular population sub-groups may be increasingly disadvantaged, if they form smaller minorities in the new, larger Areas.

- **Strengthening clinical networking.** An Area's ability to provide patients with care close to home depends on clinicians being willing to work there. Traditionally, specialists have been concentrated in established Areas with teaching hospitals and strong links to the medical universities. Colleges, with their role in sending Registrars to particular positions, tend to reinforce this distribution pattern. These factors have resulted in a strong culture amongst medical professionals that presents barriers to a more equitable distribution of services with the ultimate impact on patients and the local communities. Area amalgamations could help to reduce these barriers by strengthening the networks that have begun to develop within and across Areas. New structures may provide the stimulus for a cultural shift from clinicians' loyalty to individual hospitals to providing services throughout a much wider geographic region across different hospitals with cross-appointments.
- **Diminishing community participation.** Community participation would not necessarily be diminished through further amalgamations. The strength of identity of local communities in a metropolitan Area is open to question and each Area spans several localities. Community allegiances probably tend to be facility-based rather than Area-based. The strength of local input may well depend more on the quality of the community participation mechanisms than the size of the Area.

9.3 Make statutory corporations and other health entities more accountable

In addition to the Department and 17 AHSs, NSW Health includes four statutory corporations—the Ambulance Service, the Corrections Health Service (CHS—see Box 9.2), the New Children's Hospital and the Institute of Clinical Excellence. IPART believes that, like the AHSs, these corporations should be more accountable, and the roles of their boards more clearly focused on corporate governance and leadership. It believes that many of the changes it proposed for AHSs should also apply to these bodies, for similar reasons to those outlined in section 1.2 above. These changes include that:

- board members be included in the process for selecting their CEOs, and that the CEOs not be members of the boards, but attend board meetings as observers only. This would properly distinguish between the board's policy role and the CEO's management role. Again this is not a reflection on existing CEOs
- a hierarchical system of performance agreements be established, similar to those for AHS boards and CEOs
- the size of the Ambulance Service Board and the CHS board be reduced to seven, as proposed for the metropolitan area health boards
- proper accountability and governance mechanisms be put in place for newly created entities, such as the Cancer Institute.

In addition, IPART believes there should be a brief review of the Probation and Parole Service to reduce the overlap of its functions with the CHS, and perhaps consolidate these functions under the CHS. The Council on the Cost and Quality of Government would be an appropriate body to conduct the review, given its program review role. The review could also examine any other instances of duplication between the CHS and other bodies in the delivery of these health services.

Specific changes proposed for the Ambulance Service are discussed in section 1.4, while those for the Institute of Clinical Excellence are covered in Chapter 5.

Box 9.2 The Corrections Health Service and the health status of its clients

Although the CHS is a health agency, its clients are primarily people involved in the justice system. It provides services to people who are within the care of the Departments of Corrective Services and Juvenile Justice. It also has a court liaison service role with the Attorney General's Department. It delivers its services through correctional centres, periodic detention centres, major court and police cell complexes, juvenile justice centres and drug courts.

Most of its clients are from low socioeconomic backgrounds, and many have poor mental health. The CHC provided material to IPART's review that indicates that over 78 per cent of male prisoners and 90 per cent of female prisoners suffer some form of mental disorder. Compared to the general population:

- the incidence of psychosis is nearly 25 times greater among male prisoners and 37 times greater for female prisoners
- the incidence of depression is nearly five times greater for male prisoners and nearly four times greater for female prisoners
- the incidence of anxiety is nearly five times greater for male and female prisoners.

The CHC's clients also have a significantly higher incidence of drug and alcohol abuse than the general community. They also have higher rates of illnesses that are public health risks, such as hepatitis C and HIV. All these factors affect the potential to rehabilitate inmates and reduce their recidivism.

9.4 Improving procedures for ambulances and emergency patients

One of the significant challenges facing the health system, especially in the metropolitan Areas, is reducing the diversion of ambulances from hospital emergency departments (EDs) due to the unavailability of beds—known as 'access block'.

In recent years, the Department has attempted to manage access block by introducing a traffic light reporting system to monitor the daily status of EDs. This is called the Emergency Department Network Activation (EDNA). While there are now common and objective means of reporting the ED status at each hospital, this information is not networked. That is, the hospitals report to the Department and the Ambulance Service, but each hospital is not aware of the status of other hospitals, particularly neighbouring hospitals. Further, it is not clear that all periods when hospitals go on code 'red' are genuine.

The Government has recently announced a \$124 million package over four years to improve the performance of EDs. This includes rolling out Emergency Medical Units and Rapid Assessment Teams across the greater metropolitan area. The Ambulance Service has also introduced procedures to triage 000 calls—that is, to better prioritise these calls.

NSW Health is also developing a model to further improve the interaction between ambulances and EDs and thus improve ED performances. Under this model, each hospital's ED will be part of a status network, so that the Ambulance Service will be able to monitor the status of each ED, and each hospital will be able to monitor the status of the other hospitals in the network. It intends to base the new model at the Ambulance Service's Sydney Operations Centre, which would become an integrated coordination centre for ambulances and EDs.

IPART supports this model for a number of reasons:

- it will help the Ambulance Service in dispatching ambulances to minimise the diversions from 'blocked' EDs
- it will enable nearby hospitals to better support each other
- it will apply peer pressure to those hospitals that are consistently code 'red' or 'orange' to address the problem by reviewing the underlying systems in their hospital
- it is consistent with IPART's view that the Department should focus on more strategic matters, and leave operational matters such as this to the AHSs and statutory corporations
- it will provide data that can be used as a forecasting tool to predict likely pressure points in the system.

IPART believes that to operate more effectively, the new model should be managed by a new position of Coordinator of Ambulances and Emergency Care. The person who fills this position should be a senior clinician who can provide additional expertise and authority to the task. The position should be located at the Sydney Operations Centre. In some ways, this approach is analogous to the management centres that have been established to monitor the performance of the road and rail systems. The new Coordinator post is similar to the current position of Coordinator-General of Rail.

In addition, IPART suggests that funding for the new system should be coordinated by the Department, drawing on contributions from the relevant AHSs and the Ambulance Service. On a related issue, it believes that the Ambulance Service's system of charges should be reviewed to ensure a more soundly based system of pricing and hence use of ambulances. Current charges are substantially different from those in other states and may not signal the costs of these services appropriately.

In considering the overall performance of EDs, it is important to realise that improving this performance depends on more than addressing access block. The Commonwealth can have a big impact increasing the availability and affordability of GPs. Other parts of the hospital system can also help by ensuring the smooth flow of patients from EDs to wards. This also depends on their discharge practices, aged care assessment teams, post-acute care teams and other human service and non-government agencies. The Coordinator will need to work with AHSs and hospitals to ensure this occurs and encourage the dissemination of best practice.

Better performance through clearer roles and accountabilities

Recommendations

- 47 The current AHS structure should be retained but the respective roles and responsibilities of the Department and AHSs should be clarified. The Department's role should be focused on strategic planning and policy-setting roles as outlined in the report. AHSs should be made more accountable for meeting the health needs of their Areas.
- 48 The current Senior Executive Forum should be strengthened and reconfigured as a Senior Executive Advisory Board, to facilitate greater input by AHS and statutory corporation CEOs into system-wide matters, and to provide a vehicle for improving executive communication within the NSW health system.
- 49 The Department should formally establish an Area (and other entities) Chairperson's Forum that meets regularly with the departmental executive and the Minister.
- 50 The Department should conduct an efficiency review of circulars, policies, directions, procedures and committees aimed at reducing the 'red tape' in the system.
- 51 The Department should establish an Innovation Exchange to enable all components of the health system to share ideas and advance best-practice models, as a means of progressing reform in the system.
- 52 AHS strategic health plans should be submitted to the Department for review. Each AHS must develop its strategic health plan in line with the requirements of the State health plan, State-wide policies, four-year rolling budgets, approved capital projects and the targets and outcomes set out in their performance agreements with the Department. The Department should review plans for consistency with these requirements. Where an inconsistency is identified it should notify the AHS and request resubmission.
- 53 The Department should continue to approve major capital programs included in Area plans.
- 54 The role of AHS and statutory corporation boards should focus on strategic leadership, not day-to-day management. Board committees should have a similar focus and be supplemented by non-board members.
- 55 AHS and statutory corporation boards should be held accountable for the performance of their AHS via a streamlined performance agreement with the Minister, and be assessed and audited annually by the Department and by themselves.
- 56 AHS and statutory corporation board members should be chosen on merit to provide a variety of skills, and include at least one senior practising clinician. Board members should receive improved training.
- 57 The terms of AHS and statutory corporation board members should be limited to three years, and members should serve a maximum of two terms.
- 58 Remuneration levels for AHS and statutory corporation board members should be reviewed on a regular basis to reflect roles and accountabilities.

- 59 AHS and statutory corporation CEOs should no longer be members of boards, should be selected by a panel that includes the Chair of the AHS board and the Director-General, and should be subject to performance agreements with their board and the Director-General. The CEOs should have similar agreements with their facility, sectoral or clinical stream managers.
- 60 The boards of Sydney metropolitan and Hunter, Illawarra and the Central Coast AHSs should have no more than seven members and there should be a spill of existing board members. Rural AHS boards should be maintained at their current size (except that CEOs will no longer be members).
- 61 AHS and statutory corporation boards and CEOs that significantly or consistently fail to achieve the health and/or financial goals set out in their performance agreements should be subject to sanctions. The ultimate sanction should be their dismissal, in which case the board and/or CEO should be replaced.
- 62 The Probation and Parole Service should be reviewed by the Council on the Cost and Quality of Government to reduce any duplication of its functions with the Corrections Health Service (CHS).
- 63 The Department should establish a formal and integrated network between emergency departments in the metropolitan areas and the Ambulance Service, building on the Emergency Department Network Activation system.
- 64 To progress this network, the position of Coordinator of Ambulances and Emergency Care should be established. It should be filled by a senior clinician and based at the Ambulance Service's Sydney Operations Centre.
- 65 The pricing schedule of ambulance services should be reviewed to ensure more efficient use of ambulances.

10 More efficient support services

One of the key challenges facing health systems everywhere is to increase efficiency—that is, to provide more value with the same level of resources. One approach is to adopt the shared services model, which involves consolidating all corporate and other support services (such as food, linen and information technology services) in a separate entity. This entity can then achieve efficiency gains by eliminating duplication, achieving scale economies and exploiting its greater purchasing power, and thus provide services back to the rest of the health system at lower cost.

Evidence available to IPART indicates NSW Health may be able to achieve significant potential savings through consolidating corporate service functions and other support functions. Some progress is already being made, particularly through the operation of the ‘quadrangles’ (or groups of Areas). Many Area Health Services have already consolidated a number of support functions to the Area level but there is potential for more to be achieved. Functions where progress has been made include energy purchasing, fleet management, food services, telecommunications, payroll processing, tendering, warehousing and procurement.

IPART considers that this is an area where the Department should take a strong leadership role. Further gains through sharing and consolidating support activities could be achieved through the current structures but IPART considers that there is merit in establishing new structures to accelerate the progress. Among the options available are:

- establishing a Business Services and Procurement Agency within the Department to achieve system-wide savings in corporate support and purchasing, and to provide a network of operational support services hosted by an individual AHS for other common activities
- establishing a joint venture between the Department and AHSs to provide or source corporate services and other common support functions as efficiently as possible.

IPART considers that the second option provides the better long-term structure. Both structures are workable and, given the commitment from all participants and leadership by the Department, could achieve significant savings.

10.1 Current approaches to providing support services

The shared services approach is becoming accepted practice both in business, including in the health sector, and in Government, both in Australia and overseas. An example in the health field is in New Zealand where the district health boards have created five shared services entities for corporate and other shared services. Scotland has also established a Common Services Agency but this includes a number of more disparate functions than envisaged here. In 2001, Victoria established a separate entity for letting purchasing contracts, Health Purchasing, Victoria. It is established under the health services statute and is governed by a board.

Evidence available to the NSW Government indicates significant potential savings from the consolidation of corporate service activities. These include the processing components of human resources such as payroll as well as financial management such as billing, procurement, information technology systems and transport including fleet management. The Departmental Savings Taskforce has actually identified 36 corporate service functions for review and monitoring. Savings relate to reducing duplication of effort in both staff and types of product. The Government's Shared Services Committee has developed a framework for shared services and a pricing policy. Key aspects of the framework include consolidation of corporate services into major providers, better use of information technology, business process streaming and a focus on clients.

Many Area Health Services have already consolidated a number of functions to the Area level but there is potential for more to be achieved. This potential exists at both levels, with staff numbers for some functions increasing in recent years even though others have incurred a decline. The operation of the quadrangles is also making progress in this issue.

In particular, these groups are pursuing projects covering driver training, energy, water, fleet management, food services, telecommunications, learning and development, legal services, payroll processing, recruitment aspects, tendering, warehousing and procurement, which itself involved expenditure of \$1.5 billion a year in 2000/2001.

For example, in relation to:

- food services, one quadrangle group is evaluating the effect on costs and quality of adopting cook/chill food and extended life food uniformly across the facilities in that group. It is also investigating additional options for networking the supply of food to production facilities
- water and energy supplies, these are now to be advanced at the Departmental level. The Department has already established an Energy Consortium and is including water consumption into overall supply reform initiatives
- tendering and procurement, the groups are making savings by consolidating the best available contracts, aggregating purchases to achieve greater discounts, and issuing joint contracts as existing agreements expire
- learning and development services, with the establishment of a single Management Development Institute to consolidate these services in at least one group.

This aspect of the existing quadrangle groups has been very positive. However, it should have eventuated earlier. More of these functions and others now need to be further aggregated to the State level.

10.2 Options to improve the efficiency of support services

IPART examined a number of structural options for pursuing further efficiency improvements in the support services:

- working within existing structures
- using a central agency within the Department and networked business units within the AHSs
- establishing a joint venture between the Department and the AHSs to identify and pursue opportunities for joint service provision.

10.2.1 Using existing structures

This model would continue to use existing structures and mechanisms.

The Department would continue to work with AHSs on a service-by-service basis to tap economies through support services. This could involve the use of direction in regard to purchasing and administrative strategies. For example, it could involve direction in regard to the use of common IT systems and applications to facilitate sharing of information and the establishment of common information management systems. The Department could also work with the AHSs to identify opportunities for common purchasing arrangements across AHSs. An example of this could be the facilitation of a central pharmaceutical list and centralised purchasing.

AHSs would also continue to pursue opportunities to harmonise and coordinate the provision of support services through the quadrangles. Economies in pharmaceutical purchases could also be pursued through this route. Other opportunities may exist in the supply of food, linen and imaging.

The advantage of this approach is that it minimises the extent of change required. Its disadvantage is that its ad hoc nature may mean that opportunities are foregone or only taken up slowly.

10.2.2 Central agency and AHSs networks

Under this model the reforms in the delivery of corporate and operational support services would be developed and delivered through:

- a business services agency established within the Department for corporate support services appropriately delivered State-wide and including a procurement agency focused on the current supply chain reforms
- networked AHS business units that would deliver shared operational support services matched to the quadrangle groups.

This model builds upon and formalises the current approach.

The business services agency would be modelled on the current Human Services Businesslink and would be a business unit of the Health Administration Corporation under the direction of the Director-General of Health. Its scope would include payroll, billing and financial services, telecommunications, procurement and records management. This could be extended to include information systems and asset management. The existing functions of the AHSs would be consolidated into this agency.

The networked AHS business units would provide services across AHSs such as linen, pathology, food, imaging and warehousing. The AHSs' participation in this structure would be mandatory.

Compared to the existing approach this option is more likely to lead to a systematic pursuit of the opportunities available. Another advantage is that it largely uses existing organisations and structures. However, in formalising the two separate mechanisms (ie a central business agency within the Department or networked AHS business units) for pursuing opportunities for efficiencies it may reinforce the problems of duplication and artificial distinctions in the coverage of each structure. For example, because it requires a choice between one of two

mechanisms this model may ‘lock in’ such choices and hinder the evolution of the approaches to achieving efficiencies in support services. There may be less AHS ‘buy-in’ to a central business and within the Department. Also, a central business unit may contradict the recommendation to focus the Department on strategic direction.

10.2.3 Joint venture shared services corporation

Under this model a health shared services corporation would be established as a joint venture of the Department and the AHSs. Its managing board would comprise representatives of the Department and the AHSs, with the Director-General of Health its Chair. The objective of the joint venture would be to achieve efficiencies through the joint provision of corporate and other support services.

An initial set of functions would be agreed to be transferred to the joint venture at the outset. The joint venture’s first task would be to determine the most appropriate means of providing those services. The options available to the joint venture would include:

- direct provision of the service from a central source. An example might be the negotiation of an energy purchase contract
- direct provision of a service through multiple sites or subsidiaries. An example of this might be the provision of linen services
- contracting an external supplier or suppliers to provide the service—for example aspects of information management and technology.

The choice between these options should be based on the quality, cost and risks of each option to maximise the value of service provision to the Department and the AHSs. Efficiency gains would flow to the purchasers of those services through the charges for the services and be retained for the benefit of patients and the community.

There are a number of advantages of this approach over the second model. Firstly the structures and incentives are clearly aligned to the objective of maximising the efficiency gains and value from shared services. Secondly, it provides considerable flexibility in the choice of service delivery models to maximise these gains and allow for the evolution of these models. The disadvantage is that it requires the establishment of a new organisation and may be considered slightly riskier in that it locates these decisions in the one organisation. However, these apparent risks need to be considered in the context of the stronger and clearer incentives and accountabilities under this model.

IPART considers both the second and third models are workable and superior to the current model. Both can achieve significant gains with the commitment of all participants and appropriate direction from the Department. However, on balance, IPART recommends the third model, the joint venture shared services corporation. The following section outlines how this could be implemented.

10.3 The proposed shared services corporation for NSW Health

IPART recommends the establishment of a separate entity consisting of separate business operations and subsidiary companies. As part of the redefinition of the roles of the components of NSW Health, non-core corporate service functions should be shed to enable organisations to better focus on core functions and to achieve efficiencies that can fund improved services. The functions would be transferred to the new corporation. The Far West AHS should be separately considered, given its remote nature, as an alternative model involving other local agencies may be more suitable.

The new body will enable a sharper focus on this task, providing leadership to the whole system. This is consistent with NSW Government policy of shared services for 'back-office' functions adopted by Cabinet in December 2001.

The corporation is effectively owned by all sectors in the NSW health system. Certain operational roles, such as some human resource, finance and IT staff would be retained by the AHSs and statutory corporations. There would be different degrees of phasing to central services. The new corporation would also be the vehicle to establish State-wide or aggregated business operations for other health services such as linen, pathology or medical imaging, for example.

Specifically:

- The corporation would be governed by a board. The Director-General would chair the board, reflecting the coordinating role of that post. The board should consist of seven members, with four AHS or statutory corporation CEOs serving three-year terms, after which they would gradually be rotated, and two non-health members drawn from the private sector. The corporation's board would set the strategic directions for the entity.
- It is proposed the Chair have reserve powers to ensure the mandating of those services that are deemed significant does occur. The corporation should be managed by a full-time General Manager.
- Savings from the operation of the new body should be retained by the health sector under conditions formalised with Treasury to reduce future calls on the Budget. This is important to gain the 'buy-in' by the affected parties as part of the overall system of incentives that will apply in the health system in the future.
- The functions of the corporation could be a State-wide aggregation of existing Area or cross-Area operations or groups of cross-Area operations depending on the business case for each service. For process functions such as aspects of human resources, one operation would be suitable. For other business operations such as linen, it may be more appropriate to have more than one entity, although if one entity is determined it would probably operate from more than one site. It would seem sensible to learn from experiences in other agencies by locating related processing products at one site, eg the human services functions of leave and payroll.
- In aggregating functions, appropriate advisory mechanisms should be established with AHSs and also other affected parties. This includes employees and clinicians in the case of pharmaceuticals and pathology, for example. In relation to pharmaceuticals, these have been a significant cost driver with prices rising 45 per cent in the period 1996/97 to 2001/02. At present there is little aggregation at the Area level, let alone at the State level. It is appropriate for a State formulary or central list to be introduced. This would potentially enable better buying power by the system, learning from the Commonwealth experience.

- A taskforce consisting of the Department, AHSs, Premier's Department, Treasury and the Department of Commerce should be established to assist determining the functions to be transferred to the new corporation or to other Government agencies, and to progress business re-engineering in the affected fields. The precise commercial and pricing structure of the body will need assistance from the health agencies, Treasury and external commercial experts. This will involve in part determining the assets to be transferred to the new body and the means of adjusting the asset bases of the health agencies.
- The corporation should require each operational area to perform to industry benchmarks set by the corporation. The option of outsourcing services should also be examined by the corporation for each business case. In this context the current restrictions limiting contracting out or market testing for non-clinical services should be removed.

The new corporation should be established as an interim body on 1 January 2004, and as a formal entity from 1 July 2004.

10.4 Information Technology

The delivery of Information Technology will be one of the key corporate services to be centrally managed by the new corporation. In the case of Information Technology, IPART overwhelmingly supports the centrally mandated approach to apply across the health system in the context of a State integrated strategy. AHSs would still retain a role in relation the network and smaller local related systems and in the implementation of systems. The review accepts the strategic plan that has been developed by the Department after the Menadue report and the separate systems underpinning the plan. These include the following major projects:

- Patient Administration System (PAS)
- Universal Patient Identifier (UPI)
- Electronic Health Record (EHR)
- Point of Care Clinical System (POCCS)
- Community Health Information Management Environment (CHIME)
- Integrated Clinical Information Program (ICIP)
- Ambulance Electronic Patient Record (AEPR)
- Data Centres
- Patient Billing System.

The imperative is now the implementation of the strategy in a timely manner. The benefits of improved IT systems are better and more meaningful information, leading to more efficient clinical practices, improved quality and hence improved patient care and outcome as well as other operational benefits through e-procurement, for example. Mandating will assist this approach by achieving a unified and more efficient health system. It will still enable innovation such as the proposed partnership involving the New England Area Health Service, local TAFE colleges and the University of New England for a regional broadband network, linked to Sydney.

Box 10.1 New England Area Health Service

New England AHS secured a \$5.5 million Commonwealth grant from the Office of Information Technology to build broadband infrastructure across the region, linking it to Sydney. It reduced recurrent costs for the project from \$6–\$7 million to about \$600,000–\$700,000 by forming an alliance with TAFE and other major institutions in the area. It now needs to find supplementary funding from its budget, potentially with support from the Department, to implement the project. If it can, the project is expected to deliver substantial savings on travel costs, improve communication networks and enhance service delivery.

In relation to the individual systems that are being deployed under the overall IT strategic plan, the main issue is the need to expedite the roll-out of these systems. This will have two key benefits. First, the review has been advised there will be significant savings to the State Budget's capital program in rolling out, for example, the POCCS over three years rather than over a longer period. A saving of around 40 per cent has been indicated. This leads to the second point. The health system will gain improvements to clinical practices/processes and associated efficiencies flowing from standardisation and benchmarking, as well as the important benefits to patient care. The review was advised if the POCCS roll-out were accelerated, the PAS and State-wide Data Centre should also be rolled out earlier, to gain the full benefits of the POCCS.

In light of recent occurrences in other fields and new Government guidelines, Treasury and the Office of Information Technology should undertake a full reassessment of all the individual projects, and the integrated nature of the projects, to confirm the capital and system efficiencies described above. If this is confirmed, Treasury should consider increasing the cap they apply to the overall Health capital program to enable the roll-out of the key IT systems to maximise the financial, clinical and patient benefits from them.

The Corporation should also establish a commercial reference group for information technology to supplement its expertise.

Recommendations

- 66 NSW Health must ensure that the opportunity for efficiency gains, through the aggregation of corporate and shared services, are realised and used to provide better health care.
- 67 IPART considers that this can be achieved through a new body, the Health Shared Services Corporation, established to ensure that corporate and other services currently provided by the Department, AHSs and statutory corporations are managed in the most cost-effective manner. The current restrictions limiting contracting-out or market testing for clinical services should be removed.
- 68 The new corporation should be governed by a board, chaired by the Director-General, with four Area or statutory corporation CEOs and two private sector representatives. The Area and statutory corporation CEOs should be rotated approximately every three years. The corporation should be managed by a full-time General Manager.
- 69 A taskforce should be established to assist in determining the functions to be transferred to the new corporation or to other Government agencies, and to progress business re-engineering. It should consist of the Department, AHSs, statutory corporations, Premier's Department, Treasury and the Department of Commerce.
- 70 Each service should be subject to a business case to determine the best model for its provision whether as a centralised service, by a group of AHSs, or by other contractual means. Savings from the new procedures should be retained within the Health system.
- 71 The option of outsourcing services should also be examined by the corporation for each business case.
- 72 The Chair of the corporation should have reserve powers of veto to ensure the mandated approach can be applied where it is essential to the efficiency and effectiveness of the system, such as Information Technology.
- 73 Increased uniformity of Information Technology and management solutions is essential, and it is an area that requires clear direction. This should be a high priority for the new Health Shared Services Corporation.
- 74 Treasury should review the funding cap for capital to enable the Department's IT program to proceed as soon as possible, subject to final review of their business cases by Treasury and the Office of Information Technology.

II A more integrated performance measurement system

NSW Health currently collects between 500 and 1,000 indicators of the health system's performance. Approximately 125 of these are used as the basis of the budget agreement between NSW Health and Treasury. Over 80 indicators are used to measure AHSs' performance against their performance agreements with the Department.⁴²

This number alone makes it difficult for staff to understand why a particular indicator is being reported on, and who is accountable for reaching the target associated with that indicator. In addition, INSPIRIT Management Services identified a number of other concerns about the current performance measurement system,⁴³ including that:

- there is no culture within hospitals to use information to drive change
- there is little devolution of accountability and responsibility for innovation (from the Department to AHSs, and from AHSs to hospitals)
- there is no information management culture
- the use of performance indicators seems to be reactive rather than proactive.

IPART's 1998 review recommended that NSW Health report on a suite of 12 KPIs on a monthly basis. NSW Health incorporated these KPIs into its reporting requirements, but has since discontinued the use of some indicators (the scatter plot diagram, activity versus net cash targets⁴⁴) and begun to report on others annually rather than monthly.

More recently, the Department has established a Health System Performance Indicators Committee as a working group reporting to the Corporate Governance Steering Committee. This committee has reviewed the performance indicators used in the NSW health system and produced a 'management dashboard' of 20 KPIs to be used at the departmental, or State-wide level.

As part of this review, IPART assessed how NSW Health could better use performance indicators to improve health outcomes, access, quality and value for money, including reviewing this committee's findings. It believes that NSW Health should:

- develop an overall framework for its performance measurement system within which KPIs cascade from a set of high-level indicators used at the departmental level, down to lower-level indicators used at the Area, facility and ward levels, and these KPIs are clearly linked to the strategic objectives and priorities at the relevant level
- adopt the Health System Performance Indicators Committee's management dashboard as the high-level indicators used at the departmental level, and require AHSs, hospital, and wards to develop their own KPIs based on those in the management dashboard
- ensure that all parts of the health system have integrated, compatible IT systems to ensure efficiently produced and timely performance data

⁴² The Health System Performance Indicator Committee, *NSW Health System Performance Indicators*, 2003.

⁴³ INSPIRIT, *Review: Using information to drive change in NSW public hospitals*, 2003.

⁴⁴ IPART, *A review of NSW Health: Report to the NSW Treasurer and the Minister of Health*, 1999.

- ensure that the performance measurement system reflects and supports the goals and allocation of responsibilities set up in the three governance structures, and includes a system of incentives and sanctions to reinforce these accountabilities.

11.1 Develop an overall framework based on strategic maps

NSW Health's performance management system needs to measure the performance of the health system at a number of levels and for a number of reasons:

- At the micro level, individual hospitals and wards should measure their performance against KPIs and report back to their AHS CEO and board. At this level, performance measurement should be used to establish accountability and drive positive change (for example, in the quality of care and in response to adverse events).
- At the next level, AHS CEOs should measure their performance against KPIs that are linked to their business plan, and report back to their board. Performance measurement at this level should be used primarily to hold CEOs accountable for meeting service standards within their Area's budget.
- Also at the Area level, AHSs should measure their performance against the targets and outcomes set out in their performance agreements with the Department. At this level, the main purpose should be to ensure that AHSs are accountable for meeting service and financial standards consistent with the AHS and State-wide plans and priorities.
- At the highest level, the Department should measure the overall performance of the health system and report to the Director-General. The KPIs used at this level should be small in number and focused on overall measures and key priority areas. The Director-General reports to the Minister, who has a stewardship role on behalf of the citizens of NSW and is ultimately accountable to the community for the performance of the health system.

The Department also has several other reporting requirements. It reports to the Commonwealth against the Australian Health Care Agreement, and to the NSW Treasury against the Service and Resource Allocation Agreement.

To be effective, NSW Health's performance measurement system needs an overall framework that integrates the KPIs used at each of these levels. One way to do this is to organise indicators in a cascading way, starting from the small number of high-level KPIs used at the departmental level. Below these KPIs—and aligned with them—there would be additional layers of indicators that provide more information about performance at the Area, facility and ward levels. This will enable NSW Health to drill down to explore why a particular high-level target has been exceeded or not achieved, and to identify centres of excellence within the health system. The alignment between the indicators used at different levels will also help all staff to understand why and how indicators are used.

In addition, the performance measurement system needs a framework that unambiguously links the KPIs used at each level to the strategic objectives and priorities for that level. These links, together with clearly defined accountabilities, will enable NSW Health to use performance indicators to assess the extent to which its strategies are achieving the desired outcomes and also to foster a culture of innovation and continuous improvement.

A more integrated performance measurement system

The Health Indicators Committee has taken a first step towards the creation of this kind of framework, by linking its proposed management dashboard of KPIs to the four strategic objectives of the NSW health system—healthier people, fairer access, quality health care, and better value. IPART believes the next steps should be to:

- consider using the balanced scorecard model to link Area and facility level performance indicators to local objectives and priorities
- involve AHSs, facilities and wards in developing the KPIs to be used at these levels and provide training and other support to ensure they can use the information to drive performance improvement
- ensure that indicators can be used to benchmark parts of the health system against each other, to drive performance improvement.

11.1.1 Consider using the balanced scorecard model

NSW Health should draw on best practice here and overseas in developing and using performance indicators. ‘Balanced scorecard’⁴⁵ approaches are often cited as providing good models and can provide a means to link the performance indicators used at AHS, facility and ward levels with State-wide and local objectives and priorities. This model would involve three components:

- a strategy map, which is a one-page visual summary of what is important and why it is important
- a balanced scorecard plan, which includes measures, strategic and annual initiatives, targets, responsibilities and time frames
- balanced scorecard results, which include measures, stretch targets and actual annual and monthly performance.

Hunter AHS is using a balanced scorecard model for its performance measurement system, and it seems to work quite well at the AHS level (see Box 11.1).

Box 11.1 Hunter AHS’s balanced scorecard model

Hunter AHS uses a balanced scorecard model to manage its services and to measure success. At the heart of its performance measurement system is a strategy map, which summarises Hunter’s priorities, based on its mission statement and vision, and states the three strategic themes necessary to achieve this mission and vision. It also identifies five areas of responsibility—community and patients, partnerships, integration and internal processes, financial accountability and people, learning and innovation.

This system helps to assign accountabilities to different levels of the organisation, and shows how the strategic themes are to be supported in the five areas. It also helps staff at Hunter to focus on the important matters and to communicate the direction the organisation is going and how it is performing.

The balanced scorecard model has been accepted very well within Hunter AHS. Staff feel that it provides them with clear directions, encourages organisational alignment, focuses on what is important, and is comprehensive and credible.

⁴⁵ Kaplan RS & Norton DP. *The balanced scorecard: Translating strategy into action*, Boston: Harvard Business School Press, 1996.

11.1.2 Involve AHSs and facilities in developing their own KPIs

To help ensure that performance measurement is used to drive performance improvement, all staff need to clearly understand why a particular performance is measured. Clearly linking KPIs to strategic objectives should make this relatively easy. However, the Department also needs to effectively communicate that the main purpose of performance measurement is to foster a culture in which information is used to drive positive change, and encourage staff buy-in and ownership of the indicators used at the AHS, facility and ward levels.

IPART believes the most effective way to do this is to closely involve AHSs, facilities, wards and even clinicians in developing the KPIs they will use. The primary reason for collecting and reporting on indicators at these levels is to help them manage effectively and meet their local objectives and priorities. These indicators should be based on the management dashboard KPIs, but should also reflect these local objectives and priorities. This will help to create a sense of ownership of the indicators among managers and clinicians, and will make it easier to get buy-in from staff.

The process of developing indicators will require strong leaders at the AHSs and facility levels. The Department should provide the designated leaders of this process with the leadership and change-management training where necessary. In addition, every AHS, facility and business unit should display their strategic maps and performance indicators where all staff members can see them, to make the indicators and their relationship to the strategic plan more transparent.

11.1.3 Ensure indicators can be used for benchmarking

Also to help ensure performance measurement can be used to drive performance improvement, indicators need to be developed in a way that allows them to be used for benchmarking. For example, a hospital that wants to improve in a particular area should be able to benchmark its performance against its peers, and seek assistance from those performing better in this area. In addition, the Department should be able to collect and compare performance indicators at the hospital level on a yearly basis. These comparisons can be conducted on a State-wide or interstate basis. This process could serve as a discussion basis for identifying changing priorities, lack in funding or other points.

11.2 Adopt the management dashboard as the high-level indicators used at departmental level

In 2003, the Department established the Health System Performance Indicators Committee as a working group reporting to the Corporate Governance Steering Committee.

The committee's purpose was to:

- review existing State, national and international resource material on health service performance
- develop a conceptual framework and draft a minimum set of health service performance indicators that:
 - can be used at both state and local level taking into account national requirements
 - require minimal or no additional data collection

A more integrated performance measurement system

- act as the technical working group for IPART's review
- provide a report including recommendations for implementation.

The committee, which comprised 26 senior executives from the Department and AHSs, produced a set of high-level indicators that align with NSW Health's four strategic objectives—healthier people, fairer access, quality health care and better value. These indicators, which have been labelled the management dashboard, also align with the six quality dimensions set out in the *Framework for Managing the Quality of Health Services in NSW* (Table 11.1).

Table 11.1 Health System Performance Indicators Committee's management dashboard indicators

KPI	Quality dimension
Healthier people	
1 Potentially avoidable deaths	Safety
2 Chronic disease risk index	Effectiveness
3 Antenatal visits before 20 weeks	Effectiveness
4 Child and adult immunisation	Effectiveness
5 Falls in older people	Effectiveness
6 Self-reported mental health	Effectiveness
Fairer access	
7 Access to emergency services	Access
8 Access to targeted treatments	Access
9 Access to hospital treatment	Access
10 Fairer distribution of funding	Access
Quality health care	
11 Safety	Safety
12 Skilled and valued workforce	Efficiency
13 Potentially avoidable hospitalisation rates	Appropriateness
14 Priority care process—stroke	Effectiveness
15 Priority care process—cancer	Effectiveness
16 Patient and consumer experience	Consumer participation
Better value	
17 Staying on budget	Efficiency
18 Maximising service output	Efficiency
19 Effective resource use	Efficiency
20 Asset utilisation	Efficiency

IPART supports the use of this high-level management dashboard of indicators at the departmental level. IPART endorses the omission of waiting list indicators from the dashboard, and the inclusion of waiting time indicators instead. Waiting lists have been used as performance indicators in the past, as they have a direct impact on the well-being of the community. However, there are several problems associated with their use. They do not necessarily give a clear indication of the performance of a particular hospital or AHS. Waiting lists are strongly influenced by GP referral patterns and post-discharge care which are outside the control of NSW Health. For these reasons, IPART believes waiting times are more appropriate for use as high-level performance indicators.

IPART also has several further suggestions in relation to the management dashboard and its use, including that:

- the management dashboard should be considered a dynamic set of indicators that changes according to NSW Health's priorities for the health system
- public health indicators should be included in the management dashboard on a rotating basis
- appropriate GP referral should be addressed through the proposed National Inquiry
- reporting performance against the management dashboard indicators should be in a simple, meaningful form, such as visual mapping
- facilities should be encouraged to start reporting publicly on patient satisfaction levels.

11.2.1 Consider the management dashboard to be dynamic

The management dashboard should not be considered as a final set of indicators. Rather, these indicators (and lower-level indicators) should be reviewed periodically, to determine if they still reflect NSW Health's strategic objectives and priorities. For example, the current priority care process indicators (stroke and cancer) focus on priorities that may change over time.

IPART also suggests that these current priority care indicators be used as a measure across the spectrum of indicators. For example, for each aspect of the dashboard (where practical), a prevalent cancer (or stroke) should be identified and analysed. This analysis starts at healthier people (eg smoking) moving through access to emergency and hospital services (urgent surgery, radiotherapy), safety aspects of care and then into assessment of effective resource use for this group of patients.

11.2.2 Public health indicators should be included on a rotating basis

One of the issues stakeholders raised with IPART during its review was the difficulty of measuring and reporting on public health indicators in a meaningful way. Most public health indicators are only meaningful if they monitored over a long time period, as the benefits of public health programs may not be evident immediately.

IPART suggests that a number of public health indicators should be included in the management dashboard on a rotating basis. This would ensure that public health is better represented on the management dashboard, and that the benefits of particular programs become more evident.

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11.2.3 Address appropriate GP referral rates through the proposed national inquiry

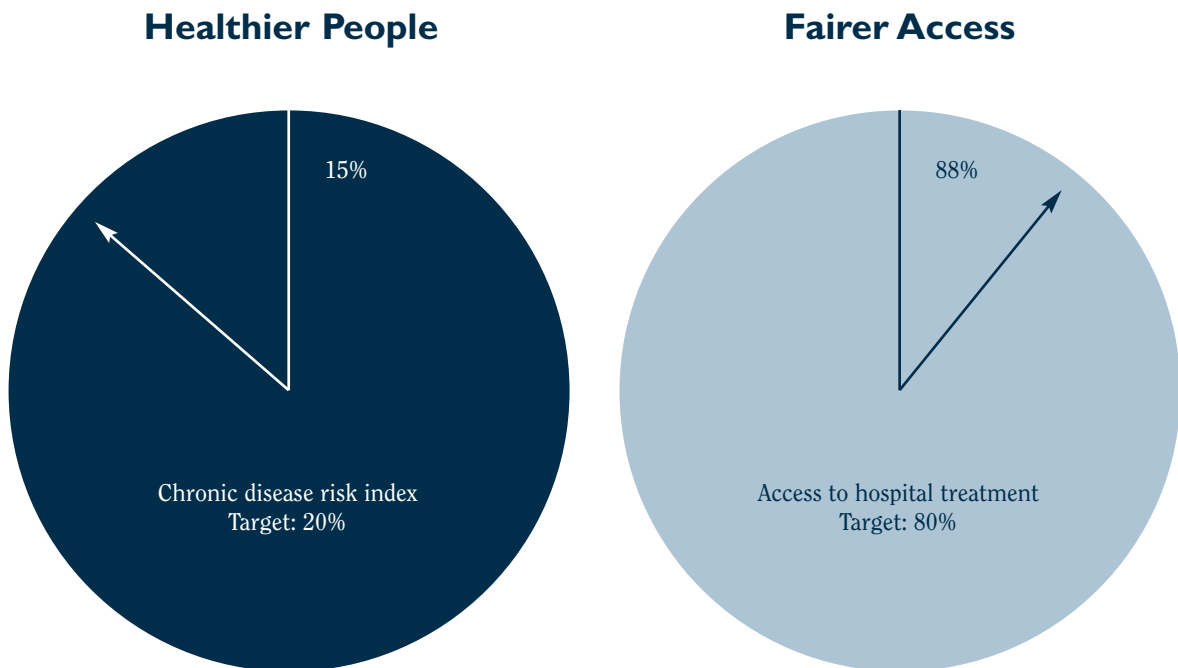
IPART notes that not all factors impacting on the KPIs included in the management dashboard are under NSW Health's control. For example, both GP referrals and post-acute care have a significant influence on potentially avoidable hospitalisation rates and the general demand on the health system, but are outside the control of system.

This fact is well recognised at all levels of management; however, the lack of data and accountability make it impossible to control these outside pressures from within the NSW health system. The potentially avoidable hospitalisation indicator takes into account the quality of health services delivered in an ambulatory setting, such as primary health care. The problem of measuring appropriate GP referral rates should be addressed as part of the national inquiry into the future of the Australian health care system, outlined in Chapter 2.

11.2.4 Report on performance in a simple, meaningful form, such as visual mapping

As one of the purposes of reporting on performance against the management dashboard of indicators is to generate productive discussions, it is important that this information be presented in a simple and meaningful way. IPART suggests that NSW Health adopts a form of visual mapping for this reporting. With visual mapping, results are presented a way that shows what the indicator is, what the target is, what the recent performance against that target is, and whether this result is good, bad or indifferent, in one simple graphic.

Figure 11.4 Traffic light presentation of performance indicators



For example, Figure 11.4 illustrates how performance against two indicators might be reported using visual mapping—the chronic disease risk index and access to hospital treatment. The target level for each indicator is shown inside each graph (20 per cent and 80 per cent respectively), and the arrow shows current performance. Colours could be used to indicate this result, eg positive (green), negative (red) or neutral (yellow).

This format tells the user in one glance whether a particular indicator needs further investigation or not. It has also proven extremely useful in other organisations as a discussion facilitator, as it does not provide excessive information (which can encourage people to be distracted by the detail) and gets directly to the point. It also helps the user to treat the information for what it is—an indication of how well the health system is performing in a particular area. If a cascading system of performance reporting is in place, trend information can be obtained by investigating a particular indicator down to the next level.

More information on the use of visual mapping to report on KPIs, and of strategic maps at departmental, AHS and hospital level can be found in Attachment 9.

11.2.5 Facilities should be encouraged to report publicly on patient satisfaction levels

One of the reasons organisations collect performance information is so they can provide it to consumers, to encourage them to use their services. Patients have a right to be informed about the performance of their hospitals, but health performance measurement systems often neglect this aspect.

While IPART recognises that it would not be appropriate to report publicly on all indicators, it believes facilities should start to publish some performance information publicly. This will signal to all staff that their work is important to patients and that the public is monitoring their performance. The indicators reported on should be chosen so as to reflect the work of the hospital as a whole, and should include patient satisfaction levels. This kind of reporting should be used to give a sense of teamwork to the hospital. See Box 11.2 for an example of how one US health care organisation has approached public reporting.

Box 11.2 Kaiser Permanente: Public performance reporting focusing on the patient

Kaiser Permanente is America's largest not-for-profit health care organisation, serving 8.1 million members. An integrated health delivery system, Kaiser Permanente organises and provides or coordinates members' care, including preventive care such as prenatal care, immunisations and screening diagnostics, hospital and medical services, as well as pharmacy services. Kaiser Permanente publishes a number of performance indicators publicly. These are grouped under the following headings:

- member satisfaction
- helping healthy people stay healthy
- helping people with medical problems
- how well we manage our business.

The first three headings focus exclusively on the patient. KPIs reported under these headings include patient satisfaction, population health indicators and indicators focusing on the effective management of acute and chronic illness. The last heading, how well we manage our business, centres on financial and workforce indicators.

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This type of public reporting could be used as a model, as it focuses on the patient, the workforce and some financial indicators. It informs patients about what really matters to them. It explicitly avoids indicators that could contribute to the creation of a culture based on blame.

11.3 Ensure all parts of the system have uniform, compatible IT systems

The collection of indicators is a time-consuming and expensive task. Duplication of work due to incompatible IT systems increases the cost of collecting indicators and reduces the timeliness of information. NSW Health needs to ensure all levels of its organisation have integrated IT systems, so that cascading performance information is available from the same source, and management can investigate individual KPIs down to the lowest level of accountability at any time.

IPART believes that NSW Health should carefully explore the available options, including whether an alternative performance reporting system can be set up on the Department's Intranet website. This could be a cost-effective way to make the performance reporting system accessible at all levels in the system. Once the data is available from a single, integrated source, standard software can be used to set up the performance reporting system in a cascading way, starting with the management dashboard and drilling down to the lowest level.

11.4 Address all levels of governance and include incentives and sanctions

NSW Health's performance measurement system should closely reflect the accountabilities and responsibilities set out in the governance structures. In addition, the targets for each indicator should be linked to clearly defined incentives and sanctions to reinforce accountabilities.

11.4.1 Link the performance measurement system to the three levels of governance

There are three levels of governance within the NSW health system—corporate, clinical and community governance (see Chapters 5, 7 and 9). The performance measurement system should include KPIs that enable performance against accountabilities in all three levels to be assessed.

Assessing performance accountabilities in the corporate governance structure is relatively easy. These accountabilities may be financial, output- or input-based (eg resource utilisation), and generally lie with AHSs and facilities or, more specifically, with their boards and CEOs.

Assessing performance against accountabilities for clinical governance is more complicated. This kind of governance focuses on quality of patient care, and accountabilities usually lie with individual facilities. Facilities may need to establish centres for clinical excellence at the local level to monitor quality.

Assessing performance against accountabilities for community governance is also more difficult. Community governance includes responsibility for the stewardship of the health system on behalf of the community, and for involving and consulting with the community in planning and decision-making about local services. Accountabilities in relation to this kind of governance lie

at the highest level—that is with the Director-General who reports to the Minister—and also at the AHS and facility level.

Of course, for any performance measurement system to be effective, the Department needs to clearly spell out who is responsible for what at each level of the system. Once clear accountabilities have been assigned, it can concentrate on providing the areas with strategic guidance instead of intervening into operational areas.

11.4.2 Link the targets for individual KPIs to incentives and sanctions

IPART believes an incentives and sanctions system is essential for assigning clear accountabilities and responsibilities across the health system. The success of a performance measurement system in driving better performance depends on the level of accountability that is perceived by the responsible staff. An incentives and sanctions system clarifies the different accountabilities, and provides stronger encouragement for better performance.

IPART believes NSW Health should develop a system of incentives and sanctions based on the indicators developed at the AHS and hospital levels. Targets should be set for individual entities so as not to penalise rural AHSs or hospitals. The incentives and sanctions system should be developed in a way that does not impact on the fundamental funding needs of AHSs or hospitals. However, it should be used to encourage local entities to take the initiative to improve on performance without the direct intervention of the Department.

In addition, there should be a form of earned autonomy for those areas that perform well within their targets. This would add an additional incentive for the Areas to monitor their performance and to take a proactive approach to managing problem areas.

Box 11.3 Use of incentives and sanctions in Victoria

In Victoria, the Department of Human Services has undertaken extensive research into how performance information could be used to provide an ongoing indication of the standards of care the health system delivers.

The Department has reviewed possible indicators, the implications and issues associated with their use, and the extent of use of similar indicators both in other states and countries. As part of this process, it surveyed hospitals across Victoria to understand the difficulties that may be involved in implementing the identified indicators and also the additional cost involved.

In addition to this, the Department has specified a number of demand management strategy measures that all hospitals are expected to report on. In some cases performance bonuses are applicable. The Department sets targets for individual hospitals for each of these measures.

This bonus system avoids the underlying negativity of sanctions. However, hospital executives in Victoria are talking about ‘funding dollars at risk’, rather than performance bonuses.

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Recommendations

- 75 The Department, AHSs, statutory corporations and facilities should draw on best practice in NSW, Australia and overseas, such as the use of balanced scorecard and strategic mapping approaches. Full engagement of the CEO is critical to the success of any approach.
- 76 Where strategic mapping is adopted, the maps should be linked to State-wide strategic directions and State health plans. Strategic maps and locally developed indicators for AHSs should cascade down from the Department's dashboard of key performance indicators (KPIs) for the health system.
- 77 The management 'dashboard' indicators developed by the Department's Committee should be used, taking effect on 1 July 2004. The indicators are high level and reflect system-wide priorities but are capable of being 'drilled down' to highlight variation in performance.
- 78 The new performance measurement system should be underpinned by an integrated IT system that produces timely data.
- 79 Facilities should start reporting patient-satisfaction levels.
- 80 A system of incentives and sanctions based on performance against targets and outcomes set in performance agreements should be established. The primary purpose of this recommendation is to enhance performance but it would also ensure that the indicators developed are an integral part of the accountability framework.

12 A more sustainable health workforce

NSW Health is the largest health care employer in Australia, with some 84,087 full-time or part-time staff.⁴⁶ Through this highly trained, highly skilled and highly respected workforce, it delivers standards of patient and community care comparable with those of the best health care systems in the world.

To ensure it can continue to deliver quality health care in the future, and respond to future health care demands, it must have an adequate supply of health care professionals in the right distribution—and these professionals must be willing to adapt their roles and work practices to new ways of delivering health care services that better meet the needs of patients. It also needs an ongoing supply of skilled health administrators to meet its future management needs.

IPART's review found that NSW Health faces a number of challenges in meeting these requirements. Like all Australian states and territories (and many other countries), NSW has a shortage of doctors, nurses and allied health staff that is expected to worsen in the future. Some of these shortages are due to the uneven distribution of health care professionals across the State. Some are due to insufficient university places for health care professionals and uncoordinated education and training that is not aligned to NSW Health's future needs.

In addition, professional boundaries within its workforce make it difficult for NSW Health to develop new models of service delivery that would give it greater flexibility and allow it to provide more coordinated, patient-focused services. Work environments tend to be divided into groups based on the different health care professions, and communication between these groups is often poor. Award structures reflect this sometimes insular approach, and employee associations have resisted attempts to introduce new approaches to the way the workforce is organised and services are delivered.

There are also concerns that NSW Health's administrative workforce is not receiving sufficient training and development to ensure that all parts the State's health system have an adequate and secure supply of skilled and experienced managers.

Finally, increasing salaries of health care professionals are placing significant pressure on NSW Health's budget. Health care is labour intensive: salary and wages represent 65 per cent⁴⁷ of NSW Health's annual expenditure. Increases in staff costs account for 51 per cent of the increase in total expenditure from 1996/97 to 2001/02.

IPART recognises that some of these challenges are beyond the scope of NSW Health to address. It also recognises that NSW Health has started to address others. For example, it is making a considerable investment in several immediate and longer-term initiatives to address health workforce shortages. In addition, nursing awards have been changed to allow appropriately qualified nurses increased clinical responsibility that matches their specialist skills and enables them to deliver better patient care.

⁴⁶ Source: NSW Department of Health, *Annual Report 2001–02*.

⁴⁷ Source: Chief Financial Officer, NSW Health.

However, parts of NSW Health can be more focused and strategic in responding to workforce challenges. In particular, IPART believes that the Department should:

- establish a strategic workforce planning unit, responsible for coordinating the development of strategies to address workforce issues (such as supply, distribution, education and training, and changing roles and patterns of practice) and substantially improve the base of information about the workforce
- develop an integrated workforce plan aimed at ensuring a flexible workforce with the right skill mix to meet changing patient needs into the future in the most cost-effective way
- implement short- and medium-term strategies with AHSs to address shortages and uneven distribution of clinicians, including investing in casual nurse pools, increasing support for and productivity of Nurse Unit Managers, streamlining overseas recruitment procedures for doctors, creating attractive working environments, and encouraging the appointment of doctors to AHSs and clinical networks rather than individual facilities
- engage with health care professionals and their unions to address the need to change their scopes and patterns of practice to reflect changes in how health care services are delivered
- establish a comprehensive management training program to identify potential managers and provide them with the skills required to meet its future management needs
- implement strategies with AHSs to control workforce costs. In the longer term, this will require reform of award structures. In the short term, savings can be achieved through strategies to reduce the use of agency nurses, an evaluation of the optimal ratio of Visiting Medical Officers (VMOs) to Salaried Medical Practitioners (SMPs), and targeted redundancy and redeployment programs for SMOs in inner-city AHSs.

IPART understands that NSW Health is establishing a NSW Health Workforce Steering Committee. This body should become the HPT for workforce development and play a vital role in leading and guiding its response to IPART's recommendations.

12.1 Establish a single workforce planning unit

At the State-wide level, the Department has managed workforce planning and strategy development through a number of units responsible for separate professional groups. These include:

- the Chief Health Officer, who is responsible for medical education, training and workforce issues
- the Office of Nursing and Midwifery, which is responsible for nursing and midwifery education, training and workforce issues
- the Employee Relations Branch, which is responsible for employment conditions, workforce performance and development
- the Primary Health and Community Care Branch, which is responsible for the allied health workforce
- the Government Relations Branch, which is responsible for coordinating advice to the Australian Health Workforce Officials Committee (AHWOC) and the Australian Health Ministers' Advisory Council (AHMAC) on health workforce activity and reform

- the State-wide Services Development Branch, which is responsible for workforce planning for other health workforce groups, workforce information, planning and research to support workforce planning.

It is only recently that an overarching strategic approach has been developed, through the establishment of the NSW Health Workforce Bureau within the Department's Government Relations Branch. The bureau is intended to be a coordinating unit and provide an interface to other agencies and jurisdictions.

While this step is an improvement, IPART believes that all workforce planning functions should be amalgamated into one unit. This would be part of this industrial relations function referred to in Chapter 9. The current arrangements do not reflect NSW Health's objective to achieve a more coordinated, flexible and adaptable workforce. Rather, they mirror the 'silo' culture of health professionals. Combining these functions into one strategic workforce unit that has responsibility for leading the development of an integrated workforce plan and driving its implementation will help to achieve better coordinated workforce planning and provide leadership for the direction of future reforms.

IPART believes the strategic workforce unit's role also needs to include substantially improving NSW Health's base of information about its workforce. The unit needs to be able to develop a workforce profile that matches labour force projections, describe the existing workforce at any one time and act on deficiencies. This will require reliable data on recruitment, distribution and remuneration of health care professionals in the NSW Health workforce.

Initially, it may be less disruptive to maintain some specific roles and structures within the new workforce unit. For example, the Office of Nursing and Midwifery has widespread support throughout NSW Health and is well resourced to deliver strategic reforms in the short to medium term. However, the new workforce unit's structure should eventually reflect the goal of a fully integrated health workforce focused on achieving better patient care.

12.2 Develop an integrated workforce plan

The challenges NSW Health faces in relation to its workforce represent a serious risk to its ongoing capacity to provide high quality patient care and health services to the community. This is widely recognised by stakeholders, and NSW Health has taken steps towards addressing these challenges.

However, the reform required to address the challenges effectively, and to ensure that the Department can meet its stated objective of 'a coordinated, flexible workforce that is responsive to changing and evolving clinical practice and changing population needs' is substantial and widespread. IPART believes that to achieve this reform, the Department needs an integrated, coordinated approach. It should develop an integrated workforce plan that sets out:

- patient needs
- workforce requirements to meet those needs
- actions and approaches needed to meet those requirements.

This plan should consider issues related to supply, distribution, education and training, remuneration, skills and patterns of practice for NSW Health's workforce. It should then be the basis for setting priorities, negotiating award reforms, and creating a culture that is focused on meeting the health care needs of patients and the community.

12.3 Implement strategies to address shortages and uneven distribution of clinicians

NSW Health faces shortages of health care professionals that are expected to worsen in the future, some of which are due to an uneven distribution of clinicians across geographic areas. Supply and distribution patterns vary for nurses, doctors and allied health staff.

NSW Health is investing in several immediate and longer-term initiatives to address these shortages, but gaps remain within and across professions and between urban, rural and remote settings. These gaps affect NSW Health's ability to respond flexibly to the needs of its client population, and at times to provide essential services to local communities. They also contribute to low staff morale, difficulties in recruiting health professionals to positions, and community concern about the health system.

In the longer term, some of the gaps are likely to be filled through the development of new categories of health professionals and changing the roles and responsibilities of the established clinical disciplines, as this will attract more health professionals with specific skills. In the short- to medium-term, however, NSW Health needs to do what it can to overcome immediate supply and distribution problems.

IPART's review identified a range of short- to medium-term strategies that NSW Health should focus on. It recognises that some of these strategies are already being developed and implemented. The strategies include:

- addressing shortages and uneven distribution of nurses by investing in developing and training casual nurses to promote increased flexibility, and improving the productivity of front-line nurse managers by providing managerial skills training and more administrative support
- addressing uneven distribution of medical staff by streamlining and centralising procedures for overseas recruitment of doctors, focusing on creating work environments that value clinicians, and facilitating the appointment of doctors to AHSs rather than individual facilities
- addressing barriers to the recruitment and retention of allied health staff to the public health system.

12.3.1 Address shortages and uneven distribution of nurses

Over the last 10 years, NSW Health has developed and implemented recruitment and retention strategies for nurses aimed at overcoming nurse shortages. Despite these efforts the numbers of nurses increased less than 4 per cent in total, over the five years to 2001/02 (see Table 12.1 below). Since then NSW Health has introduced the Nurse Reconnect program, which targets nurses not currently working in the health system to re-enter the workforce; this attracted 779 nurses to NSW Health between February 2002 and May 2003. Other initiatives included undertaking marketing and promotional activities, increasing provisions for further study and

professional development, and providing university scholarships. Similar initiatives in Victoria have attracted more than 3000 nurses since mid-2000.⁴⁸

Table 12.1 Trends in nurse numbers and salaries

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Salaries (nominal \$'000)	1,352,167	1,444,207	1,522,059	1,536,728	1,556,886	1,629,193
FTE staff	32,357	32,974	33,303	33,356	33,325	33,603
Salary cost per FTE (\$)	41,789	43,798	45,703	46,071	46,718	48,484
Index of salary cost per FTE	100	105	109	110	112	116
Average weekly earnings index*	100	103	106	107	113	118

* Australian Bureau of Statistics: Average Weekly Earnings, Australia, all occupations.

Over the five years to 2001/02, nurses' salaries increased broadly in line with average weekly earnings. However, more recently nurses have received significant real wage increases. The Industrial Relations Commission awarded a 6 per cent pay rise from 1 January 2003, on top of a previous agreement to increase wages by 4 per cent from 1 January and a further 5 per cent on 1 July. Award increases from January 2000 to July 2003 will amount to 22 per cent. These wage increases will have a significant impact on costs.

Despite these efforts, nurse shortages persist. In March 2003, AHSs were actively recruiting to fill 1,808 full-time equivalent positions (FTEs). This represents a vacancy rate of more than 5 per cent of the 33,000 FTE nurses employed by NSW Health.⁴⁹ The distribution of vacancies is uneven, with the most severe shortages being in inner Sydney, south-west Sydney and smaller rural centres.

There are also shortages of specialty nurses across the State. In metropolitan AHSs, the worst shortages are in the Intensive Care, Operating Theatres, Emergency Departments and Mental Health specialties. In rural AHSs, the worst are in the Community Health, Mental Health and Midwifery specialities.

The recent increases in nurses' salaries provide more recognition of the value of their work and qualifications, and may attract some new nurses to the NSW health system. However, salary increases are not nurses' only concern: flexibility and the work environment are also significant issues.

IPART believes that more can be done to overcome nurse shortages. NSW Health also recognises this, and the Department's Office of Nursing and Midwifery is leading the development of further strategies. Its work is well supported throughout NSW Health, and it is considered adequately resourced for the task with an annual budget of about \$26 million.

IPART has identified two strategies that it believes NSW Health should focus on: increasing the innovative use of casual nurse pools, and improving the productivity of Nurse Unit Managers. It recognises that NSW Health is already implementing some aspects of these strategies.

⁴⁸ Department of Human Services, Victoria, *Annual Report 2001-2002*.

⁴⁹ NSW Health, *Recruitment and Retention of Nurses, Progress Report*, prepared by the Office of the Chief Nursing Officer, October 2002.

Increasing the innovative use of casual pools

IPART's 1998 review suggested that NSW Health should consider increasing the proportion of nursing staff employed in casual positions from 5 per cent to 20 per cent. It argued that higher use of casual staff offers significant flexibility and has the potential to reduce costs.

Since that review, the use of casual nurses has increased marginally to an overall rate of 5.6 per cent. Within AHSs, casual nurses comprise between 1.5 per cent to 13.4 per cent of FTEs, with most AHSs falling between 4 and 7 per cent. Most facilities have established casual nurse pools. For smaller facilities a shared pool operating across several facilities may be more appropriate.

The current review also found that more innovative use of casual pools can help in the management of nursing shortages. IPART's consultations with AHSs suggested that nurses increasingly want more flexible working arrangements.

One of the difficulties in using large numbers of casual staff is that permanent staff can be disadvantaged to accommodate the shift preferences of casuals. This can drive permanent staff to become casuals, or even agency nurses. Most facilities try to manage this difficulty by imposing conditions on nurses registered in casual pools, such as a requirement to work a minimum number of shifts over a specific time period. However, this then makes the casual pools less attractive than agencies, as the latter do not impose such conditions and so offer more flexibility.

Another difficulty is that casual staff often do not receive the same development opportunities as permanent nurses, and so their experience and potential often goes untapped. Providing training for experienced casual nurses in speciality areas, nurse education or other roles, would both recognise their value and increase the value of the casual pool resource. It could also make casual pools more attractive than agencies for some nurses.

Potentially, two-tiered casual pools could be developed, with the first tier offering levels of flexibility similar to those of agencies, and the second imposing some conditions, but providing increased development opportunities for experienced nurses.

These more innovative casual pool initiatives would need to be developed and implemented at the AHS or facility level. The Department's role would be to promote the strategy of strengthening casual pools, provide models of best practice, and assist AHSs that struggle to develop effective casual pools.

Providing management skills and support for Nurse Unit Managers

IPART's review identified that filling middle-management nursing positions (Nurse Unit Managers (NUMs)) is particularly difficult. One of the reasons is that the current award structure requires NUMs to be clinical specialists, managers and administrators—a challenging role. In addition, nurses in these positions often don't receive opportunities to improve their managerial skills, or support to manage their administrative workload.

IPART believes that providing NUMs with more management development opportunities and support will help to address nursing shortages:

- NUMs are front-line managers, and therefore have the capacity to directly influence the day-to-day operations of their units and the job satisfaction and morale of the nurses they supervise. Increasing the emphasis on people management skills in the recruitment and development of NUMs, should help to promote a positive work environment, and thus help overcome nurse shortages.
- NUMs also have a significant administrative workload that requires time and additional skills. AHSs indicated to IPART that NUMs spend up to 40 per cent of their time on rostering alone. Providing improved administrative support, such as software that largely automates rostering, would free NUMs for other higher value work. The costs involved should be more than offset by improved productivity.

IPART believes NSW Health should consider how it could provide greater support to NUMs—through training, mentoring and the provision of administrative support services—as a high priority.

12.3.2 Address uneven distribution of medical staff

All stakeholders acknowledge there is an overall shortage of medical staff in the NSW Health system. The impact of this shortage is most severe in rural and outer-metropolitan areas, and has a direct effect on these areas' ability to provide services locally. In contrast, some inner-city AHSs are relatively oversupplied with medical staff, largely due to historical patterns of funding and service development.

Robust data on the supply and distribution of NSW Health's medical staff was not available for this review, which highlights the difficulty it faces in sensibly addressing this challenge. The Department did provide estimates of the number of Visiting Medical Officers (VMOs) and staff specialists in the medical workforce in each AHS. These are not FTE estimates, which makes it difficult to interpret the data. However, this data indicates that there were 5,933 VMOs and staff specialists across NSW in March 2003. Of these:

- almost half (45 per cent) were located in three AHSs—South Eastern Sydney, Central Sydney and Northern Sydney
- 19 per cent were in South Eastern Sydney alone
- South Western Sydney, which has about the same population as South Eastern Sydney, had only half as many VMOs and staff specialists.

One of the main reasons for the shortage of medical staff is that there are insufficient places at universities to train the number of specialist doctors required to meet NSW Health's current and future needs. However, as with nursing, there is some capacity for NSW Health to alleviate shortages through strategies aimed at increasing retention rates and improving the distribution of VMOs and specialist staff, to drive more equitable access to medical services across NSW. In particular, IPART believes NSW should:

- work with medical colleges to ensure the fair allocation and distribution of hospital training positions

- streamline overseas recruitment processes
- encourage AHSs to appoint doctors to the Area, or a network of Areas, rather than to a particular facility
- create a more attractive work environment.

Work with medical colleges to ensure fair allocation and distribution of hospital training positions

Medical colleges play an important role in the distribution of medical specialists. For example, the Royal Australasian College of Surgeons is responsible for the processes used to select, train and assess surgeons (including overseas trained surgeons) and accredit hospital training posts. The ACCC's recent draft report on the role of this college proposes a number of changes to ensure its decision-making process is sufficiently independent and to increase the role of Government. The report claims the emerging evidence of a shortage of surgeons in Australia heightens the need for this reform, to ensure competent surgeons are available in rural, regional and metropolitan Australia.

IPART's review supports the ACCC's findings. Many of the stakeholders it consulted within AHSs argued that the barriers created by medical colleges' decision-making processes, which include impeding AHSs recruiting overseas doctors, reinforce the currently inequitable distribution of the medical workforce across NSW. The ACCC's review of the Royal Australasian College of Surgeons has the potential to address many of these concerns and to lead to significant reform.

Some stakeholders suggested the work of the NSW Medical Training and Education Committee (MTEC) could also help to achieve a fairer allocation of training positions. NSW Health established MTEC as a Ministerial Advisory Council in 2001. Its initial focus is to work with its stakeholders to better understand how vocational training and supervision of medical graduates is working. It is currently piloting a project in three AHSs that seeks to understand training at three levels: trainee, trainer and Area/hospital administration. MTEC's long-term goal is to develop an appropriate framework for high quality and sustainable training of the medical workforce. It does not have a direct role in workforce allocation and distribution though its work may have some influence on this in the long term.

MTEC is a new body attempting to work cooperatively with a diverse group of stakeholders with conflicting priorities. IPART believes it is unrealistic to expect MTEC to solve the problems of distribution in the short to medium term. Short-term solutions will probably only be achieved through direct intervention of the Government and the Department.

Streamline overseas recruitment processes

Many AHSs argue that there are too many barriers to attracting and retaining overseas doctors. Several hundred Registrar positions are occupied by overseas recruits. Many of these trainees stay for several years, but are then forced to return home because of restrictive requirements imposed by the Commonwealth Department of Immigration, the Australian Medical Council and medical colleges.

Other AHSs are frustrated at the hurdles they need to jump to get a position declared an 'Area of Need'. The Department's Area of Need Program grants special status to particular positions on a temporary basis while efforts to attract a medical practitioner with general registration on a permanent basis continue. The program was developed as a short-term strategy rather than a long-term solution to medical workforce shortages.

The main barriers to overseas recruitment need to be addressed at the national level and in the context of global shortages. If they were removed, anecdotal evidence suggests that there is a pool of qualified doctors willing and able to fill vacancies across Australia.

Within NSW, there appears to be some scope for NSW Health to streamline its overseas recruitment processes. IPART believes that this should be pursued. NSW Health should also consider coordinating overseas recruitment efforts. It believes efficiency benefits could be gained by making one AHS with proven experience responsible for overseas recruitment, rather than individual AHSs sending their own staff overseas to recruit a small number of specialists.

Encouraging AHSs to appoint doctors to the Area or network of Areas

Some AHSs have begun to appoint doctors to the Area rather than to a particular facility, to allow them to perform procedures at any of the facilities within the AHS's boundaries. This approach parallels the clinical stream structures some AHSs have adopted, and provides the flexibility to move clinicians to where they are most needed.

IPART believes this concept could be broadened, to allow the appointment of clinicians to a network that cuts across AHS boundaries. To be effective, this approach would require the cooperation of AHSs and willingness of clinicians. However, it may be feasible in some cases, particularly where a cooperative relationship between a metropolitan and rural AHS already exists.

Create a more attractive working environment

Some AHSs will always have more difficulty in attracting doctors than others because of their location or other factors. However, the experience of organisations such as the Post-graduate Medical Council and MTEC is that AHSs and hospitals can increase their attractiveness by creating a more attractive working environment. Regional hospitals that previously had poor reputations and high staff turnover rates have been transformed by adopting strategies such as:

- providing study leave to Junior Medical Officers
- establishing mentoring programs
- upgrading accommodation facilities
- making it easier for staff to be involved in extracurricular activities, both within the health system and in social contexts.

AHSs in which doctors have productive and cooperative relationships with the administration are also favoured over those where there is persistent conflict. Several stakeholders suggested better relationships could be facilitated by improving performance management systems so that staff are more accountable but also have more opportunities for two-way communication with management and for development.

In addition, there is some scope to introduce additional incentives to attract medical practitioners to AHSs where there are shortages. For example, the CEO of one rural AHS suggested that allowing doctors to accumulate long service leave at a faster rate than usual after they have been employed for a minimum period could encourage doctors to stay longer in rural areas. However, other stakeholders were concerned that this kind of incentive would place AHSs in competition with each other for vocational groups in short supply, and could set precedents that have State-wide ramifications. Ideally, the industrial relations environment should allow AHS-specific agreements that do not flow on to other AHSs. If flow-on effects aren't restricted, specific agreements would become ineffective and high risk.

12.3.3 Address barriers to the recruitment and retention of allied health staff

Some of the most severe shortages in NSW Health's workforce are of allied health staff. There are critical shortages of pharmacists in public hospitals and shortages of radiographers and radiation therapists across the State. In rural and regional areas, there are shortages of physiotherapists, speech therapists, psychiatrists and other allied health professionals.

A significant barrier to the recruitment and retention of allied health staff is created by the rates of pay NSW Health offers them. Allied health professionals across nearly all streams can earn substantially more in the private sector. For example, a pharmacist with a private business is likely to earn two to three times more than one working in a public hospital.

Another barrier is that the training of some allied health professionals better prepares them for establishing a private business than for providing services in the public health system.

IPART believes NSW Health should explore strategies for overcoming these and other barriers to attracting and retaining allied health staff, including considering substantial pay rises.

12.4 Engage with health care professionals and unions to enable new models of patient care

Despite the major changes and advances in health care, there has been little fundamental change in the roles and responsibilities of the different health care professionals, the way they are organised, and the way they have interacted with each other for the last 30 years. However, the challenges NSW Health faces in overcoming shortages in health care professionals, meeting increasing demand for health care services, and controlling the burgeoning costs of providing these services mean that it has no choice but to find new ways to deliver health care services and seek alternative providers for some services.

This inevitably means that the roles of the doctors, nurses and allied health professionals and their scopes and patterns of practice, will need to change to match new models of delivering patient care. Indeed, the emergence of new health care providers and the roles they eventually play is expected to result in more drastic changes to the health care landscape over the next 10 to 15 years than we have seen in the past 30 years. In many ways, these changes will determine how quickly NSW Health can develop new service delivery models in the future, and what shape these models will take.

IPART identified a strong view that there should be a broad-based review of the skills needed to deliver health services across the system. This review should not be based on existing professional boundaries, but on the needs of patients. The professions should then model their work practices on the needs of patients, rather than on these boundaries.

Such broad-based reform will be difficult to achieve—it is a complex task and there may be strong resistance from some groups. However, IPART believes NSW Health should engage with health care professionals and their unions to address the need for change in scope of their roles and responsibilities and patterns of practice. The unifying goal of delivering better patient care could be used to drive a change program.

This kind of change is likely to occur incrementally at first. NSW Health has already begun to develop and implement strategies to begin this change, and this should continue. IPART's review also identified some potential first steps in creating new models of service delivery that are already occurring in other jurisdictions and are achievable—employing non-nursing staff for some roles currently performed by nurses, and employing non-medical specialists in roles currently performed by medical staff. These approaches are discussed below.

12.4.1 Employ non-nursing staff for some roles currently performed by nurses

Registered nurses (RNs) are highly qualified specialists. After their graduate year, nurses generally elect to work and train in a specialty field, such as emergency, cancer, and mental health. Specialisation results in improved patient outcomes but less flexibility. Enrolled nurses (ENs) and Assistants in Nursing (AINs) have a more generic role that complements the skills and work of RNs.

Since IPART's 1999 review, NSW Health has focused on developing the clinical role of nurses. For example, it has introduced two new nursing roles—Nurse Practitioners and Clinical Initiatives nurses—which provide advanced practice in a number of care settings. The new roles have improved patient care in a range of settings, from rural hospitals to metropolitan Emergency Departments. They have also improved job satisfaction and career opportunities for nurses. NSW Health anticipates it will have more than 150 Nurse Practitioners by 2006.

Health departments in other jurisdictions, however, have gone a step further, by beginning to employ 'non-nursing' staff for specific 'non-clinical' roles. For example, in Victoria, the increasing demand for care for people with dementia has resulted in the employment of 'sitters' whose main role is to watch patients at risk of falling out of bed or wandering away, particularly at night when fewer nurses are on duty. The need for sitters will increase as Australia's population ages and life expectancy increases.

Also in Victoria, a nursing shortage crisis in dialysis units was alleviated by advertising for technicians rather than nurses. Initially, nurses resisted this strategy but it has been largely successful. The specialist skills required are now provided by trained technicians. In the USA, technicians rather than theatre nurses also provide many of the support services required by surgeons in operating theatres.

IPART believes NSW Health should evaluate the potential for employing non-nursing staff in positions that don't require all the specialist clinical skills of nurses, such as sitters and dialysis technicians. The first step might be to focus on the non-clinical tasks currently performed by nurses, including administrative functions. The benefits of implementing this strategy would include:

- alleviating nurse shortages
- making nursing roles more rewarding roles by making optimal use of their skills
- improving patient care by ensuring adequate staffing and treatment by the most appropriately qualified staff.

The strategy would complement NSW Health's existing approach of shifting nursing roles towards increased clinical responsibility and specialisation. Experience in other jurisdictions suggests it can be implemented quickly.

12.4.2 Employ more non-medical specialists in roles currently filled by medical staff

Over the last decade, NSW Health has increasingly involved other health professionals in services traditionally provided by doctors. For example, Nurse Practitioners now perform some medical procedures previously only performed by doctors. These practitioners have not replaced doctors, but in certain instances, involving them rather than doctors achieves both optimal patient care and better use of available resources.

Experience in the US suggests there is potential for other health professionals to undertake more of the tasks previously undertaken only by doctors. For example, midwives could be trained for a broader role in maternity services, and Nurse Practitioners could be trained for work in labour-intensive neonatal care wards.

A further example is physician assistants. This role was first created in the USA in the 1960s, with the aim of improving access to health care for people in areas under-supplied with medical services. Today, physician assistants are interdependent, semi-autonomous clinicians who practise in partnership with physicians in most medical and surgical specialties. They perform many tasks previously only done by physicians including examination, diagnosis, treatment and prescribing.

Studies have shown that the quality of care given by physician assistants is equal to that given by physicians in comparable situations, and results in high levels of patient satisfaction.⁵⁰ Most physician assistants practise in primary care, where they are estimated to have the capacity to provide 80 per cent or more of the type of services previously provided only by physicians.

There are many similarities between physician assistants and nurse practitioners. However, physician assistants receive generalist training modelled on medical school curriculums whereas nurse practitioners are usually trained in a nursing specialty. The setting for care and the specialty usually determines how these two professions practise, rather than legislative or professional regulations.⁵¹

⁵⁰ Mittman DE, Cawley JF, Fenn, WH. Physician assistants in the United States. *British Medical Journal* 2002; 325:485-7.

⁵¹ Ibid.

IPART believes NSW Health should examine whether it is feasible and desirable to make greater use of non-medical specialists in roles currently filled by medical staff—for example, by establishing the role of physician assistant. The US experience illustrates the potential for alternative models to improve patient access to services.

12.5 Establish a comprehensive management training program to strengthen the administrative workforce

IPART's review identified concern at both the Departmental and AHS levels about the adequacy of the training and development provided to managers and administrators across NSW Health. The turnover rate for AHS CEOs and hospital administrators is reported to be high relative to other industries, and there is concern that managers of the next generation are not being adequately prepared for their future roles. IPART observed, through its consultation process, that the highest levels of NSW Health's management workforce are highly professional, motivated and dedicated. However, their concerns about the need for better planning for future management needs are valid.

All parts of the health system should be developing workforce initiatives that promote excellence and innovation and recognise talent regardless of experience or employment status. This requires a well-funded and planned training and development program.

Potentially, such a program could include the following elements:

- a centrally coordinated graduate program that exposes graduates to a range of experiences within the Department and across AHSs and that fosters a culture driven by curiosity and innovation
- proactive identification of potential managers at all levels of the system for whom development pathways are planned, incorporating a comprehensive program of management training and concurrent work experience
- a coordinated exchange program that allows staff to apply for fixed short-term secondments in other parts of the system, to promote cooperative relationships and help staff develop a system-wide view
- a targeted program of voluntary redundancies in the context of promoting cultural change in the system.

This program should be incorporated into the integrated workforce plan, as strong management is vital to delivering nearly all components of such a plan and ultimately to delivering better patient care.

12.6 Implement strategies to control workforce costs

Staff salaries are the most significant pressure on NSW Health's budget. In recent years, health care professionals' salaries have increased rapidly, partly in recognition of their qualifications and skills.

In the long term, the kind of changes in roles, responsibilities and patterns of practice discussed in section 12.4 should deliver a more cost-effective mix of skilled staff. For example, some of the tasks currently performed by nurses do not require four years of university training. Other appropriately trained staff could perform these tasks at lower cost while also freeing university-qualified nurses for tasks that better match their skills.

However, there is also potential for NSW Health to achieve savings in the short to medium term. IPART has identified several strategies which should be a high priority—these include:

- controlling the costs of salaried medical staff by optimising the ratio of visiting medical officers (VMOs) to salaried medical practitioners (SMPs) in hospitals, and establishing redeployment or, if necessary, targeted redundancy programs for SMPs in inner-city AHSs
- restricting the use of agency nurses.

12.6.1 Controlling costs of salaried medical staff

Despite an overall shortage of medical staff, the total number of salaried medical staff employed by NSW Health has increased by 10 per cent since 1996/97. Salary costs per FTE have increased by 33 per cent, and total costs have increased by 46 per cent (Table 12.2). Clearly, salaried medical staff costs have become a major cost driver for NSW Health.

Table 12.2 Trends in salaried medical staff numbers and salaries

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Salaries (nominal \$'000)	424,815	479,141	525,528	554,874	588,752	622,178
FTE staff	5,613	5,720	5,751	5,969	6,140	6,175
Salary cost per FTE (\$)	75,684	83,766	91,380	92,959	95,888	100,758
Index of salary cost per FTE	100	111	121	123	127	133
Average weekly earnings index*	100	103	106	107	113	118

* Australian Bureau of Statistics: Average Weekly Earnings, Australia, all occupations.

One of the factors that may be influencing the increase in SMP staff costs is that NSW Health is increasing its use of SMPs and decreasing its using of VMOs. This trend was identified in IPART's 1998 review and is more pronounced in 2003. Time-in-lieu and rostering requirements have added significantly to the cost of using SMPs. The Department of Health indicated that in some locations, particularly for emergency physicians, SMPs may receive a full-time staff specialist salary for working only two weekend shifts. IPART believes NSW Health should evaluate the relative cost-effectiveness of employing VMOs compared to SMPs. IPART believes this evaluation is likely to show that resources will be optimised by employing more VMOs in preference to SMPs.

Another factor may be that some inner-city AHSs are oversupplied with staff specialists in some clinical streams, which is lowering their productivity and reinforcing the uneven distribution of specialists across the State. NSW Health should consider whether a targeted redundancy and redeployment program is justified in these areas. Such a program would provide an opportunity to drive cultural change in those areas, may reduce the pressure on salary increases across the State, and could potentially increase the attractiveness of AHSs with shortages of medical staff, encouraging a better distribution of staff.

12.6.2 Restrict the use of agency nurses

Although most agency nurses receive equivalent rates of pay to other nurses, the agencies charge commission rates of up to 42 per cent which makes agency nurses much more expensive than other nurses. NSW Health's payments to agencies are a small but rapidly growing proportion of its overall nursing staff costs, and place an increasing pressure on some AHS budgets. Since 1996/97, these payments have increased by 376 per cent (Table 12.3). As a proportion of total nursing costs, they have increased from 0.7 per cent in 1996/97 to 2.4 per cent in 2001/02.

The use of agency nurses varies from Area to Area, and reflects the pattern of nurse shortages. For example, the New Children's Hospital Westmead, Central Coast AHS and several rural AHSs don't use agency nurses at all or use them at a negligible rate. South West Sydney, Central Sydney and Far West use agency nurses at relatively high rates, and South Eastern Sydney is the highest user and accounts for nearly one-third of NSW Health's total payments to nursing agencies.

Table 12.3 Trends in nursing agency payments

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	Change
Nursing agency payments (\$'000)	9,564	19,733	24,050	27,379	36,180	45,529	376%

The main benefits for AHSs of using agency nurses are that they are a highly flexible workforce, and can be used as a 'stop gap' measure when faced with shortages. However, they may not be the most cost-effective way to obtain these benefits. In addition, there are several disadvantages to using agency nurses. As well as their higher costs, agency nurses are less likely to be familiar with a particular work place, resulting in increased dependence on assistance from other nurses and increased risks to patients.

In Victoria, the Department of Human Services has responded to concerns about public hospitals' increasing use of agency nurses by issuing a directive in March 2002 requiring hospitals to limit the use of agency nurses. The four major elements of the directive were:

- 1 Agency nurses should only be used for unplanned absences unless an exemption is gained from the Department of Human Services.
- 2 Hospitals were instructed on the amount they can pay for agency nurses (based on an hourly casual rate as per the award rate plus a component for salary-related costs plus a 'management fee' for the cost to the agency).
- 3 Hospitals were to restrict their own nursing staff from working as agency nurses in their own organisation.
- 4 Hospitals were directed to provide flexibility through the provision of nurse banks (known as casual pools in NSW).

Provisions were made to enable hospitals to apply for exemptions from the directive to minimise risks to the continuity of service. The initiative was also supported by a proposal by Health Purchasing Victoria (HPV) to issue one tender for nurse agency services for all Victorian public hospitals in an attempt to stabilise prices and competition. The tender was intended to result in exclusive use of a small number of preferred providers for the duration of the tender period.

The HPV proposal was considered by the ACCC which concluded in December 2002 that the public benefit likely to result from the arrangements would outweigh any anti-competitive detriment that may arise. However, the authorisation process is not complete as at least one nursing agency has requested a review of the determination. The tender cannot proceed until the review process is complete.

The Department of Human Services' initial estimates suggest that expenditure on agency nurses by metropolitan health services in 2002/03 will be at least \$20 million less than it would have been if the nurse agency directive had not been issued. The decrease in demand for agency nurses has resulted in many nurses opting to be included in nurse banks. The banks are operated by facilities and designed to provide nurses with similar flexibility to agency nursing, but nurses are paid casual award rates.

Considerable savings have been achieved relatively quickly in Victoria, even without a central contract for use of agency nurses. There are few barriers to applying a similar directive in NSW. NSW Health will need to decide if it is appropriate for the Department to play such a role; however, the Victorian experience suggests that the needs of nurses who require flexibility can be met by appropriately structuring casual pools for facilities or Areas. If these are well managed, nurses have little incentive to register with an agency.

Recommendations

- 81 The Department should establish a single strategic workforce planning unit to coordinate the development of this workforce plan, and to substantially improve the base of information about NSW Health's workforce.
- 82 The Department should develop an integrated workforce plan designed to ensure a skilled, flexible and adaptable workforce that meets changing patient needs into the future.
- 83 The Department should engage with health care professionals and their unions to address the need to change these professionals' scopes and patterns of practice to enable the development of new models of service delivery and provide more satisfying work environments for employees.
- 84 NSW Health should establish a comprehensive management training program aimed at identifying potential managers and equipping them with the skills necessary to fulfil future management needs.
- 85 AHSs, assisted by the Department, should invest in the development and training of casual nurses to optimise the use of skills and experience available in casual pools. AHSs should accommodate the need of some nurses for high levels of flexibility, perhaps by developing a two-tiered casual pool structure.
- 86 The Department, together with the AHSs, should develop and implement a policy that limits use of agency nurses.
- 87 AHSs should improve the productivity of front-line nurse and other managers by providing more training in managerial skills and additional administrative support.
- 88 The Department should work towards streamlined and centrally coordinated procedures for overseas recruitment of medical staff.
- 89 AHSs should consider appointing more doctors to the AHS rather than individual facilities. This could be extended to clinical network appointments with the cooperation of other AHSs.
- 90 The Department and AHSs should develop strategies to control the increase in salaried medical staff costs. This should include an evaluation of the optimal ratio of VMOs to salaried staff. The Department and AHSs should develop coordinated strategies to achieve greater equity in the distribution of medical staff across Areas.
- 91 The Department should consider strategies for attracting and retaining allied health professionals to the public health system including allowing them to work in both the private and public health sector.

Attachment I Terms of reference

IPART Review of Key Issues in New South Wales Health

This review is to be conducted by IPART under Section 9 of the *Independent Pricing and Regulatory Tribunal Act, 1992*.

‘Strategic Direction for Health 2000–2005’ identified the four key goals of NSW Health:

- 1 healthier people
- 2 fairer access
- 3 quality health care
- 4 better value.

Although the budget for NSW Health has increased in real terms, the challenge remains to meet these goals in the context of rising community expectations.

In the context of:

- 1 the above goals and scenarios for the future demand for health services
- 2 the implementation of the NSW Government’s Action Plan for Health
- 3 the negotiations for the renewal of the Australian Health Care Agreement from 1 July 2003 and relevant issues identified by NSW Health.

IPART is to review and report on:

- 1 issues arising from Commonwealth and State responsibilities for health and associated funding arrangements
- 2 initiatives of NSW Health since the 1999 IPART review to improve the delivery of health services by the public health system through greater productivity and reform
- 3 opportunities to further enhance the effective, efficient and equitable allocation and utilisation of available health resources
- 4 appropriate indicators of performance in the NSW health system to improve health outcomes in the quality dimensions of safety, effectiveness, appropriateness, consumer participation, access and efficiency
- 5 the governance structures across NSW Health.

This review is to consider the impact of recent reviews of NSW Health including:

- the IPART Review (1999)
- the Health Council (2000)
- the Quality Framework (2000)
- the Committee on Health Services in Smaller Towns (2000)
- the Auditor-General.

In conducting the review IPART is to consult with relevant stakeholders and present its final report by 30 June 2003.

Attachment 2 Recommendations

Reform of the National Health System

- 1 A national inquiry into the future directions of the Australian health system should be established under the auspices of COAG and completed within 12 months, to especially progress collaborative service delivery and more unified funding.
- 2 Pending more substantial reform following the proposed national inquiry, NSW should continue to work with the Commonwealth Government to progress innovative and joint service delivery models that deliver better health outcomes for patients and the community.

Planning to focus on patient needs

- 3 NSW Health should undertake a fundamental review of strategic directions to ensure that they are clearly focused on the patient and the health of the community, developed in conjunction with policy-oriented scenario planning, and provide a vision of the health system in 5 and 20 years' time.
- 4 NSW Health should develop a State health plan. The plan should include specific scenarios for models of care and the major causes of ill health and death, taking into account major cost drivers in the system, and be used to guide plans for metropolitan and rural NSW, for regions and for Areas.
- 5 The NSW Government should conduct a Summit on the Future Directions in Health to assist NSW Health's long-term planning process and engage the community in this process.
- 6 In developing the new State health plan, the Department should actively involve the Health Care Advisory Council (HCAC), the new Institute for Clinical Excellence and Patient Care (ICE-PC), Health Priority Taskforces and the Health Participation Council.
- 7 The role of primary health care, including public and community health, in disease prevention and health promotion should be a major priority in the planning process and consequent funding decisions.
- 8 AHSs must develop strategic health plans that cover the medium term and must be consistent with the State health plan, clinical service guidelines, the AHS's four-year budget and approved capital expenditure programs.
- 9 The Department must take responsibility for the development of metropolitan and rural Area plans, and any other cross-Area plans in consultation with the HCAC, AHSs and other stakeholders. These plans should be guided by the State health plan.
- 10 AHSs need to ensure there are specific plans for population health and report outcomes against these plans. The AHSs should put systems in place with the Department to ensure funding is not diverted into general services.

Better quality care and patient safety

- 11 The Institute for Clinical Excellence (ICE) should be transformed into the Institute for Clinical Excellence and Patient Care (ICE-PC) and have its role expanded to include leading the development of clinical frameworks and guidelines, assisting with their implementation and improving quality and safety systems and processes throughout the NSW health sector.
- 12 The Department, in close consultation with the HCAC, should identify State-wide priorities for the development of clinical guidelines by the ICE-PC to ensure that the work of the ICE-PC is integrated with the strategic directions and State health plan.
- 13 Clinical guidelines developed by the ICE-PC should be referred to the HCAC for review and comment prior to submission to the Department for endorsement and State-wide application.
- 14 The Health Priority Taskforces proposed in recommendation 26 should support the ICE-PC to realign the operation of the health system to improve the quality of patient care.
- 15 The ICE-PC's funding base should be reviewed to ensure it can fully and effectively perform its roles.
- 16 The Department should have a strong monitoring, auditing and reporting role to enforce the promotion of quality across the health system.
- 17 Consistent with national and international trends, the Department should publish annually, in a consolidated form, the key indicators of quality for every public hospital and facility in the NSW health system.
- 18 Every AHS and health facility should be obliged to have in place an effective clinical governance structure to achieve improved quality and patient care outcomes.
- 19 The Health Care Complaints Commission's operations, legislation and funding should be reviewed to ensure it effectively performs its functions, especially its investigation and prosecutorial functions.

More integrated service delivery

- 20 The coordinated human service approach should be strengthened through the trialling and subsequent evaluation of regional Human Services Action Plans developed through Regional Services Boards in three AHSs. This could be further progressed by other mechanisms developed through Regional Services Boards such as a pooled regional funding approach.
- 21 NSW Health should progress strategic reform of the health system and stronger linkages with other government objectives through the relevant committee of Cabinet.
- 22 A CEOs group of Premier's, The Cabinet Office, Health, Community Services, Police, Corrective Services, Juvenile Justice, and Disability, Ageing and Home Care and other relevant agencies should oversee the development of a cross-departmental strategy for mental health.

- 23 NSW Health should review its regulatory function in aged care with the purpose of minimising duplication of the Commonwealth's role. If the function is to be retained, NSW Health should consider whether it is more appropriately located within the Department of Ageing, Disability and Home Care.

Stronger structures for clinician and community participation

- 24 A new peak advisory body, the Health Care Advisory Council (HCAC), should be established to replace the Clinical Council.
- 25 The HCAC's key roles should be to guide the Department in the development of the State health plan and clinical guidelines, and advise the Department and the Minister on clinical and health issues. The HCAC should also be able to initiate policy ideas for consideration by the Department and the Minister.
- 26 The current specialist clinical and other groups established under the GAP process (including the GMTT) should be replaced by 11 Health Priority Taskforces (HPTs) to streamline and reinforce clinician and community input to, and leadership of, the change process commenced under GAP. The HPTs should be focused on:
- Workforce Development
 - Aged and Continuing Care (Care of Older People, Chronic Care, Community Health, Primary Health Care and Post-acute Care)
 - Indigenous Health
 - Public Health Forum
 - Maternity and Child Health
 - Rural Health
 - Acute Medical and Surgical Services
 - Mental Health
 - Critical Care Services (Intensive Care, Emergency and Trauma)
 - Cancer (through the NSW Cancer Institute)
 - Information Management and Technology.
- 27 The clinical co-chairs of the HPTs should be part-time members of the Department and members of the HCAC.
- 28 The HPTs should report through the ICE-PC for quality issues and the HCAC for other issues.
- 29 The Department should provide support to champion the work of the HCAC and HPTs by providing policy development, logistics and secretariat support.
- 30 Each AHS should establish permanent, effective community participation arrangements to ensure the role of the community is embedded in the planning, decision-making and performance-monitoring processes within the AHS.
- 31 These arrangements should include best-practice models of community participation and communication, and AHSs should ensure they are adequately supported and resourced.

More equitable health outcomes and more effective funding arrangements

- 32 The current system of three-year budgets should be extended to four-year rolling budgets to give greater budget certainty to the AHSs.
- 33 The Department's recently revised Resource Distribution Formula (RDF) should be phased in over a period of four years or less, depending on the availability of growth funds for use as transition funding to ease the adjustment process.
- 34 The current 2 per cent allowance under the actual RDF share should be phased out so that underfunded AHSs receive their true RDF share.
- 35 The RDF should be updated each year, taking into account actual and prospective flow reversals.
- 36 The actual formula for the RDF, as opposed to data input, should be subjected to a fundamental review at least every four years.
- 37 The Department should consider providing a pool of growth funds to further enhance the provision of services closer to the patient to enable services to be established or relocated to growth and rural areas.
- 38 The mental health RDF should be implemented as soon as possible.
- 39 The Department's proposed further roll-out of budget holding should proceed, providing that the weaknesses in the initial phase are addressed, to achieve the desired outcome for the populations of each Area.
- 40 The episode costing system should be mandatory for all AHSs and be fully adopted across the health system for appropriate services as the means by which AHSs can manage their services and budgets.
- 41 The Department should implement its policy for capital charging in line with its proposed timetable.
- 42 NSW Health should fully explore the use of PFPs in funding and delivering their capital projects.
- 43 In relation to State-wide services, the Department should:
 - continue the system of State-wide program funding but on a restricted basis, limiting its application to a maximum of four years
 - finalise the State-wide and selected speciality funding policy, to be progressively implemented from July, 2003. Funding under this policy should be transparent and be accompanied with output-based or outcome-based performance agreements to ensure accountability.
- 44 The Department should retain a pool of contingency funding each year similar to the Treasurer's Advance for the whole general government sector.
- 45 The Department should establish an Innovation Fund to advance clinical and corporate reforms to the system.
- 46 AHS and statutory corporation budgets and their outcomes should be published each year.

Better performance through clearer roles and accountabilities

- 47 The current AHS structure should be retained but the respective roles and responsibilities of the Department and AHSs should be clarified. The Department's role should be focused on strategic planning and policy-setting roles as outlined in the report. AHSs should be made more accountable for meeting the health needs of their areas.
- 48 The current Senior Executive Forum should be strengthened and reconfigured as a Senior Executive Advisory Board, to facilitate greater input by AHS and statutory corporation CEOs into system-wide matters and to provide a vehicle for improving executive communication within the NSW health system.
- 49 The Department should formally establish an Area (and other entities) Chairpersons' Forum that meets regularly with the departmental executive and the Minister.
- 50 The Department should conduct an efficiency review of circulars, policies, directions, procedures and committees aimed at reducing the 'red tape' in the system.
- 51 The Department should establish an Innovation Exchange to enable all components of the health system to share ideas and advance best-practice models, as a means of progressing reform in the system.
- 52 AHS strategic health plans should be submitted to the Department for review. Each AHS must develop its strategic health plan in line with the requirements of the State health plan, State-wide policies, four-year rolling budgets, approved capital projects and the targets and outcomes set out in their performance agreements with the Department. The Department should review plans for consistency with these requirements. Where an inconsistency is identified it should notify the AHS and request resubmission.
- 53 The Department should continue to approve major capital programs included in Area plans.
- 54 The role of AHS and statutory corporation boards should focus on strategic leadership, not day-to-day management. Board committees should have a similar focus and be supplemented by non-board members.
- 55 AHS and statutory corporation boards should be held accountable for the performance of their AHS via a streamlined performance agreement with the Minister, and be assessed and audited annually by the Department and by themselves.
- 56 AHS and statutory corporation board members should be chosen on merit to provide a variety of skills, and include at least one senior practising clinician. Board members should receive improved training.
- 57 The terms of AHS and statutory corporation board members should be limited to three years, and members should serve a maximum of two terms.
- 58 Remuneration levels for AHS and statutory corporation board members should be reviewed on a regular basis to reflect roles and accountabilities.
- 59 AHS and statutory corporation CEOs should no longer be members of boards, should be selected by a panel that includes the Chair of the AHS board and the Director-General, and should be subject to performance agreements with their board and the Director-General. The CEOs should have similar agreements with their facility, sectoral or clinical stream managers.

- 60 The boards of Sydney metropolitan and Hunter, Illawarra and the Central Coast AHSs should have no more than seven members and there should be a spill of existing board members. Rural AHS boards should be maintained at their current size (except that CEOs will no longer be members).
- 61 AHS and statutory corporation boards and CEOs that significantly or consistently fail to achieve the health and/or financial goals set out in their performance agreements should be subject to sanctions. The ultimate sanction should be their dismissal, in which case the board and/or CEO should be replaced.
- 62 The Probation and Parole Service should be reviewed by the Council on the Cost and Quality of Government to reduce any duplication of its functions with the Corrections Health Service (CHS).
- 63 The Department should establish a formal and integrated network between emergency departments in the metropolitan Areas and the Ambulance Service, building on the Emergency Department Network Activation system.
- 64 To progress this network, the position of Coordinator of Ambulances and Emergency Care should be established. It should be filled by a senior clinician and based at the Ambulance Service's Sydney Operations Centre.
- 65 The pricing schedule of ambulance services should be reviewed to ensure more efficient use of ambulances.

More efficient support services

- 66 NSW Health must ensure that the opportunity for efficiency gains, through the aggregation of corporate and shared services are realised and used to provide better health care.
- 67 IPART considers that this can be achieved through a new body, the Health Shared Services Corporation, established to ensure corporate and other services currently provided by the Department, AHSs and statutory corporations are managed in the most cost-effective manner. The current restrictions limiting contracting out or market testing for clinical services should be removed.
- 68 The new corporation should be governed by a board, chaired by the Director-General, with four Area or statutory corporation CEOs and two private sector representatives. The Area and statutory corporation CEOs should be rotated approximately every three years. The corporation should be managed by a full-time General Manager.
- 69 A taskforce should be established to assist in determining the functions to be transferred to the new corporation or to other Government agencies, and to progress business re-engineering. It should consist of the Department, AHSs, statutory corporations, Premier's Department, Treasury and the Department of Commerce.
- 70 Each service should be subject to a business case to determine the best model for its provision whether as a centralised service, by a group of AHSs, or by other contractual means. Savings from the new procedures should be retained within the Health system.
- 71 The option of outsourcing services should also be examined by the corporation for each business case.

- 72 The Chair of the corporation should have reserve powers of veto to ensure the mandated approach can be applied where it is essential to the efficiency and effectiveness of the system, such as Information Technology.
- 73 Increased uniformity of Information Technology and management solutions is essential, and it is an area that requires clear direction. This should be a high priority for the new Health Shared Services Corporation.
- 74 Treasury should review the funding cap for capital to enable the Department's IT program to proceed as soon as possible, subject to final review of their business cases by Treasury and the Office of Information Technology.

More integrated performance measurement system

- 75 The Department, AHSs, statutory corporations and facilities should draw on best practice in NSW, Australia and overseas, such as the use of balanced scorecard and strategic mapping approaches. Full engagement of the CEO is critical to the success of any approach.
- 76 Where strategic mapping is adopted, the maps should be linked to State-wide strategic directions and State health plans. Strategic maps and locally developed indicators for AHSs should cascade down from the Department's dashboard of key performance indicators (KPIs) for the health system.
- 77 The management 'dashboard' indicators developed by the Department's Committee should be used, taking effect on 1 July 2004. The indicators are high level and reflect system-wide priorities but are capable of being 'drilled down' to highlight variation in performance.
- 78 The new performance measurement system should be underpinned by an integrated IT system that produces timely data.
- 79 Facilities should start reporting patient satisfaction levels.
- 80 A system of incentives and sanctions based on performance against targets and outcomes set in performance agreements should be established. The primary purpose of this recommendation is to enhance performance but it would also ensure that the indicators developed are an integral part of the accountability framework.

A more sustainable health workforce

- 81 The Department should establish a single strategic workforce planning unit to coordinate the development of this workforce plan, and to substantially improve the base of information about NSW Health's workforce.
- 82 The Department should develop an integrated workforce plan designed to ensure a skilled, flexible and adaptable workforce that meets changing patient needs into the future.
- 83 The Department should engage with health care professionals and their unions to address the need to change these professionals' scopes and patterns of practice to enable the development of new models of service delivery and provide more satisfying work environments for employees.

- 84 NSW Health should establish a comprehensive management training program aimed at identifying potential managers and equipping them with the skills necessary to fulfil future management needs.
- 85 AHSs, assisted by the Department, should invest in the development and training of casual nurses to optimise the use of skills and experience available in casual pools. AHSs should accommodate the need of some nurses for high levels of flexibility, perhaps by developing a two-tiered casual pool structure.
- 86 The Department, together with the AHSs, should develop and implement a policy that limits use of agency nurses.
- 87 AHSs should improve the productivity of front-line nurse and other managers by providing more training in managerial skills and additional administrative support.
- 88 The Department should work towards streamlined and centrally coordinated procedures for overseas recruitment of medical staff.
- 89 AHSs should consider appointing more doctors to the AHS rather than individual facilities. This could be extended to clinical network appointments with the cooperation of other AHSs.
- 90 The Department and AHSs should develop strategies to control the increase in salaried medical staff costs. This should include an evaluation of the optimal ratio of VMOs to salaried staff. The Department and AHSs should develop coordinated strategies to achieve greater equity in the distribution of medical staff across Areas.
- 91 The Department should consider strategies for attracting and retaining allied health professionals to the public health system including allowing them to work in both the private and public health sector.

Attachment 3 List of consultation meetings

Organisations

Ambulance Service
Australian Medical Association
Australian Salaried Medical Officer's Federation
Central Sydney Area Health Service
Clinical Council
Corrections Health Service
Darlinghurst Community Health Centre (post-acute care team)
Department of Health
Department of Health and Aged Care, Commonwealth
Department of Human Services, Victoria
Departmental Savings Taskforce
External Review and Evaluation Reference Group
Far West Area Health Service
Greater Metropolitan Transition Taskforce
Health Care Complaints Commission
Health Participation Council
Hunter Area Health Service
Illawarra Area Health Service
Institute of Clinical Excellence
Medical Staff Executive Council
Medical Training and Education Committee
Mid North Coast Area Health Service
Mid North Coast Consumer and Community Health Forum
Ministerial Advisory Committee on Quality
Northern Sydney Area Health Service
New England Area Health Service
NSW Treasury
Post-graduate Medical Council
Premier's Department
Productivity Commission
Public Health Forum
Quadrangles (Greater Western Sydney, Southern, Northern)

Rural Area Health Service CEOs Group
Senior Executive Forum
South East Sydney Area Health Service
South West Sydney Area Health Service
The Cabinet Office
Western Sydney Area Health Service

Individuals

Professor Stephen Duckett
Professor John Horvarth
Dr Sue Ieraci
Professor Brian McCaughan
Dr Louis McGuigan
Professor Ron Penny
Professor Beverley Raphael

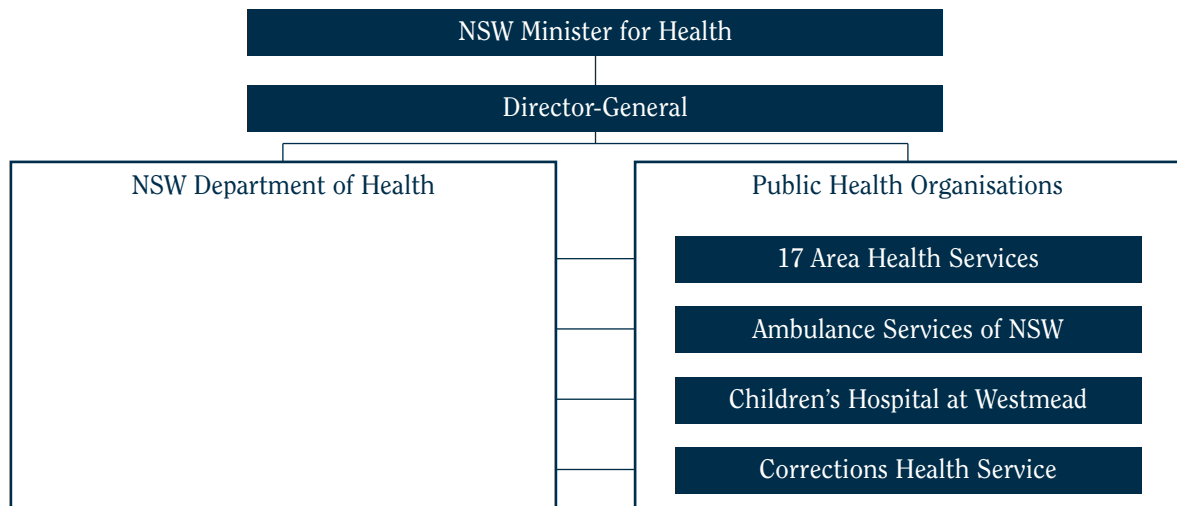
Attachment 4 Current structure of NSW Health system⁵²

The aim of NSW Health is to provide a sustainable health system for the people of NSW, that not only meets today’s health needs but also responds to the health needs of the future.

NSW Health is made up of:

- the Department of Health (the Department)
- 17 Area Health Services (AHSs), which provide hospital and community health services within a defined geographic area
- four statutory corporations—Corrections Health Service, Ambulance Service of NSW, the New Children’s Hospital at Westmead and the Institute of Clinical Excellence.

Figure A4.1 Structure of NSW health system



NSW Minister for Health

The Minister for Health is responsible for the provision of health services within NSW.

Under the *Health Administration Act*, 1982, the Minister formulates policies to promote, protect, maintain, develop and improve the health and wellbeing of the people of NSW, given the resources available to the State. The Minister is also responsible for Acts of Parliament relating to a range of health activities.

NSW Department of Health

The NSW Department of Health is responsible for providing the people of NSW with the best possible health care. It also supports the statutory role of the Minister for Health and monitors the performance of the NSW health system.

⁵² Source: NSW Department of Health, *Annual Report, 2001–2002*.

The Department makes recommendations to the Minister on funding public hospitals and community health services, develops policy, and manages public health issues and some aspects of long-term and community care. It is responsible for regulating private hospitals, nursing homes, and public and environmental health.

Public health organisations

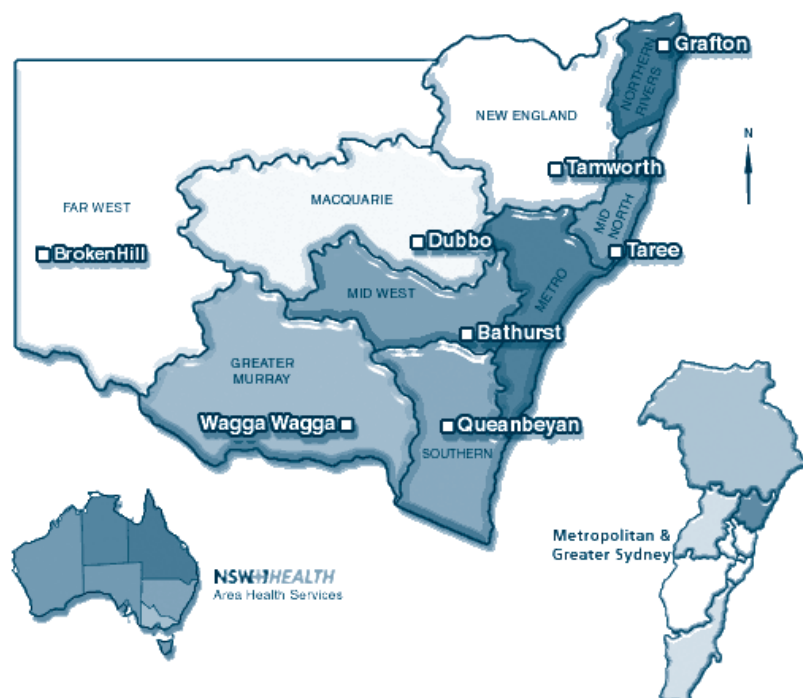
The *Health Services Act, 1997* describes Area Health Services and other legal entities within the NSW public health system as ‘public health organisations’. These organisations, which operate as separate entities within the NSW health system, include 17 Area Health Services, the Ambulance Service of NSW, the New Children’s Hospital at Westmead, Corrections Health Service and the Institute of Clinical Excellence.

Public health organisations play a major role in the planning, delivery and coordination of local health services. They are responsible for providing services such as public and community health, public hospitals, psychiatric hospitals, emergency transport, acute care, rehabilitation, counselling and many community support programs. These services are provided in a wide range of settings, from primary care posts in the remote outback to metropolitan tertiary health centres.

Affiliated health organisations are managed by religious or charitable groups. These services and facilities are recognised under the *Health Services Act, 1997*, and are also an important part of the NSW public health system.

Figure A4.2 Map of Area Health Services

Source: NSW Department of Health, *Annual Report, 2001–2002*.



Health Administration Corporation

The Director-General, as the Health Administration Corporation, has a pivotal workforce relations role in the NSW public health system. The Corporation is the legal employer of health system staff for the purpose of negotiating and determining wages and conditions of employment, and overseeing industrial matters.

Attachment 5 Trends in hospital admissions and activity levels

Analysis of hospital admission trends

IPART engaged consultants Hardes and Associates to analyse the impact of population growth, ageing and underlying admissions rates on total admissions by public and private hospitals for the period from 1996/97 to 2001/02. This attachment reports the results of the analysis by Hardes and Associates.

This analysis is important to the extent that the Department, AHSs and facilities should include demand driver analysis in their medium- to long-term planning. It is important to know what the underlying drivers of hospital services demand are as management has to know to what extent it can influence future demand levels.

This attachment also benchmarks relative hospital utilisation rates by AHSs and public and private hospitals. The purpose of this benchmarking is to analyse and compare the level of supply of public and private hospital services in rural and urban areas of NSW. This forms another important part of the medium- to long-term planning of the Department, AHSs and hospitals. This section identifies that the level of supply of private hospitals can have a considerable influence on the utilisation rates of public hospital services.

Lastly, the relative utilisation rates of public and private hospitals in NSW, Victoria and Queensland were benchmarked. The aim was to understand what the NSW pattern of admissions would look like if residents of NSW accessed hospitals at the same rate as Victorians and Queenslanders; and how many bed days would be used if residents of NSW had the same length of stay profile as Victorians and Queenslanders (while keeping the NSW casemix constant).

Detailed analysis of the trends indicates that:

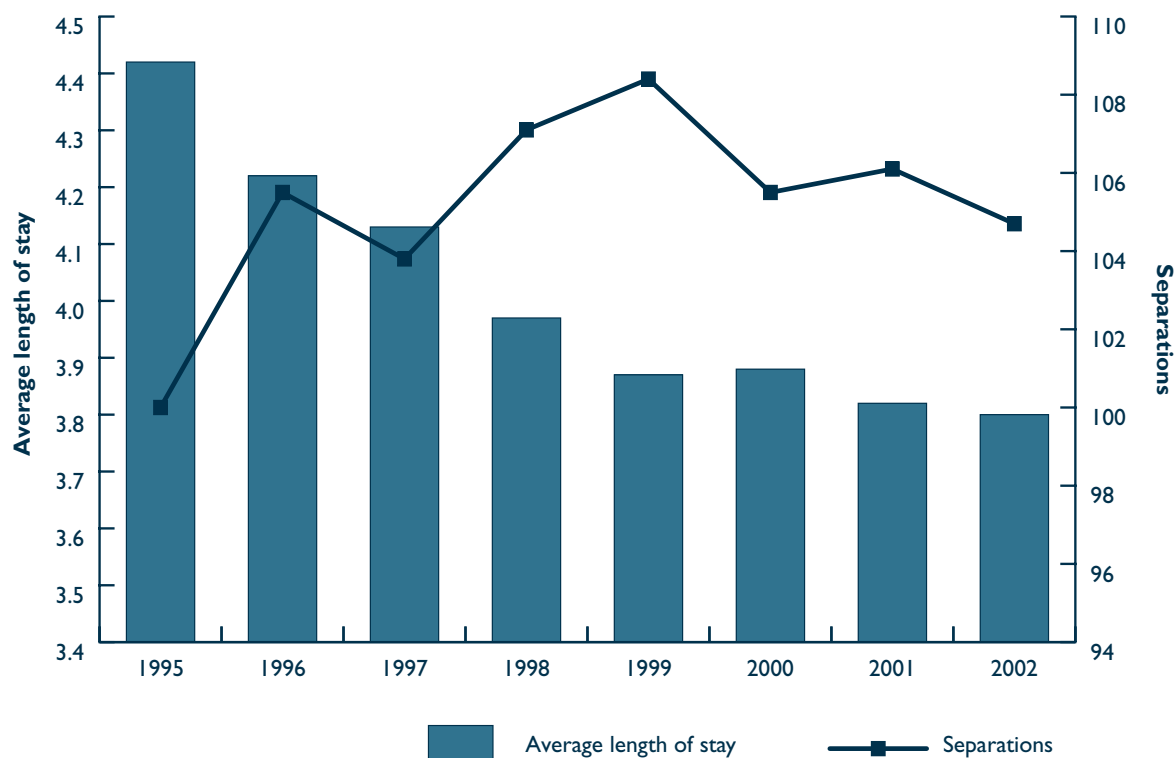
- The influence of non-demographic factors—such as new procedures—on total growth in separations in public hospitals is considerably less compared to the analysis undertaken for the 1998 IPART review with correspondingly higher influence of population growth and ageing.
- Rural areas are undersupplied in public and private hospital services compared to urban areas. Furthermore, there is a significant degree of variation in health status and outcomes between metropolitan and remote areas.
- The NSW public health system seems to concentrate on providing core overnight services. The Victorian casemix approach on the other hand encourages and rewards higher levels of activities. There is also a substantial difference in private hospital usage between NSW and Victoria. The comparatively low private hospital usage in NSW may be a significant factor in determining pressure on the NSW public health system.

Some of the conclusions the Department can draw from this analysis include that:

- there is a need for better planning and analysis of trends in hospital utilisation
- an undersupply of private hospitals in rural areas of NSW entails a relatively high utilisation rate of public hospitals compared to urban areas
- the comparison of NSW to Victoria and Queensland indicates that the Department should explore whether increases in activity levels linked to casemix funding could achieve better health outcomes in NSW.

Figure A5.1 illustrates the trend in decreasing average length of stay (ALOS) and growing separation numbers (equivalent to admissions to hospitals) from 1995 to 2002 in public hospitals in NSW. The trend in decreasing ALOS has continued over the last three years. There is however a slight decrease in overall separations since 1999 which might indicate that NSW Health has taken a proactive approach to managing surgical volumes in hospitals. It has to be noted that decreases in ALOS do not necessarily imply a decrease in cost as the overall intensity of care has been increasing. The data also does not include patients treated as outpatients. It therefore understates the overall activity level of the NSW public health system.

Figure A5.1 Acute public hospital separations and average length of stay for all service-related groups (SRGs)



Source: NSW Health.

Note: Separations include principal referral and other acute separations. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

Attachment 5 Trends in hospital admissions and activity levels

The Department has undertaken steps to reduce length of stay in hospitals by setting targets for day-of-surgery and day-only surgery admissions.

The Acute Care Implementation Coordination Group, established under GAP, set two targets for booked surgical admissions in 2000:

- 1 80 per cent of booked surgical patients requiring overnight hospitalisation following the procedure to be admitted on the day of surgery
- 2 60 per cent of surgical patients to be booked as day only.

These targets were incorporated in the performance agreements of AHSs with most achieving, and many exceeding, the targets within the first two years. In September 2002, the rate of day-of-surgery admissions was 84.7 per cent and day-only admissions was 58.3 per cent.⁵³

Benefits of the targets are improved patient care through reduced infection rates and blood clotting, better preparation of patients for their procedure and better utilisation of beds.

The targets demonstrate effective use of outcome indicators by the Department to drive improved delivery of services that enhance patient care. The effectiveness of this approach to achieve change is widely acknowledged.

As the following analysis indicates, there is more work to be done, especially in regards to conducting a thorough analysis of the demand drivers for hospital services. This kind of analysis should form an integral part of the medium- and long-term planning of the Department, AHSs and facilities.

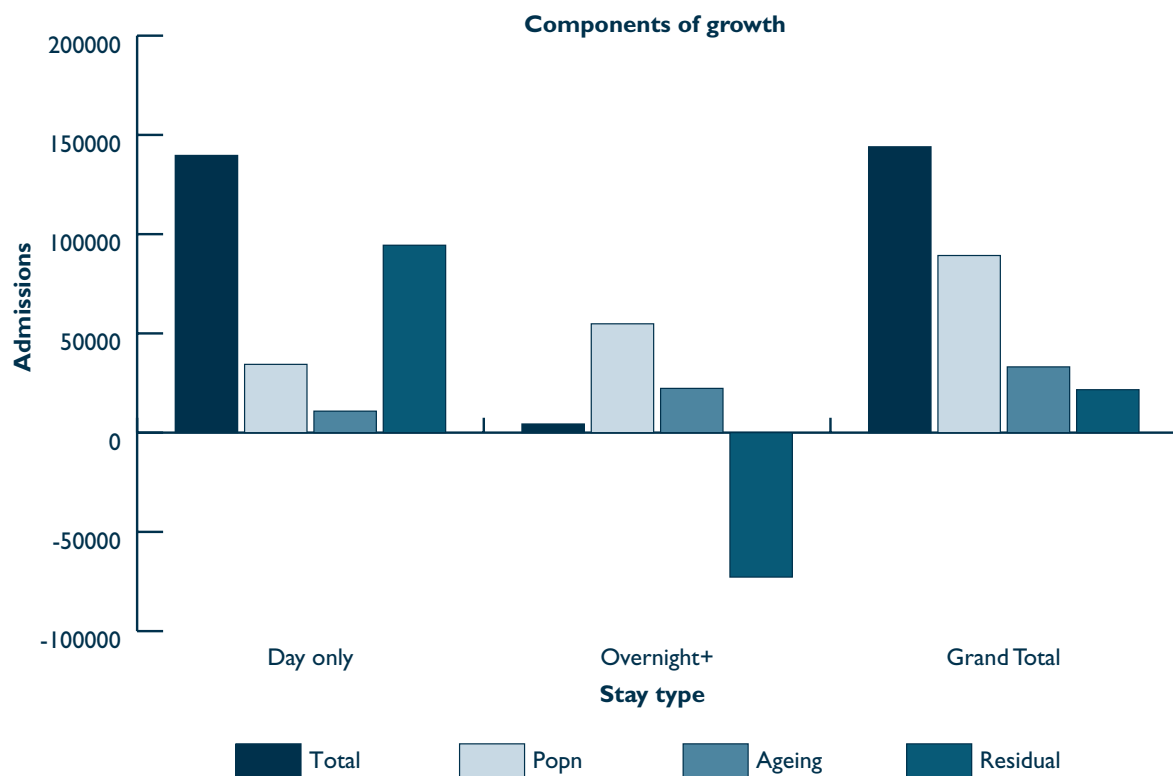
Analysis of trends in acute hospital admissions in NSW

Hardes and Associates found that overall there has been an increase of about 144,000 admissions or 9.7 per cent in public and private hospital admissions for the period from 1996/97 to 2001/02. However, overnight admissions in public hospitals have decreased by 3.4 per cent. Same-day admissions during the same period have increased by about 15 per cent. For NSW to control the growth in admissions, it is important to understand whether these increases are due to population growth, ageing or underlying admission rates. While the Department has some control over the latter, the former two cannot be contained easily. The increase in same-day procedures (36.5 per cent) has been even greater in the private sector as it has been targeting services with high potential to expand beyond population growth.

Figures A5.2, A5.3 and A5.4 show the absolute change of separations in total and by public and private hospital for the period from 1996/97 to 2000/01. Tables A5.1, A5.2 and A5.3 show the same numbers as percentage contributions to the absolute change in numbers of separations. The number of separations is broken down into their estimated contribution to absolute growth of separations over the period.

⁵³ External Review and Evaluation Reference Group, *Report on NSW Government Action Plan for Health 2000–2002*, 2002.

Figure A5.2 Estimated breakdown of absolute total change in all separations (public and private) in NSW 1996/97—2001/02



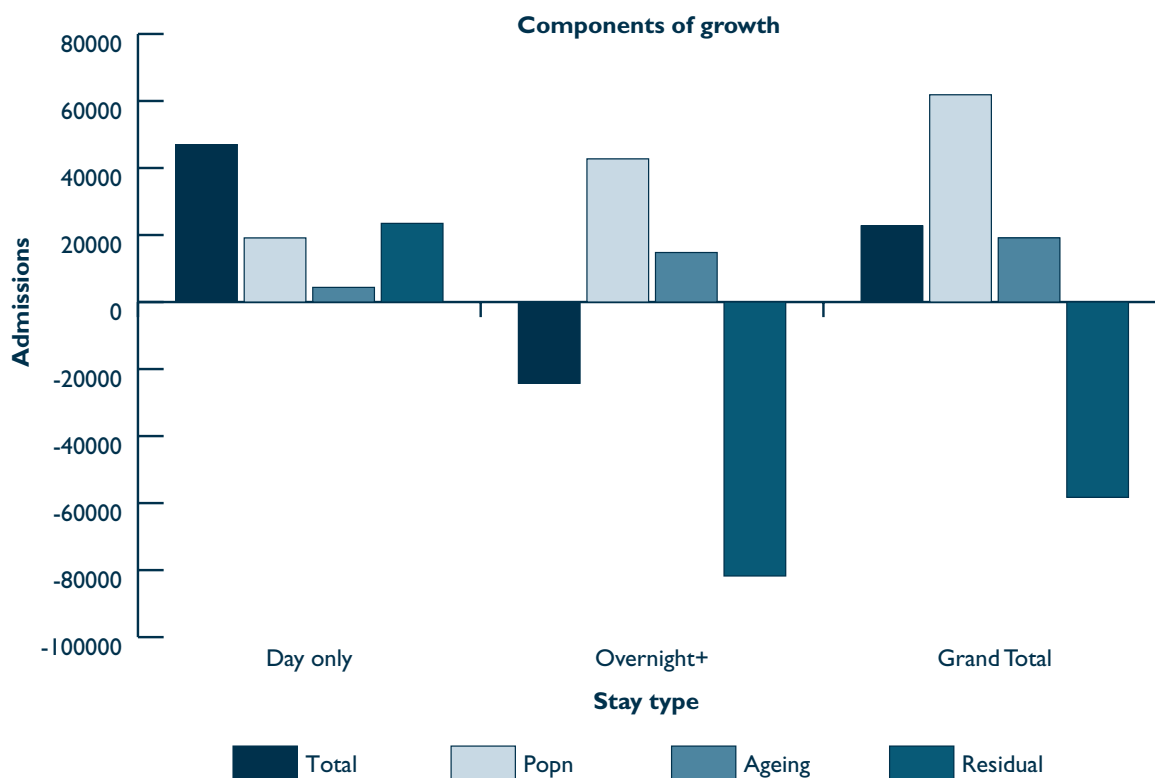
Source: HARDS & ASSOCIATES 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

Table A5.1 Percentage contribution to absolute total change in all separations (public and private)

Stay type	Percentage contribution		
	Population growth	Ageing	Underlying admissions
Day only	25	8	68
Overnight+	1257	511	-1668
Total	62	23	15

Attachment 5 Trends in hospital admissions and activity levels

Figure A5.3 Estimated breakdown of absolute change in public separations in NSW 1996/97 – 2001/02

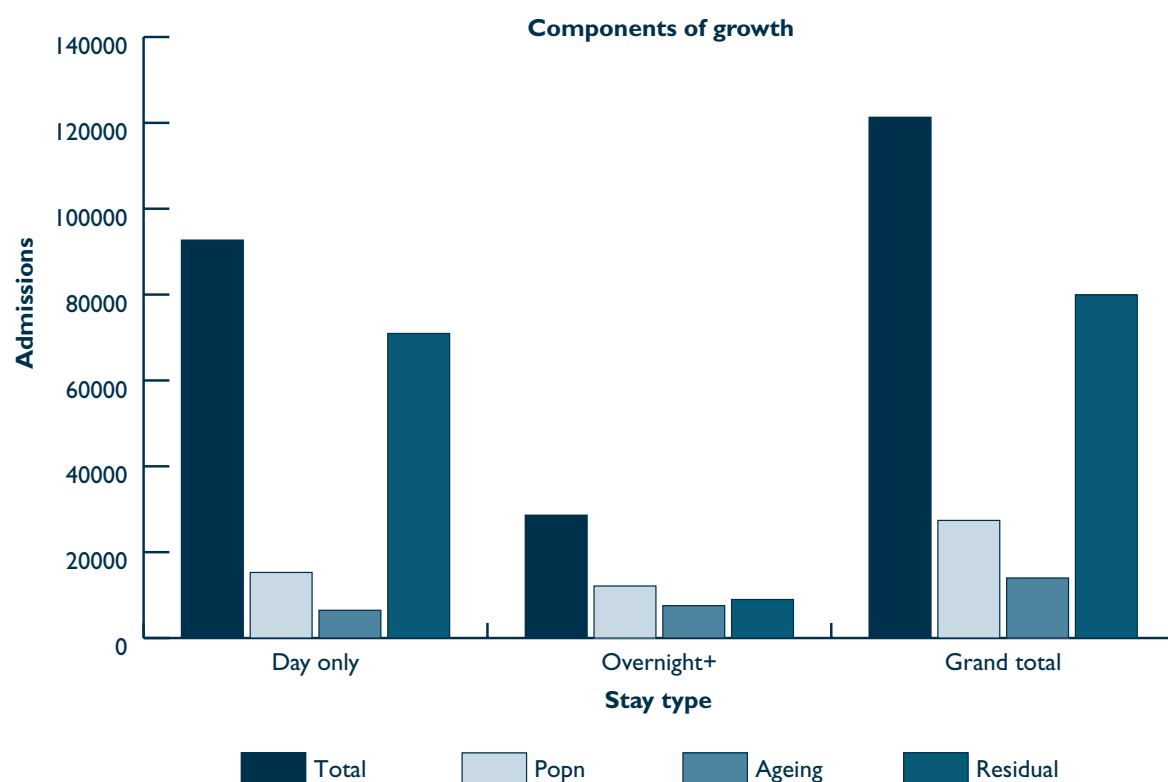


Source: Harde & Associates 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

Table A5.2 Percentage contribution to absolute total change in all separations (public)

Stay type	Percentage contribution		
	Population growth	Ageing	Underlying admissions
Day only	41	9	50
Overnight+	-176	-61	337
Total	272	84	-256

Figure A5.4 Estimated breakdown of absolute change in private separations in NSW 1996/97 – 2001/02



Source: Hardes & Associates 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

Table A5.3 Percentage contribution to absolute total change in all separations (private)

Stay type	Percentage contribution		
	Population growth	Ageing	Underlying admissions
Day only	16	7	77
Overnight+	42	26	31
Total	23	12	66

Figure A5.2 and Table A5.1 indicate that the increase in admissions in NSW hospitals in percentage terms (public and private) is due to population growth (62 per cent), ageing (23 per cent) and a residual of 15 per cent reflecting increases in underlying admission rates. The residual admission growth reflects changes in the underlying admission rate and picks up the effect of supply side factors such as new technologies, new procedures and increasing use of existing procedures.

For example, for day-only admissions (public and private) the major driver is underlying admission rates (ie the residual)—accounting for 68 per cent of growth (from Table A5.6). This figure is too high to be simply a function of work moving from overnight to day-only. Clearly, this is a challenge to the health system. NSW Health and clinicians have to ensure the underlying changes in treatment are properly supported by evidence-based medicine.

Attachment 5 Trends in hospital admissions and activity levels

It is interesting to note, however, that compared to the 1998 IPART review the influence of admission growth is considerably less, with correspondingly higher influence of population growth and ageing. This is consistent with the data in Table A5.2.

The figures in Table A5.4 represent the relative contribution to overall growth based upon population growth, ageing and a residual representing underlying admission rates. These figures cannot be directly compared to the figures in Tables A5.1, A5.2 and A5.3 as they are estimates of the expected utilisation rates when population growth is set at 6 per cent.

Table A5.4 Relative contribution—estimated breakdown of the expected growth in weighted separations in NSW—2001/02 based on population growth, ageing and admission rates.

All separations	Population	Ageing	Residual	Total
Total	6.0%	2.2%	1.5%	9.7%
Overnight +	6.0%	2.5%	-8.0%	0.5%
Day only	6.0%	1.9%	16.5%	24.5%
Public separations				
Total	6.0%	1.9%	-5.7%	2.2%
Overnight +	6.0%	2.1%	-11.5%	-3.4%
Day only	6.0%	1.4%	7.4%	14.8%
Private separations				
Total	6.0%	3.1%	17.6%	26.7%
Overnight +	6.0%	3.7%	4.5%	14.2%
Day only	6.0%	2.6%	28.0%	36.6%

Source: HARDS & ASSOCIATES 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

In absolute terms, total admissions (public and private) grew by 9.7 per cent over the last five years. This figure can be disaggregated into a 6 per cent increase due to population growth, a 2.2 per cent increase due to ageing and a residual of 1.5 per cent which represents an increase in underlying admission rates.

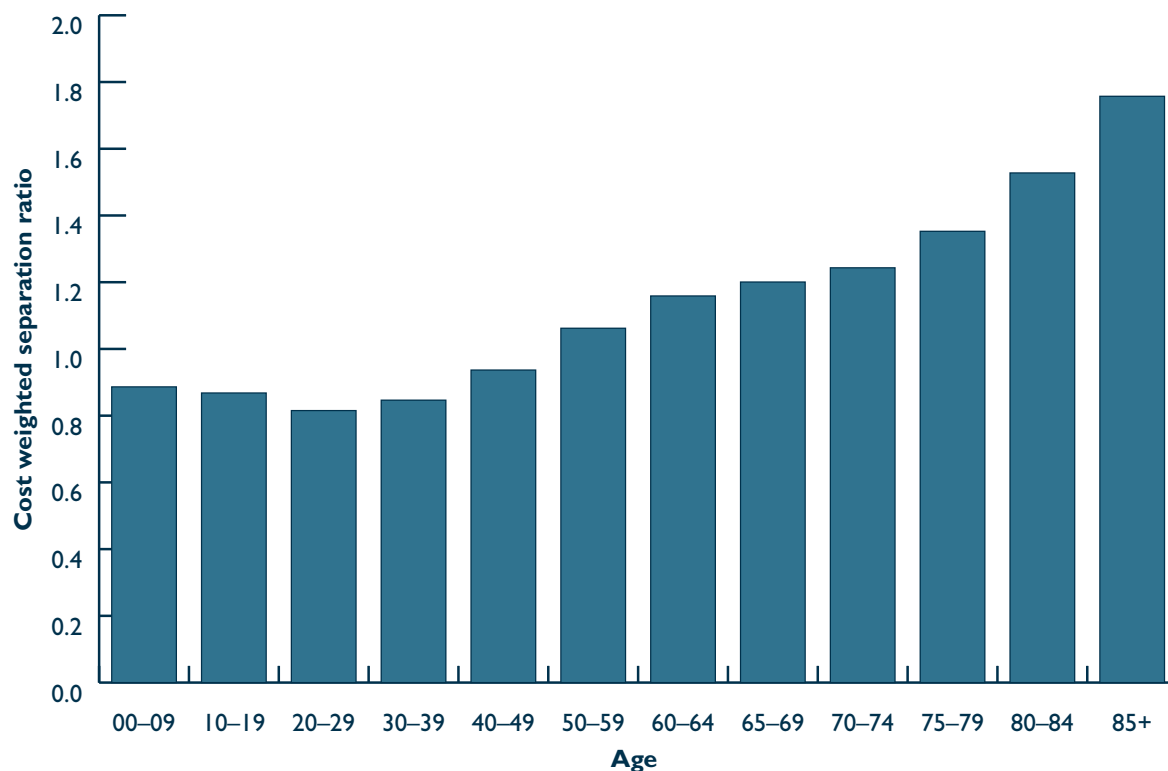
However, Table A5.4 indicates that the relative influence of population growth, ageing and change in underlying admission rates varies enormously according to hospital type and stay type.

Figure A5.2 also indicates that there has been virtually no growth in overnight admissions (public and private)—a remarkable fact given that population growth should have increased admissions by 6 per cent and ageing a further 2.5 per cent. The total effect of growth has been almost offset by an 8 per cent decrease in admission rates. Public hospitals have experienced a high decrease in underlying admission rates of 11.5 per cent leading to a total decline of 3.4 per cent in overnight admissions. Part of the decrease in overnight admissions would be due to change in clinical practice, including the shift to day-only services and to non-inpatient

services. It is important to note that unlike day-only admissions, many of the overnight admissions (especially those associated with urgent/emergency admissions) are undertaken mainly in the public sector. These services are relatively inelastic and the public health system has done well to control the growth in overnight admissions.

It also has to be noted that there is a substantial difference between the cost weights for different age groups of the population, which has implications for the ageing component of growth. Figure A5.5 displays cost-weighted separation ratios for different age groups in 2002.

Figure A5.5 Cost-weighted separation ratio by age group in 2002



Source: NSW Health.

Note: Separations include principal referral and other acute separations. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates.

Figure A5.5 clearly shows the rise in health costs for age groups above 70–74. The cost-weighted separation ratio for the 85+ age group is almost double that of the 20–39 age groups. Thus the pressures on the health system from the ‘baby boomers’ will come when that generation exceeds 75 years of age, in 2020 and beyond.

Another area to be investigated is the cost of changes in technologies. Public Health Professor Stephen Leeder from the University of Sydney says that the *Intergenerational Report* indicates that technology is actually accounting for two-thirds of the price pressure in health care, and ageing one-third, which he says is quite different from the impression the Federal Government has given.⁵⁴

⁵⁴ Armstrong F. What next for health funding? (Feature.) *Australian Nursing Journal*, July 2002; 10(1): 25–27.

Attachment 5 Trends in hospital admissions and activity levels

Unlike the public sector where most concern is with equity of access and the management of demand, the private sector is actively seeking to provide services with high expansion potential, ie services where there is significant growth over and above population growth and ageing. These services can generally be characterised as highly elastic and extremely responsive to supply. Table A5.4 indicates that over the last five years there has been a 26.7 per cent increase in total admissions to private hospitals. Most of this (17.6 per cent) is attributed to increases in the underlying admission rates. For day-only admissions, the contribution to the absolute increase of 36.6 per cent is mainly due to a 28 per cent increase in admission rates. This indicates that the private sector is successfully targeting services with high potential to expand above and beyond population growth. This is in clear contrast to the public sector—reinforcing the need to use sector-specific analyses rather than overall figures that comprise components with very different casemixes and imperatives.

Table A5.4 shows that overall growth in admissions in the public sector was only 2.2 per cent. This did not keep up with the impact of population growth and ageing. Admission rates fell by 5.7 per cent in absolute terms. Overall growth in day-only admissions was 14.8 per cent in absolute terms, substantially less than in the private sector. This also reflects that some in-patient procedures are becoming outpatient procedures in the private sector.

One of the implications of this analysis is that more people are being treated in public hospitals, but fewer as overnight patients—despite population growth and ageing. NSW Health has been successful in managing demand for acute admissions. The intensity of care for patients admitted overnight is increasing while average length of stay is decreasing.

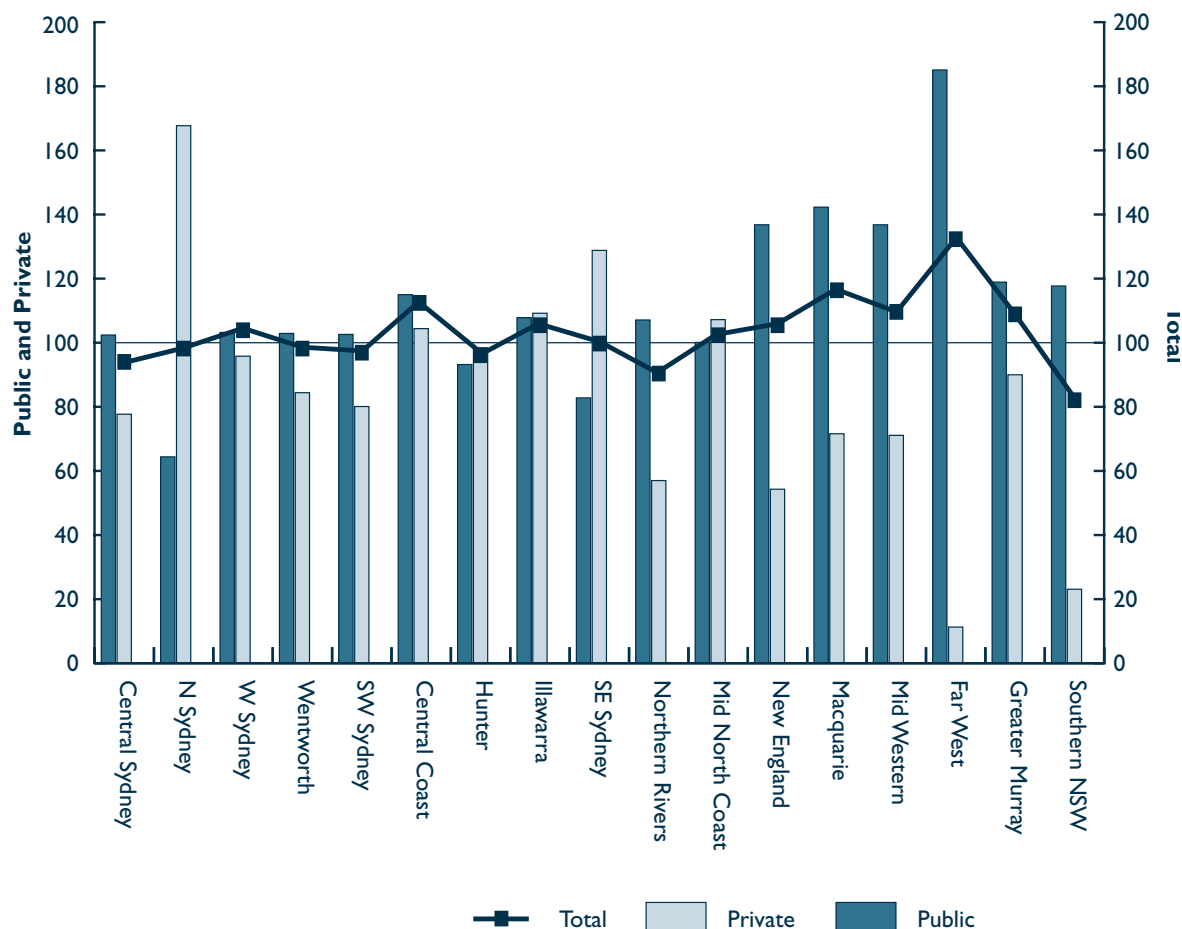
Benchmarking comparison within Areas of NSW

The Tribunal analysed the relative utilisation rates of AHSs in NSW to understand:

- how effective the RDF-based funding model has been in achieving an equitable distribution of health services across the State
- the relative utilisation rates of public and private hospitals across the State.

Figure A5.6 indicates that the supply of public and private hospital services in rural Areas of NSW is well below that of metropolitan Areas. The figure shows relative utilisation rates by AHS and public and private sector. The average utilisation rate across the State is indexed at 100. The relative utilisation rate is representing the use of public hospital services in one AHS relative to the state average. NSW residents treated interstate are not included. As a consequence, relative utilisation rates for Areas such as Northern Rivers and Southern NSW are lower than actual utilisation when interstate treatment is included.

Figure A5.6 Relative utilisation rates for NSW AHSs by public and private hospitals and same-day and overnight admissions



Source: Harde & Associates 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis and 74 Unqualified Neonates. Each series is converted to an index where 100 equates to average utilisation.

A first observation is that there is a fairly high relative public hospital utilisation rate in the more remote areas of NSW. Relative utilisation of the non-metropolitan Area Health Services is generally higher than metropolitan rates. This can partly be explained by the need to practise medicine more conservatively in rural areas, eg patients are generally discharged later in rural than in urban areas. Another important factor that impacts on non-urban relative utilisation rates is the undersupply of private hospitals in rural areas. This is confirmed by the very low relative utilisation rates of private hospitals in rural areas. The low supply of private hospitals in rural areas is accompanied by increased supply of public hospitals. This variation in public/private mix will also be reflected in patterns of activities. Rural areas have typically higher rates of medical admissions and lower rates of surgical/procedural admissions.

Attachment 5 Trends in hospital admissions and activity levels

Figure A5.7 Health indicators—urban/rural, rates per 100,000 persons

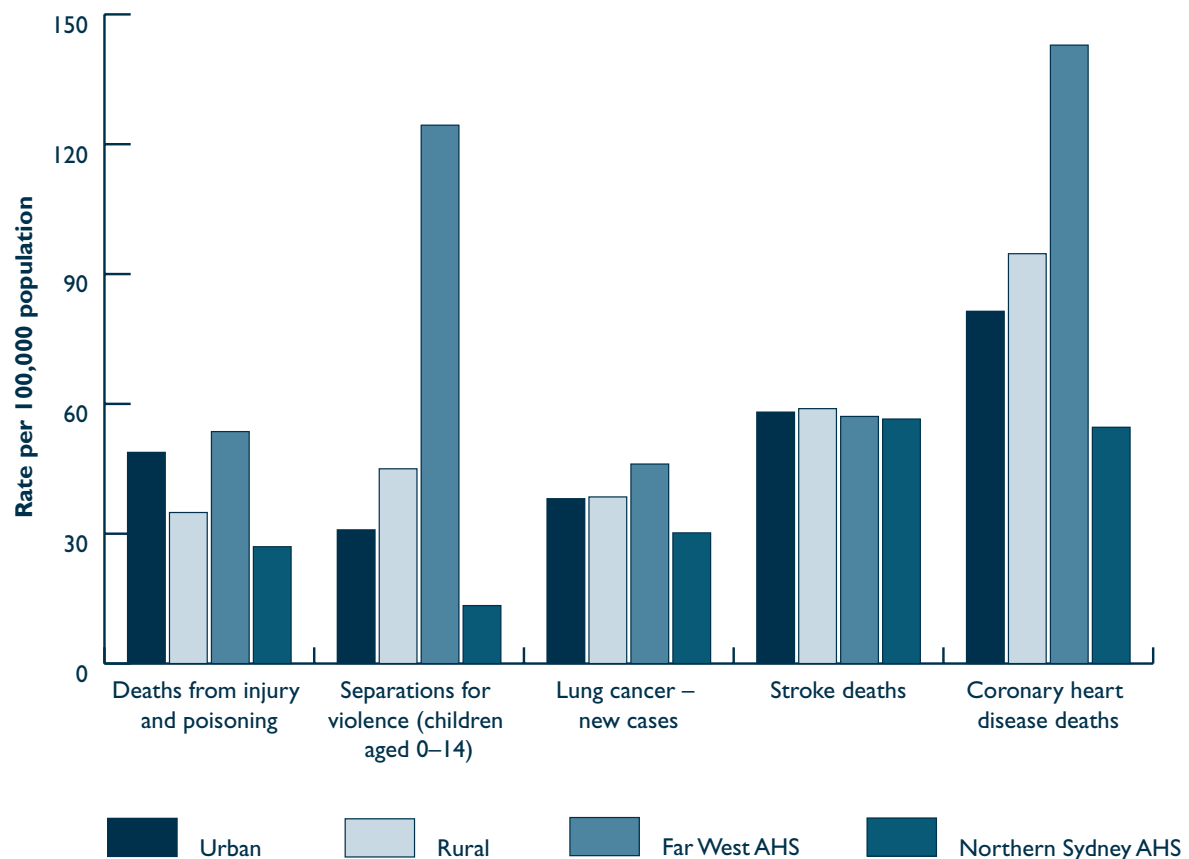


Figure A5.7 indicates that there is still a very high degree of variation in the health status and outcomes between the urban and rural population of NSW. Except for strokes, rural areas seem to be undersupplied in clinical services. Furthermore, external factors, such as lifestyle, impact considerably on the amount of health resources needed in rural areas. This is very clearly indicated by the much higher rate of new lung cancer cases in the Far West AHS as compared to Northern Sydney AHS.

Much of the variation experienced in rural areas is due to an uneven distribution of clinical specialists. This also has an effect on the supply of private facilities in non-metropolitan areas. In these circumstances it is not possible to reduce all of the geographic variation by using the RDF alone. A more equal distribution of the workforce could support NSW Health's effort to reduce geographical inequalities in health resource distribution.

Benchmarking comparisons of NSW with Victoria and Queensland

Benchmarking can be used to understand whether there are differences in health service provision for NSW. Ideally one would like to use health outcomes for the community as the basis for comparison. However this is difficult and this section compares outputs such as relative utilisation and average length of stay for NSW, Victoria and Queensland. This allows us to gain some insight into the relative performance of the NSW health system as compared to Victoria and Queensland. While it is then possible to compare this to inputs, the absence of comparative health outcomes and quality-adjusted outputs is an important limitation.

Relative utilisation rates

Tables A5.5 and A5.6 set out the relative utilisation rates of public and private hospitals in NSW, Victoria and Queensland. The relative utilisation rate represents expected separations in NSW if it had Victorian/Queensland admission rates. A figure lower than 1 indicates the rate of admissions in NSW is lower than in Victoria/Queensland for the same population mix.

Table A5.5 Relative utilisation—ratio of sex/age-adjusted admissions—NSW/VIC

Stay type	Public	Private	Total
Day only	0.77	0.84	0.80
Overnight+	1.09	0.80	1.00
Total	0.96	0.82	0.90

Source: Hards & Associates 2003.

Note: Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis.

Table A5.6 Relative utilisation—ratio of sex/age-adjusted admissions—NSW/QLD

Stay type	Public	Private	Total
Day only	0.95	0.67	0.79
Overnight+	1.05	0.59	0.87
Total	1.01	0.63	0.84

Source: Hards & Associates 2003.

Note: Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis.

The relative utilisation rates give us some interesting insights into what the NSW health system would look like if it were operated like the Victorian/Queensland health system. Under this scenario, overall admission rates in NSW are only 90 per cent of the rates in Victoria and 84 per cent of the rates in Queensland. At 96 per cent, total public admissions in NSW are slightly lower than in Victoria. NSW and Queensland total public admission rates are very similar at 101 per cent.

It has to be noted that private hospital rates in NSW are considerably lower than in Victoria for both day-only and overnight admissions (total of 82 per cent), and even lower when comparing NSW to Queensland (total of 63 per cent). This indicates that NSW has a much lower supply of private hospital services than Victoria and Queensland. NSW Health should investigate why this is the case as it obviously puts pressure on the public system.

Lastly, total public relative utilisation rates look very similar for NSW, Victoria and Queensland. However, the breakdown into day-only and overnight admissions shows that NSW performs considerably fewer day-only and more overnight services than both Victoria and Queensland. NSW performs 77 per cent of the day-only admissions performed in Victoria and 95 per cent of those performed in Queensland.

Several points are noted. Lower private hospital relative utilisation rates in NSW may reflect a more aggressive private sector in Victoria. However, NSW has more rural areas with fewer private hospitals and this could explain at least in part the lower rates for private hospital utilisation in NSW.

Attachment 5 Trends in hospital admissions and activity levels

In addition, an important priority of the NSW health system is to achieve equity, not simply to increase activity levels. Many of the differences in relative utilisation rates may be explained by the differences between pursuing a population-based funding model designed to achieve equity of access and utilisation in NSW and the Victorian casemix approach that encourages and rewards higher levels in activity.

The other important divergence between NSW and Victoria/Queensland is the substantial difference in private hospital usage. While the private sector is not a perfect substitute for the public sector, the comparatively low private hospital supply and utilisation in NSW may be a significant factor in determining pressure on public hospitals. The NSW public health system seems to have concentrated on providing the core overnight services in public hospitals and has not sought to provide the same volume of *discretionary* services as Victoria or Queensland. Due to low supply and utilisation of private hospitals in NSW, these services have not totally been picked up in the private sector.

Average length of stay

The following analysis shows how many bed days would be used if residents of NSW had the same length-of-stay profile as residents of Victoria and Queensland (while keeping the NSW casemix constant). Table A5.7 sets out the NSW casemix-adjusted day-only admissions and average length of stay figures.

Table A5.7 Comparison of average length of stay NSW/Vic and Qld in public hospitals

	Day only		Overnight	
	Admissions %	Adjusted to NSW casemix	ALOS	Adjusted to NSW casemix
NSW	33.4	–	5.10	–
Victoria	41.9	37.3	4.97	5.03
Qld	36.7	32.9	5.21	4.82

Source: Harges & Associates 2003. Excludes the following SRGs: 20 Chemotherapy, 23 Renal Dialysis.

Overall, NSW public hospitals treat 33.4 per cent of admissions on a day-only basis, compared to 41.9 per cent in Victoria. However, when adjusted to the NSW casemix, the Victorian figure falls to 37.3 per cent.

Compared to Queensland, these figures are slightly lower, with day-only admissions at 36.7 per cent and when adjusted to the NSW casemix, the Queensland admission rates are slightly lower than in NSW at 32.9 per cent.

Average length of stay for overnight patients in NSW public hospitals is 5.1 days compared to 4.97 days in Victoria. When adjusted to the NSW casemix, the average Victorian stay increases to 5.03 days.

Average length of stay in Queensland is higher than in NSW at 5.21 days. When adjusted to the NSW casemix however, this figure falls to 4.82 days, which is lower than both NSW and Victoria.

Using the Victorian figures, the combined effect of the higher day-only admission rate and the marginally lower length of stay for overnight admissions is that NSW public hospitals would utilise around 230,000 fewer bed days for their current patient mix and volumes if they adopted Victorian profiles. From a base of about four million bed days this represents a possible saving of 5.6 per cent. It is however questionable if this saving would be realised. Fewer bed days may imply that there would be an increase in the number of separations and therefore no real cost saving would be achieved.

However, it is important to bear in mind that the Victorian admission rates to public hospitals are about 4 per cent higher than in NSW and substantially higher for day-only admissions. If we assume that the underlying health requirements are similar it may be concluded that the additional admissions to Victorian hospitals would be generally for slightly less severe cases within any given Australian National Diagnosis-Related Group (ANDRG). This would contribute to a lowering of length of stay in Victoria relative to NSW. This variation is often explainable in terms of public/private hospital mix and distribution of clinical support.

The differences between NSW and Victoria seem less related to efficiency of service delivery than to historic differences in approaches to managing public hospitals—and to public health goals. The same is true for Queensland. As mentioned earlier many of the differences in relative utilisation rates may be explained by the differences between pursuing a population-based funding model designed to achieve equity of access and utilisation in NSW and the Victorian/Queensland casemix approach that encourages and rewards higher levels of activity.

Especially Victoria seems to be doing more with less compared to NSW. However, it remains uncertain whether:

- this involves better health outcomes
- there are NSW specific factors such as costs which impact on the analysis.

The analysis also does not take explicit account of community and population health programs.

While there are these uncertainties, the comparisons do set a challenge for NSW Health to:

- understand the cause of the differences
- look for opportunities to achieve better health outcomes through higher activity levels.

Attachment 6 Funding and cost drivers for NSW Health

Table A6.1 Funding for NSW Health

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	1996/97 –2001/02 Change
Total revenues*	809	803	902	974	1,012	1,069	32.2%
Recurrent appropriation	4,563	4,934	5,345	5,588	5,939	6,235	36.6%
Govt acceptance of employee liabilities	246	257	296	298	334	360	46.5%
Capital appropriation	356	294	308	314	378	434	22.1%
Total Govt contribution	5,165	5,485	5,948	6,199	6,652	7,029	36.1%
Operating and maintenance expenses	5,173	5,710	5,895	6,360	6,615	7,088	37.0%
Depreciation and amortisation	255	293	316	305	316	338	32.6%
Other expenditure**	545	490	767	528	575	589	8.1%
Total expenses	5,973	6,494	6,978	7,193	7,506	8,015	34.2%
Govt contribution as % total expenses	86.5%	84.5%	85.2%	86.2%	88.6%	87.7%	1.4%
Real total Govt contribution (2001/02 \$)	5,838	6,201	6,638	6,757	6,842	7,029	20.4%
Real recurrent Govt appropriation (2001/02 \$)	4,037	4,364	4,789	5,126	5,774	6,235	54.4%
Real increase in Govt contribution (2001/02 \$)	–	6.2%	7.0%	1.8%	1.3%	2.7%	–
Real increase in recurrent Govt appropriation (2001/02 \$)	–	8.1%	9.7%	7.0%	12.6%	8.0%	–

Source: NSW Health *Annual Reports*. All amounts expressed in 'million dollars of the day'.

* Revenue excludes loss/gain on the sale of assets.

** Grants and subsidies, finance costs and asset devaluation.

Table A6.2 NSW Health expenditure by category (nominal)

Cost category	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	Change	% of total change
Medical salaries	424,815	479,141	525,528	554,874	588,752	622,178	46%	10%
Nursing salaries	1,352,167	1,444,207	1,522,059	1,536,728	1,556,886	1,629,193	20%	14%
Administrative and clerical salaries	429,050	509,511	568,453	614,777	620,952	667,939	56%	12%
Ambulance uniformed officers salaries	131,671	156,037	166,857	174,010	185,114	194,918	48%	3%
Other salaries	911,452	1,015,589	1,044,225	1,055,093	1,072,419	1,126,943	24%	11%
Superannuation	252,375	254,274	293,344	295,995	330,211	363,507	44%	5%
Nursing agency payments	9,564	19,733	24,050	27,379	36,180	45,529	376%	2%
Other agency payments	1,477	2,686	2,726	6,586	11,998	13,608	821%	1%
Workers compensation	112,470	132,400	157,609	161,755	136,227	153,858	37%	2%
Payroll/fringe benefits tax	3,029	3,486	3,897	3,500	3,777	4,483	48%	0%
VMOs	260,857	286,643	299,007	290,923	292,358	320,271	23%	3%
Drugs	191,202	212,003	232,350	246,257	255,946	276,718	45%	4%
Medical and surgical supplies	229,247	238,868	275,438	293,287	313,342	346,715	51%	6%
Special service departments	123,727	119,963	118,426	125,305	133,691	150,595	22%	1%
Domestic charges	71,081	69,545	73,915	77,575	79,963	83,467	17%	1%
Food supplies	61,168	64,763	62,409	63,870	64,077	69,063	13%	0%
Fuel, light and power	55,815	52,959	47,912	52,100	54,368	56,304	1%	0%
Computer-related expenses	18,629	31,992	31,538	38,593	49,653	60,472	225%	2%
Travel-related costs	34,103	39,734	73,270	69,481	76,557	80,543	136%	2%
Postal and telephone	37,154	43,144	46,364	47,502	46,498	49,051	32%	1%
Staff-related costs	20,004	36,128	23,826	24,544	34,458	38,661	93%	1%
Insurance	47,933	57,614	66,030	71,086	93,868	138,316	189%	4%
Interstate patient outflows	64,404	66,201	69,696	87,101	91,994	88,426	37%	1%
Operating lease rental expense	8,339	–	–	12,900	32,525	36,408	337%	1%
Rental, rates and charges	17,869	28,881	26,330	24,418	21,036	23,680	33%	0%
Printing and stationery	27,187	30,421	32,658	33,211	34,970	40,007	47%	1%
Aircraft expenses	12,072	12,770	19,410	22,173	24,045	18,910	57%	0%
Contract for patient services	55,316	61,274	64,581	64,219	68,535	74,321	34%	1%
IPTAAS	6,140	6,132	6,834	6,701	7,272	6,551	7%	0%
General expenses	95,693	75,788	96,907	84,662	99,638	86,654	–9%	0%
Maintenance and repairs	162,744	158,123	189,071	193,508	197,815	220,662	36%	3%
Depreciation	254,941	293,186	316,287	304,821	315,558	337,988	33%	4%
Payments to affiliated health organisations	296,511	328,603	342,865	360,883	385,459	373,135	26%	4%
Other grants	120,948	135,809	142,323	156,364	180,104	206,378	71%	4%
Finance costs	10,196	11,580	11,116	11,113	9,824	9,352	–8%	0%
Other expenses	61,781	14,416	1,068	–	–	–	–100%	–3%
Total expenses	5,973,131	6,493,604	6,978,379	7,193,294	7,506,070	8,014,804	34%	100%

Attachment 7 Systems to ensure quality care in other countries

Developing effective systems to ensure quality care is clearly a challenge facing many countries. The following quote from a paper on patient safety prepared by the World Health Organization (WHO) for the fifty-fifth World Health Assembly⁵⁵ aptly describes the task involved:

Enhancing the safety of patients includes three complementary actions: preventing adverse events; making them visible; and mitigating their effects when they occur. This requires (a) increased ability to learn from mistakes, through better reporting systems, skilful investigations of incidents and responsible sharing of data; (b) greater capacity to anticipate mistakes and probe systemic weaknesses that lead to an adverse event; (c) identifying existing knowledge resources, within and outside the health sector; (d) improvements in the health care delivery system itself, so that structures are reconfigured, incentives are realigned, and quality is placed at the core of the system.

The paper also summarised several studies investigating adverse events in acute care hospitals between 1984 and 2000, undertaken in the US, Australia, the UK and Denmark. The adverse event rate varied between 3.2 per cent and 16.6 per cent depending on the methodology used. Two studies in Australia and the US using the same methodology had rates of 10.6 and 5.4 per cent respectively.

The WHO paper also reported on the financial costs of adverse events. In the UK, the additional cost of hospital care is estimated at 2,000 million pounds a year and annual litigation costs to the NHS of 400 million pounds. Hospital-acquired infections are estimated at a further 1,000 million pounds a year. In the US the total cost of preventable adverse events is estimated between US\$17,000 and US\$29,000 million year.

The UK's Bristol Report of 2001 was a critical point in the development of clinical governance. This report's key recommendations included the patient being at the centre of the health system, transparency, the impact of organisational systems, uniformity of standards and monitoring. The UK established a separate Commission for Health Improvement (CHI), which is being restructured into a Commission on Health Auditing and Inspection (CHAI). CHI's roles include reviewing clinical governance, investigation of serious service failures, reviewing implementation of standards set by other bodies such as the National Institute of Clinical Excellence (NICE), as well as new powers covering inspection, independent performance assessment, publishing comparative performance ratings, clinical audits, and patient and staff surveys.

The new CHAI will include CHI as well as value-for-money auditing and health care standards, the latter two functions will be transferred from other agencies. Other bodies include NICE for clinical and pharmaceutical guidance, the Modernisation Agency which advises on clinical practice, the Health Development Agency which provides clinical governance for public health programs as well as the Royal Colleges which set professional standards.

⁵⁵ World Health Organization, *Quality of care: patient safety*. Fifty-fifth World Health Assembly. Provisional agenda item 13.9, 23 March 2003.

In 2002, Scotland also undertook a review of its complex clinical governance structure. A discussion paper⁵⁶ proposed two new and consolidated bodies: a Quality and Standards Board for Health in Scotland, supported by a new partnership council; and the Quality Strategy Group. The Board's functions are extensive and include strategic and standards development, promoting clinical governance, inspection and monitoring of compliance, clinical audit, investigation of serious service failures, accreditation, professional performance, technology assessment, best practice, evidenced-based clinical guidelines, safety, information and communications.

The organisation would be governed by a board which would consist of non-executive and executive members. The council's role includes acting as a reference group on clinical effectiveness and quality, informing policy development, advising on clinical governance and quality, and supporting Quality and Standards Board. The Scottish model is a more integrated than the UK approach, even under their revised model. Given the size of the NSW system, a more streamlined model than applies in the UK is favoured, but not to the extent of having an all-embracing body as in Scotland. In particular, IPART believes there is a need to separate the implementation and inspection roles.

⁵⁶ *A Quality and Standards Board For Health in Scotland: Consultation Paper*, Minister for Health and Community Care, 1 March 2002.

Attachment 8 Inspirit report on benchmarking



Review: Using Information to Drive Change in NSW Public Hospitals

May 2003

For: Independent Pricing and Regulatory
Tribunal

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Scope:

Review and Report on the use of Performance Indicators in Hospitals

Review prior IPART and NSW Health reports.

Conduct informal interviews with 3 to 4 selected senior hospital executives from NSW hospitals covering key issues, current practice and innovations.

Conduct informal interviews with 2 to 3 senior hospital managers in other states in order to identify innovative practice. It would be possible to involve IPART staff in teleconference discussions if desired. It is intended to cover specifically the topic of innovations in the use of information in order measure and manage factors affecting performance.

Preparation of a high level report that focuses on public hospitals and outlines:

- how hospitals are currently developing and using performance indicators,
- the issues relating to the use of indicators at the public hospital level,
- possible principles for developing useful sets of indicators for hospitals to use to manage performance and drive change within their organisation,
- examples of relevant and useful indicators for managing hospitals,
- ways Area Health Services and the Health Department could use to performance indicators to monitor hospital's clinical, quality and financial performance.

Conduct Roundtable – “How to Drive Positive Change in Health”

Hold a one day workshop that would review identified innovations and consider, refine and set priorities for changing measurement practices for driving positive change in health in NSW

- Use outcomes from the above report to brief participants on issues and innovative ideas
- Involve IPART staff and NSW health representatives, and extend invitations to selected NSW and possibly interstate hospital Chief Executives (with a target size of about 30 people for the Roundtable)

Produce a written report that summarises the findings of the Roundtable stakeholders.

Executive Summary

1. There is no culture at the hospital level in NSW to use information to drive change. In general, hospitals tend to be reactive. Their use of information is driven by financial imperatives and requests for information initiated at Area, Department or Ministerial level.
2. Leading Hospitals in Victoria, Queensland, and South Australia, by contrast, use wide ranging clinical, outcome and quality information as well as financial information to manage and push change.
3. Developing an “information management culture” in the NSW health system will require devolution of accountability and responsibility for innovation from Area Health Services to Hospitals and to Clinical Units.
4. Understanding the differences between using information for accountability and using information to drive innovation is key to effectively using information.

“Accountability Measures” are needed to ensure that the health system is meeting public expectations. For example, the waiting time for surgery or in an Emergency department should be measured and subject to public scrutiny.

“Innovation Indicators” are also needed to allow managers to compare their performance with peers to identify opportunities for improvement. These indicators are often transitory, imprecise, and require collaboration amongst the peer groups to understand the underlying differences. Public scrutiny of these indicators and the use of the indicators for accountability are often self-defeating.

5. Accountability Measures can be used at all levels, from Health Department down to individual hospitals and clinical units. Financial, activity and quality based measures are commonly used to benchmark a hospital’s performance and in some instances; financial incentives and stretch targets have been tied to performance on these measures.

6. Innovation Measures must be “owned” by peer groups, and kept out of the accountability system to work effectively in driving change.

7. In most states, the hospital Chief Executive is seen as the key person to own the indicators and to drive change. The ‘CEO factor’ was felt to be most important. It was clear from leading hospitals that when the CEO does this, it rubs off onto senior managers and very quickly the whole organisation starts to pay more attention to the information available.

8. Internal disclosure of performance on both Accountability Measures and Innovation Indicators is crucial. Major hospitals all have intranets and this is the ideal environment to disseminate information to staff. Departmental and Unit managers need to be able to see the information for their department.

9. Peer-group comparisons are essential to challenge the “but, we’re different” culture that is used to insulate established practices from change. Consultation with those who provide the information is important. If an organisation, group or individual is to be expected to collect and use information.

What Needs to Happen

For NSW Health to establish a culture of using information to both manage and to drive change and innovation the following needs to happen.

10. Identify a small number (less than 20) Accountability Measures that cascade from the Health Department, to Areas, to Hospitals, and to Clinical Units and report them via a scorecard or dashboard. Accountability Scorecards should be made available to the public (as in the UK).

Information must be accurate and easily accessible.

Information systems need to be as integrated as possible.

Manually collected information should be avoided.

Definitions should be consistent, tight and workable.

Constant refinement of the measures will be needed, as creative interpretations and strategies develop as coping mechanisms

11. Empower peer-group collaboration on “Innovation Indicators” while avoiding imposition of specific data requirements and definitions. Simply requiring all health care organisations to work collaboratively with intra- and inter-state peer groups, and to report their successes should be sufficient oversight at the Area and Health Department level, provided that adequate resources are provided to collect data, identify opportunities, and implement change.

The main conclusion: Operational innovation and target attainment work best when responsibility for them lies with the operational entity.

1. Culture - NSW

There is no culture at the hospital level in NSW to use information to drive change. In general, hospitals tend to be reactive. Their use of information is driven by financial imperatives and requests for information initiated at Area, Department or Ministerial level.

A thorough review of how NSW hospitals and health services are currently using information was not within the scope of this Report. However, in establishing context for this review, a small number of hospitals were visited and the following observations were made.

Area Health Services and Hospitals in NSW vary greatly in how they use information.

While all collect the required information for The NSW Health Department (DOH) including the range of indicators specified by DOH, and also collect the data for the Australian Council on Health Care Standards (ACHS) EQUIP set of recently revised indicators, their approach to the use of information within their organisations is, in most cases, adhoc and reactive.

Most hospitals visited took a very traditional approach to information:

Hospitals do use and report information. But this information tends to be

- focussed on financial and activity measures,
- reviewed on a monthly basis and
- remains at the senior executive level of the hospital.

Individual hospital departments (particularly clinical departments) often collect their own information using local databases.

Sometimes these are commercial databases acquired by those departments and others are locally developed but in most cases they are single purpose databases where the data is used to measure and manage a specific project. These databases are usually standalone, i.e. not integrated with the hospital wide information system.

This should be qualified by noting that there are exceptions to this illation, for example Hunter Health are very strong users of information and have developed a culture of using information to drive change. Organisations such as Hunter Health may be used as models for other hospitals in NSW to follow.

2. Culture - Leading Hospitals

Leading Hospitals in Victoria, Queensland, and South Australia, by contrast, use wide ranging clinical, outcome and quality information as well as financial information to manage and push change.

Victoria

The Department of Human Services (DHS) has undertaken extensive research into how information could be used to provide an ongoing indication of the standards of care delivered in Victorian Hospitals as well requiring Hospitals (via Networks) to provide the regular financial, activity, clinical and quality based information.

In two Reports^{1, 2}, the Department has undertaken an extensive review of possible indicators, the implications and issues associated with their use, and the extent of use of similar indicators both in other States of Australia and Internationally. This included surveying hospitals across Victoria to understand the difficulties that may be involved in implementing the identified indicators and also the additional costs involved.

The indicators finally selected to monitor clinical and quality standards of care in Victorian Hospitals³ are listed in Appendix 4.

The Alfred Hospital, Melbourne

The Alfred has been producing and publishing on its intranet a “KPI Performance Report Card for the last 18 months. This Report Card identifies the Corporate Objectives and Strategies and then the measures (indicators) associated with each Strategy /Objective.

Examples of Key Performance Indicators associated with the objective/strategy of (optimising) patient care are listed in Appendix 5.

The Scorecard itself is very visual with ticks and crosses indicating results inside or out of benchmarks or targets. There is also the capability to drill down to investigate results and dig for possible reasons or locations where variances are occurring. The Scorecard can be viewed by Campus, Directorate and Unit levels of staff as well as by different time periods.

The Alfred views its current Scorecard as a prototype, evolving continually since its inception. Initially the concept of Key Performance Indicators was overwhelmed by the inclusion of Hospital Activity and Finance Reports. The concept is seen by some as evolving towards a “Management Portal”

¹ **Acute Health Division, Department of Human Services Victoria**, Acute Health Performance Indicators: Strategy for Victoria, 1997,

<http://www.health.vic.gov.au/clinicalindicators/strategy/>

² **ACHS Care Evaluation Program & Monash University Department of Epidemiology and Preventive Medicine** Acute Health Clinical Indicator Project Final Report, July 1999,

<http://www.health.vic.gov.au/clinicalindicators/clip/vol1a.doc>

³ *ibid*

providing centralised access to Key Performance Indicators, Finance, HR/Payroll, Quality and ad hoc reports.

At the end of 2002, there were over 250 active subscribers to the Alfred's Balanced Scorecard.

Austin Health, Melbourne

The Austin Health has an organised and well structured use of information to support its Management and Board decisions. Apart from the standard financial reports most hospitals prepare, Austin Health uses a 'traffic light' system to formally monitor the progress of the initiatives it introduces each year.

Austin Health also collects a set of non financial indicators broken down into the areas of acuity, efficiency, quality, occupational health and access. These indicators are reported graphically with trend data, an indication of whether the result is above or below benchmark and a brief commentary. These indicators are reported to the Executive and the Board and are available to staff on the hospital intranet. Staff can drill down to see the financial or non financial information (WIES, Bed Days, Length of Stay, patients booked) for their own department or clinical area (or any other department). There are targets set down to Unit level.

Austin Health has a formal process to review information and to highlight areas that need closer attention or remedial action as well as process to follow this through.

South Australia

Flinders Medical Centre, Adelaide

After attending a Health Roundtable on Key Performance Indicators, the Chief Executive Officer of Flinders Medical Centre decided to implement a Balanced Scorecard system at FMC.

Flinders was facing problems because their information system at the time was limited to financial indicators and data sources and collection points were extremely fragmented.

That was three years ago and at that time the hospital embarked on revamping their information system. They now have a Dashboard type system based on four quadrants:

- Quality, Safe Practice and Risk
- Financial
- Productivity and Efficiency
- Staff

Five or six indicators are collected for each quadrant. and these indicators are cascaded down to departmental level and available to staff on the hospital intranet.

Flinders rate the key features of a successful information system as being:

- Driven by the CEO
- Readily available to all staff
- Easy to maintain

Queensland

The Princess Alexandra Hospital information systems function in conjunction with the Queensland Health 'Measured Quality Program'⁴, a benchmarking program for all Queensland Hospitals. This is a state-wide benchmarking program in both clinical and non-clinical areas. Indicators were broken down into three main components:

1. Internal Business: Clinical Utilisation and Outcomes indicators
2. Financial Efficiency indicators
3. System integration and change indicators

These include a range of clinical indicators collected on a 6 monthly basis. Where hospitals do not meet the set standard they will be given a "please explain" (similar to other states). The information collected is considered very sensitive and not published.

Princess Alexandra Hospital, Brisbane

Princess Alexandra Hospital (PAH) uses information widely.

PAH uses a two pronged approach to managing using information. A Clinical Indicator Oversight Committee that includes as members, the Chairs of the Clinical Departments and the Clinical Services Evaluation Committee regularly meets and reviews indicators and action taken where indicators do not meet benchmark levels. Also the hospital uses its Health Information Management Service to follow up areas where information indicates action is necessary. This is a specialist department that has the capability and authority to review and undertake root cause analysis if necessary. All management level staff have clear targets and goals set as part of their regular performance review, these are measured using performance indicators.

⁴ **Queensland Health**, *Technical Supplement for the Measured Quality Health Report*, July 2002

3. Developing an “Information Management Culture”

Developing an “information management culture” in the NSW health system will require devolution of accountability and responsibility for innovation from Area Health Services to Hospitals and to Clinical Units.

DOH and Area Health Services have a need to use information to drive change at the State or Area Level. However, as DOH and Areas do not actually provide the service, they need to rely on the providers (i.e. hospitals, community health services, district nurses etc.) to implement and drive service provision change.

The desire to influence change can be confused with the accountability role that DOH and the Areas have in managing and funding the service providers. Because service providers in this environment will tend to focus on meeting targets and working within financial parameters this makes it more difficult to achieve change. It could be argued that DOH (especially) is too remote to attempt to drive change at, say the service provision level and rather should develop strategies to sponsor and encourage providers to do this themselves.

An organisation being directed is less likely to be fully committed to own and use the information to drive change. Whilst the information will be produced if it can be, the organisation is more likely to find reason why the information is hard to collect, or why there will be an additional cost and importantly the organisation is less likely to use that information itself.

Central authorities need to overtly devolve authority and responsibility to service providers to develop an information management culture.

Once the commitment to do this is made, strategies can be developed toward achieving devolution. These may include many of the recommendations in this report, for example:

- providing an environment and incentives for providers such as hospitals to use information.
- providing incentives by tying specific funding grants to the introduction of broad based service improvements
- setting realistic and achievable stretch targets against indicators for high priority service delivery areas for individual service providers set in the context of their own environment.
- encouraging service providers to participate in peer group collaboration in an environment free of influence from funding providers.

4. Accountability versus Innovation

Understanding the differences between using information for accountability and using information to drive innovation is key to effectively using information.

“Accountability Measures” are needed to ensure that the health system is meeting public expectations. For example, the waiting time for surgery or in an Emergency department should be measured and subject to public scrutiny.

“Innovation Indicators” are also needed to allow managers to compare their performance with peers to identify opportunities for improvement. These indicators are often transitory, imprecise, and require collaboration amongst the peer groups to understand the underlying differences. Public scrutiny of these indicators and the use of the indicators for accountability is often self-defeating.

Accountability	Innovation
Top Down	Peer to Peer
<ul style="list-style-type: none">• Indicators are mandated• Uniform data is assumed• Indicators are tightly defined• Score is “win/lose”• Denial by losers• Gaming the system• Auditors needed	<ul style="list-style-type: none">• Voluntary comparisons• Search for differences<ul style="list-style-type: none">⇒ Data methods⇒ Clinical practices• No “right” or “wrong”• Opportunity focus• Gradual fine tuning• Peer Managed

5. Use of Accountability Measures

Accountability Measures can be used at all levels, from Health Department down to individual hospitals and clinical units. Financial, activity and quality based measures are commonly used to benchmark a hospital's performance and in some instances; financial incentives and stretch targets have been tied to performance on these measures.

The traditional use made by DOH and Area Health Services of information is to measure accountability. The Health Department measures and compares the performance of Areas and Hospitals (and other services for which it is responsible) using indicators amongst a range of measures. It does this as part of its overall governance role. Similarly Area Health Services, hospitals and clinical units and departments all have a need to measure and compare the performance of services it delivers for the same reasons and often with the same, or similar, indicators.

Accountability measures are often seen as a 'control measure' and regarded by hospitals or other services as an imposition. Sometimes the measures are not felt to be relevant, sometimes the measures are felt to be poorly defined, and sometimes comparisons are felt not to be valid because of demographic or other differences.

Where a service is not achieving the benchmark result the central authority will approach this service with either a please explain or in more dire circumstances it may intervene and take some corrective action itself. Alternatively if the indicator highlights ongoing problems with a poorly run service, the focus may increase on that service and lead to its micromanagement by DOH, Area or Hospital.

There are ways to improve 'buy-in' from services that are being measured.

- **Involvement** of the users on the development of indicators is really crucial to obtaining 'buy-in'. This can be achieved through workshops or other forms of consultation (for example Hunter Health are running workshops with their staff develop both objectives and measures)
- **Feedback** to the information providers on a regular basis that is current and provided whether it is good or bad is also very important.

These also lead to benefits to the measuring organisation in obtaining real buy-in from the people providing the information; definitions are likely to be more robust, information is more likely accurate and more relevant.

6. Use of Innovation Measures

Innovation Measures must be “owned” by peer groups, and kept out of the accountability system to work effectively in driving change.

The closer change is initiated to where it occurs and impacts, the more likely it is to be owned and the more likely it is to be successful. It is human nature to be committed to something you do and want to see succeed; it is also human nature to be less committed to something you have been told to do without being involved in its inception.

Consider the likely difference in outcomes:

DOH decides that hospitals need to focus on reducing length of stay of fractured Neck of Femur patients. Clinical units are directed to review their cases and take action to reduce length of stay. Human nature and experience both say that the staff in the unit are likely to: Firstly, find reasons why their patients are different, and secondly, find ways to make it appear that their unit is performing better (gaming). They may, but are less likely to really look for ways to reduce length of stay.

Or,

A hospital or a clinical unit focuses on the length of stay of, for instance, fractured Neck of Femur patients. This may involve undertaking peer group comparisons and initiating changes to the care plan and treatment protocols and measuring the outcomes to determine if the change has been successful.

Experience with the Health Roundtable (Point 11) has shown that when hospitals and / or clinical units or departments identify issues and proceed to initiate change to improve the outcome, barriers are more likely to be overcome and effective and positive change occurs.

7. CEO Factor

In most states, the hospital Chief Executive is seen as the key person to own the indicators and to drive change. The ‘CEO factor’ was felt to be most important. It was clear from leading hospitals that when the CEO does this, it rubs off onto senior managers and very quickly the whole organisation starts to pay more attention to the information available.

Effective use of information must be driven from the top. In each of the observed organisations that were using information positively to manage and drive change, the CEO was the sponsor and ensured that all the staff were aware this was an initiative from the ‘top’.

When the Chief Executive is seen to be using the information regularly, and questioning managers about why a result is “too high” or “too low”, this will be contagious and managers and staff will want to be aware of the information and the reasons why results are as they are.

For instance, the CEO may ring or drop by departments and ask why their length of stay is higher than similar units, or what they are doing to lift their

DOSA (Day of Surgery Admission) rate above the 68% it is currently at, or raise questions about which departments are meeting their quality targets at the weekly executive meeting, or be seen logging onto the hospital intranet and checking a unit's sick leave rate.

It was clear from leading hospitals that when the CEO does this, it rubs off onto senior managers and very quickly the whole organisation starts to pay more attention to the information available.

The CEO can be the driver but **a champion is needed** to provide the impetus throughout the organisation, at least in the initial stages of implementing a new system.

The champion is needed to be the implementer, the person who ensures that the right information is available and staff have input and understand how to use the information they have available to them.

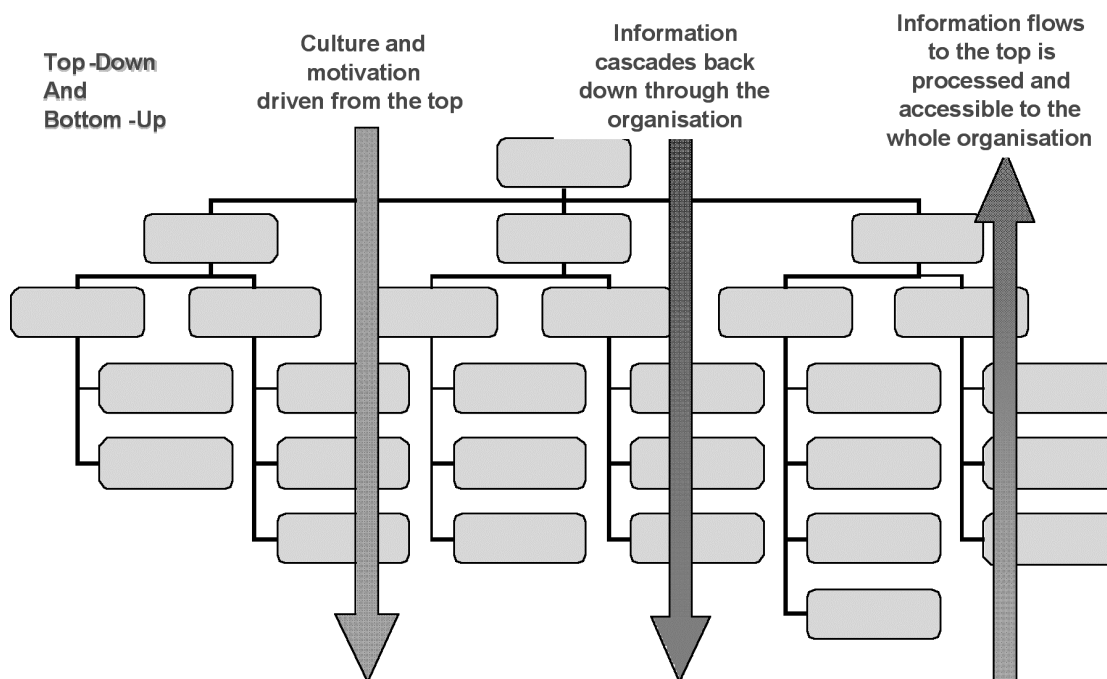
8. Internal Disclosure

Internal disclosure of performance on both Accountability Measures and Innovation Indicators is crucial. Major hospitals all have intranets and this is the ideal environment to disseminate information to staff. Departmental and Unit managers need to be able to see the information for their department.

Information needs to be available to all staff, as it is in the leading hospitals who presented their stories to the Roundtable Discussion. Major hospitals all have intranets and this is the ideal environment to disseminate information to staff. Departmental and Unit managers need to be able to see the information for their department. This could include financial, workforce, activity, quality and safety information. Comparative information is also important, i.e. managers need to see how other units and departments are travelling. This puts the onus on the organisation to ensure the information is correct and realistic.

The best way to do this is to cascade information to different levels of the organisation (it may be an Area or a hospital). This means that information is all derived from the same source, but is shown, for example, in greater detail for use by a Departmental or Unit Manager than it is for the whole organisation where the information is rolled up to present a broad picture of the whole organisation.

Hospitals that have successfully done this have also been able to demonstrate that they **do not need to invest substantial amounts of money toward information technology** in order to make information available throughout the organisation. Simple, cost effective and straightforward solutions have been able to provide full access including drill-down capability.



9. Consultation

Peer-group comparisons are essential to challenge the “but, we’re different” culture that is used to insulate established practices from change. Consultation with those who provide the information is important. If an organisation, group or individual is to be expected to collect and use indicators.

Information comes from all parts of the organisation, from the wards, admissions, outpatients, pathology, operating theatre and just about every other department or unit. Implementation of an information strategy should include progressively involving staff from wards, departments and units in workshops to develop indicators. This will also help them to appreciate the benefits of identifying the information they need to manage their own ward/department/unit and using information to assist both them and to the organisation.

The common response from clinicians, when presented with information about their service is to say “but, we’re different” “our patients are older”, “our patients are sicker”, “our cases are more complex”, “a higher proportion of our patients are admitted via Emergency Department”. Information does need to take all into account all of these consideration but there will be more commitment when clinical staff are involved and consulted and can see that information is accurate, and, for instance, is weighted to take into account their patient mix.

Part of this is to make the information needed easily accessible to all. Hospitals have been able to do this by using the organisation’s intranet and

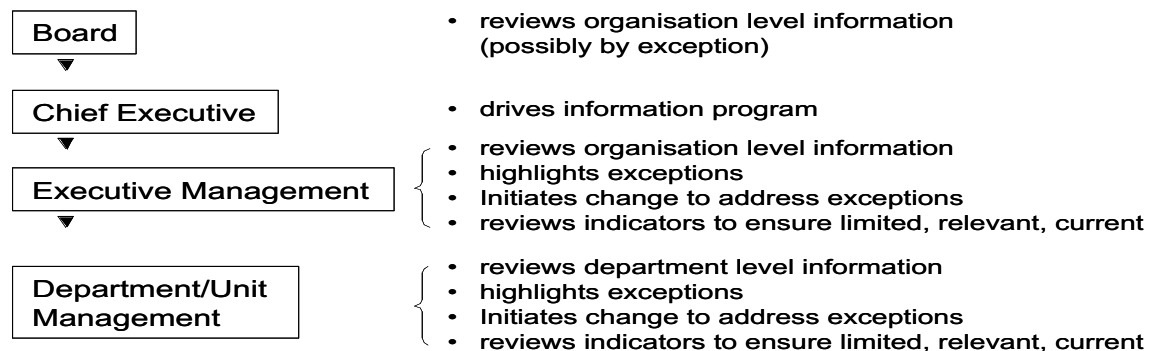
providing some form of drilldown database that allows the indicators used by senior management to be cascaded down to each department to be used in day to day management as discussed in Point 8.

Regularly Review Information and Take Action

Organisations successfully using information typically review information regularly at Board and Executive level. This may be by exception or it may include reviewing a limited set of organisation wide indicators designed to keep the organisation on track against its business plan.

Some organisations have in place a group of staff specifically established to review the organisation level indicators. An example of this is at Princess Alexandra Hospital Queensland where the Chairs of the hospital's Clinical Departments meet to review indicators, identify areas where some form of further review or action may be necessary and initiate and follow-up any changes to ensure targets are again met.

Out of sight – out of mind
Things must be measured to be
managed....



As well as reviewing information at Executive level, Departments, Wards and Units should be encouraged to put in place similar review and follow-up processes.

10. Identify a Small Number of Indicators

Identify a small number (less than 20) Accountability Measures that cascade from the Health Department, to Areas, to Hospitals, and to Clinical Units and report them via a scorecard or dashboard. Accountability Scorecards should be made available to the public (as in the UK).

- **Information must be accurate and easily accessible.**
- **Information systems need to be as integrated as possible.**
- **Manually collected information should be avoided.**
- **Definitions should be consistent, tight and workable.**
- **Constant refinement of the measures will be needed, as creative interpretations and strategies develop as coping mechanisms**

Both the literature and experience in hospitals indicate that a set of indicators totalling between 15 and 30 is optimum. Fewer than about 15 probably means that the view of the organisation being taken by the indicators is not wide enough to pick up all the areas that need to be watched. Greater than about 30 indicators increases the chance of missing an important signal just because of the sheer numbers of indicators that have to be reviewed or imposes such an additional workload that the use of information becomes a burden.

“Most of the performance indicators are quite sensible but there are just too many of them: it takes a huge amount of time to report the information, diverting clinicians away from more pressing clinical tasks.”

The Economist “NHS – A Solution?” 12/12/2002

The authors of *The Balanced Scorecard*⁵ and *The Strategy Focussed Organisation*⁶ stress the need to firstly develop and express strategy and business plans in operational terms and to directly align the information used within the organisation to these plans and strategies. This is a well documented process that will not be discussed further in this paper.

⁵ **Kaplan R, Norton D**, *The Balanced Scorecard: Translating Strategy into Action*, 1996, Harvard business School Press, Boston, Massachusetts

⁶ **Kaplan R, Norton D**, *The Strategy Focused Organisation: How Balanced Scorecard Companies Thrive in the New Business Environment*, 1996, Harvard business School Press, Boston, Massachusetts

Hunter Health

Hunter Health is an excellent example of an organisation working strongly toward a Balanced Scorecard approach to implement its Corporate Plan and Strategy and achieve its Vision⁷

The use of the Balanced Scorecard driven by the Hunter Health Service Corporate Plan provides a model that may be followed by other areas in NSW.

Over the past ten years the Hunter Health has been deliberately and progressively pursuing an information driven approach to the delivery of health care in the Hunter Region.

Initially Hunter Health implemented a range of clinical, quality and management indicators to assist the Executive to focus on day-to-day operational performance and in taking management decisions.

Over the past three years this approach evolved to a Balanced Scorecard approach enabling the Board, executive and senior management to focus on indicators tied directly to the organisation's Business and Corporate Plans.

Its Annual Report for 2001/2002 clearly demonstrates how effectively Hunter Health is using the Strategic Balanced Scorecard approach. Page 3 of the Annual Report visually outlines the Balanced Scorecard Strategy Map including its Vision Mission, the Strategic Themes and the Focus Areas each with specific Objectives identified. The Annual Report is structured on the Focus Areas in the Strategy Map and within those areas, reports based on balanced scorecard measures designed to evaluate performance at each dimension.

Hunter Health is currently undertaking a process of cascading the process down into the organisation to include clinical areas such as wards.

The Manager of the Performance Improvement Unit for Hunter Health, Dr McDonald highlighted an example of how this approach can assist to focus staff: One of the best opportunities health professionals have to assist people toward achieving a healthy lifestyle is when they are a patient in hospital. By encouraging ward level staff to measure how often they tell patients about the availability of healthy lifestyle services available in the community or offer assistance with specific issues while an inpatient, helps to keep the focus directly on the Mission of Hunter Health: "To improve the health of the people of the Hunter and those referred to us." This process is supported through exit questionnaires to patients by asking if staff offered healthy lifestyle advice.

Data Accuracy

Accuracy of data is very important, as soon as accuracy is questioned, credibility of the information is lost and the confidence and support of those using the information is lost.

⁷ **Hunter Area Health Service**, *Annual Report*, p3 2001/2002

Data Accessibility

Data accessibility remains a problem in most hospitals. Information is often collected in standalone databases leading to difficulty in integrating that information centrally within the organisation. A quote from a recent Victorian report supports this: *“Victorian hospitals possess a large number of databases, half of which are not linked to the main administrative databases. Many of these are under-resourced and of uncertain reliability. There is a need to audit databases and train data collectors”*⁸.

Data needs to be accessible to obtain the information required. This can be achieved technically in a number of ways, however the point to make is that if staff have to go to a number of places to obtain the information they need it will increase the staff frustration factor and decrease the likelihood of the information being used effectively.

Integration of Data

Data collection systems need to be fully integrated. This should be a mandatory requirement in any software acquisition. This may seem to be stating the obvious, but there are still examples in all states where integration has not yet been fully achieved.

New software is often implemented without the capability to fully integrate to existing hospital systems (an example of this is the continued difficulties in fully integrating the Cerner PAS with the HIE leading to hospitals not being able to cost activity on any more than a modelling basis).

Automated Data

In some cases data is still collected manually. Data collection needs to be fully automated. At some stage much of the data will be entered into a computer and into a central repository, but this should be as part of a work process such as admissions. Manual collection jeopardises accuracy and leads to staff discontent.

Definitions

It is often said that most problems with information are easily resolved if the information is defined properly. In a perfect world proper definitions and data complying with those definitions will resolve many problems. However hospitals are complex organisations that have each evolved to do things slightly differently. Tight definitions may help to overcome many of these issues but organisational complexities and the human factor will always confound a proportion of situations.

The difficulties with definitions can best be shown using an example:

Average Length of Stay appears to be a simple calculation of the time a patient stays in hospital, but in practice it strikes many snags:

When is a person a patient?

- When a person occupies a bed? – or a couch? – or a chair?

⁸ ibid p76

- When a person receives treatment? A consultation? A service?
- When a person is public? Privately insured? Self payer?

When does stay start?

- Arrival in ED? In Ward?
- When admitted? What are the criteria for being admitted?

How do you count time?

- In days?
- In hours?
- In minutes?

When does stay end?

- When leaving the bed?
- When leaving hospital?
- When changing care type?
- Where does hospital-in-the-home fit?

What are the exclusions?

- Those who depart on the same day?
- Those pronounced dead on arrival?

What about multiple episodes for the same admission?

A systematic and clear approach to setting down definitions should be taken. It is also important to ensure the definitions are realistic and achievable given the data and systems associated with the information being processed.

*Unintended consequences
drive constant rule changes*

Regularly Review Indicators

A trap organisations commonly fall into is to accumulate indicators or just information until they have perhaps 50 pages of tightly spaced information to review each month. This makes it difficult, if not impossible, to distinguish between what is important and what has just been progressively added to the accumulation because someone felt it would be “interesting to collect”.

Organisations need to have in place a formal structure that regularly reviews the indicators collected for relevance as well as accuracy and currency. Such a review should be conducted regularly and separately to any review of the results of information. It would be useful to develop a set of principles to use as a guideline.

11. Empower Peer-Group Collaboration

Empower peer-group collaboration on “Innovation Indicators” while avoiding imposition of specific data requirements and definitions. Simply requiring all health care organisations to work collaboratively with intra- and inter-state peer groups, and to report their successes should be sufficient oversight at the Area and Health Department level, provided that adequate resources are provided to collect data, identify opportunities, and implement change.

Some hospitals have been successfully collaborating and sharing information for a number of years in an organisation called the Health Roundtable. The benefits of collaboration can be seen in this brief review of Roundtable activities.

Since its inception the Health Roundtable has worked with member hospitals providing benchmarking and operational review services to enable hospitals access to current comparative data and to use that data in a trusting environment to drive change within their organisations.

Casemix Benchmarking

The initial benchmarking services provided by the Health Roundtable allowed hospitals to compare their Casemix with other member hospitals. The data, supplied every 6 months, for the previous 6 or 12 months, provides hospitals with Casemix data from the organisation level to the DRG level with the capability to drill down if required. The data is weighted to take into account various factors such as age, co-morbidity, source of admission. It also takes into consideration services such as Dialysis and Chemotherapy that can greatly distort the overall position of a hospital. To ensure the accuracy and relevancy of the information provided, member hospitals meet after each data iteration to review methodology and results.

This allows hospitals to benchmark Casemix data with other peer hospitals in their Health Roundtable Chapter, to understand how their service provision compares with others and identify areas where their performance is below that of their peers.

Member hospitals with exemplar outcomes are asked to outline the reason they believe to be the success factors in achieving this outcome and this is discussed within the group. If other member hospitals decide that the success may be transferred to their organisation they are encouraged to seek further details.

Key Performance Indicator Benchmarking

Following on from the successful benchmarking of Casemix data, Hospital members of the Health Roundtable decided to collect and benchmark a set of Key Performance Indicators. The indicators collected currently are listed in Appendix 6.

Significant policy and procedural differences between the States have always meant that benchmarking of KPIs across Australia and New Zealand is complex and difficult. However, the principles followed by the Roundtable

have led to the successful use of Key Performance indicators and have made it possible to overcome many of these difficulties.

These basic principles include:

- **Keep it simple** – focus on a few important Key Performance Indicators
- **Regularly review the indicators and the process.**
Staff involved in the collection of the Health Roundtable Key Performance indicators meet six monthly to:
 - ◆ review the data,
 - ◆ consider whether the indicators are still relevant,
 - ◆ consider whether the definition adequately specifies the data needed, and
 - ◆ consider whether there are new indicators that need to be included.

CEOs and senior managers also review the indicators on an annual basis. In their review they look at ongoing relevance of indicators but as well, decide if new indicators are required and also discuss outcomes and reasons why some results indicate that particular hospitals are doing better than others in certain areas.

- **Limit the number of Indicators collected.**
This has always been considered to be important. The desirable number of indicators was felt to be about 15. The Health Roundtable currently collects about 30 indicators so whilst the HRT has not been able to achieve its objective (maximum 15), it is satisfied that the current number is workable and cannot agree on any indicators that should be removed. This said, if the indicators collected by the HRT are rolled up to highlight the efficiency of certain areas e.g. Emergency Department then they come much closer to the targeted number of 15.
- **Set Benchmarks as milestones.**
Up until recently the HRT members have compared their performance with that of peer hospitals and in some cases use an ACHS or other recognised benchmark (e.g. for Time to be seen by Triage Level in Emergency Departments). At a recent review meeting, HRT Chief Executives agreed to set broad benchmarks for all indicators, using the 25th percentile of all member hospital as a milestone target results where no recognised benchmark existed.
- **Keep Indicators at a 'high level'.**
There is always the temptation to go into more detail, for example, when monitoring the number of Cardiac Arrests, to separate out certain ward areas instead of just counting for acute patients.

Another example, with the indicator – “Percentage of Pressure Ulcers per Patients Admitted”, the group has resisted classifying the indicator

according to the grade of the pressure sore.

In both these cases, it was felt that the change would add complexity in collection where the raw number would be sufficient to highlight an unusual trend.

➤ **Take an organisation wide view:**

- ◆ Access via Emergency,
- ◆ Elective access (Wait List)
- ◆ Intensive Care
- ◆ Clinical Quality
- ◆ Human Resources

The Chief Executives initially decided to exclude financial indicators. The reason for that decision went back to the nature of these indicators, i.e. they are Australian & New Zealand wide so any comparison of financials may be distorted by State influences and it was felt that there was already sufficient focus on financial matters internally within their organisations. At the most recent review, the Chief Executive Officers reviewed this and decided to add several financial indicators (yet to be finalised).

➤ **Indicators not measures.**

The principle users of information need to keep in mind, is not to become obsessed with the detail of the indicator, but rather to treat the information for what it is – an indication that the organisation is performing well, adequately or otherwise against a benchmark that is set in collaboration with peer hospitals and used to assist to identify exceptions.

The main purpose of the indicators collected by the Roundtable Hospitals is to give CEOs an early warning system, an indication that some function, perhaps the Emergency Department, perhaps ICU or perhaps a workforce issue is developing.

Roundtable Clinical and Operational Workshops

The simple process followed by the Roundtable methodology allows hospitals to share ideas with their peers in an environment of trust where they can be confident that any shortcomings in their systems or their organisation will not be publicised or used against them.

When a particular clinical function or operational process is identified for review, a detailed survey is prepared that collects a range of information about that process or function. This provides participants with background for the workshop about the processes used by their colleagues in other hospitals, including similarities and differences in processes, staffing levels and categories, and outcomes. Hospitals are strongly encouraged involve staff of different disciplines, desirably including the Chief Executive or a member of the hospitals senior executive. The multidisciplinary approach encourages

openness and flexibility and the presence of a senior person encourages organisational buy-in and gives authority to any commitment.

Completing the Loop

Participants always conclude workshops by deciding on what they will take away and try to achieve in their hospitals. These actions are recorded and the hospitals asked to report back in the future on the success (or otherwise) of their implementation and on any barriers to success and how they were overcome.

Networking

Networking is one of the major benefits to come out of attending a Roundtable meeting. The opportunity to meet people in similar roles and share stories, find out how different hospitals are doing things and understand that other hospitals face similar issues and challenges is always reported as one of the major benefits of Roundtable workshops. There is also the spin-off that staff attending get the opportunity to spend several days with a member of the senior executive, allowing discussion, networking and relationship building that would not normally occur in the day-to-day hustle and bustle of hospital life.

Why has this Process been so successful?

The process is based on the reasoning that each hospital will be good at something (but not everything!) and each hospital can learn something from peer hospitals. The bond of trust between member hospitals means that any information shared will be used appropriately and positively.

As an autonomous group of hospitals, the Health Roundtable retains a small group of highly motivated and experienced professionals to facilitate meetings, process data and generally drive the whole process rather than do this themselves or rely on Government to their Health Departments to do it for them.

When hospital groups have attempted to undertake a similar process of grouping together and sharing information by organising it themselves, they have not been successful. Their lack of success has been largely due to the fact that they attempted to facilitate and drive the process themselves and they were diverted by the many other pressures they face on a day to day basis.

The process is owned by the hospitals and in particular the hospital's Chief Executive Officer.

Hospitals can only join if the CEO agrees the nominal member of the Roundtable (in the case of the founding Roundtable groups, the CEO's are the Board Members of the non-profit company that runs the Roundtable).

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Appendix 1: Workshop Outcomes

On 8th May 2003 a Workshop was held to allow a range of senior Hospital, Area Health Service and Health Department executives to participate in a Roundtable Discussion on Performance Indicators. The workshop consisted of presentations by several Chief Executives from leading interstate hospitals and interactive workshops by the participants.

THE WORKSHOP WAS CONDUCTED UNDER THE CHATHAM HOUSE RULE AND ACCORDINGLY NO INFORMATION IS ATTRIBUTED TO ANY INDIVIDUAL OR ORGANISATION

The Roundtable Discussion will be subject to the Chatham House Rule in order to promote a free, unencumbered discussion amongst all participants:

“Participants are free to use the information received during the discussion but cannot quote or attribute comments to their contributor outside the discussion. Neither the identity nor the affiliation of the contributors of comments can be revealed outside the discussion.”

A summary of the Plenary Reports follows:

How should ‘Good’ Clinical Units be using Performance Indicators to manage activities?

It was suggested that Indicators should be

- underpinned by a customer focus and business plan within the Clinical Unit.
- based on resourcing and activity, and
- should cascade down and so be consistent with information from the Area and the Hospital

It was agreed that definitions are important for Accountability Measures. There should be consultation mechanisms need built into the process and they should include clinicians and patients.

Budget performance measures should be based on:

- Activity
- Length of Stay (Efficiency)
- Flow Measure (Access Block, Throughput and Exit Block)
- Quality (Patient Outcomes)
- Clinical Costing (Episode Funding)
- Wastage (Variance) (Variance against benchmark, days above standard)
- Customer Outcomes

Measures for Innovation (Promote Cultural Change / Risk Taking) should be based on:

- Resources (Data management)
- Skills development
- Risk taking
- Research Activity

Organisations need to put in place appropriate benchmarking ideally including an external basis for comparison.

Indicators that are to be used for Innovation should be user friendly and transparent. A no-blame culture is very important.

What Information at a Clinical Unit Level could be used to assist Consumers?

The group identified a number of areas where information at the Clinical Unit level could be used to assist consumers. These issues included:

- access to clinical staff for consumers to talk to.
- access to the service itself
- access to information about services, care, specific clinical treatments

The group also identified the culture and quality of the service as being important to consumers. The point was made that if Clinicians are to lead then the system needs to be structured to allow that to happen.

How should 'Good' Hospitals be using Performance Indicators to manage activities?

The group felt that indicators should be positive rather than negative e.g. an Emergency Department indicator benchmark could be > 99% Open (rather than > 1% Closed)

Care is moving into the community so there should be a greater number of Community based indicators

Accountability indicators at a hospital level should measure:

- Financial
- Quality and Safety
- Efficiency

Indicators to achieve innovation at a hospital level should measure:

- Quality and Safety,
- Efficiency,
- Timeliness and
- Work Practice

To achieve this it is important that there be commonality of data and data transparency. It is also important that information be accurate, timely and easy to use and also be available across all staff.

Good management will also include provide feedback on actions and ensure that the change process is reviewed i.e. close the loop. Staff should be rewarded for good results.

What Information at a Hospital Level could be used to assist Consumers?

At the hospital level, the group felt that it was important to know how safe the environment was for the consumer. Also issues such as access to grounds and buildings and the level and quality of hotel services were important to the consumer. Communicating with the consumer is important at all levels.

How should 'Good' Area Health Services be using Performance Indicators to manage activities?

Accountability indicators at this level should measure:

- Safety and Quality
- Financial ↘ output/unit costs; total costs
- Waiting times
- Wait List Deferrals
- Staff sustainability
- Occupational Health and Safety
- Consumer Satisfaction
- Health Status
- Public Health / Network Coordination
- Targeted High Risk Groups

Indicators to achieve innovation should measure:

- Development of pathways
- Compliance with pathways
- New treatment regimes
- Individualised stretch targets

Appropriate systems need to be in place to collect and manage data. This would include skilled staff for input and analysis of the data, software and hardware capable of doing the job proper training and appropriate feedback. Decision making needs to be transparent and based on the data provided

External benchmarking needs to be facilitated.

The information needs to be readily accessible at all levels, clinical, frontline and executive.

Data collection needs to deliver information to improve performance.

The right incentives need to be in place – both carrot and stick.

What Information at an Area Health Service Level could be used to assist Consumers?

Access including transport

Safety indicators

Coordination of Care – i.e. effective information sharing between providers

How responsive is the service to its consumers?

To what extent do clinical outcomes meet expectations?

How responsive is the clinical unit to community needs?

What is the clinical staff ratio?

What is the health status of the community?

How can the community be better educated to use information?

Acute performance is being measured but not the General Practitioner disease burden that may convert to acute care.

How should ‘Good’ State Health Departments to be using Performance Indicators to manage activities?

Accountability indicators at this level should measure:

- Financial
- Quality
- Efficiency
- Access / Wait list
- Disaster planning

Performance should be cross dimensional, including input from the colleges, ACHS etc.

NSW should interface with Commonwealth and other states.

Indicators to achieve innovation should measure:

Efficiency – DOSA, Day Surgery, Substitution

Financial and other incentives are important – not just the big stick.

Consider using a rating system – three stars

The degree of intervention will also be important

Service enhancement seeding grants should be included

Controls can stifle innovation for example, forcing all hospitals to comply with EMU and DOSA may slow other ideas.

State Departments should avoid micromanaging if the Area/Hospital is performing well

What Information at a State Health Department Level could be used to assist Consumers?

Issues of access, quality and safety as they relate to the consumer are important

It is also important to report regularly to consumers updating them on how organisations within the health service are performing

There should be some measure of the level of consumer involvement

Appendix 2: Top indicators Identified at the Workshop

Efficiency

1. ***Length of Stay – overnight patients only***
2. ***Case-weighted cost per episode***
3. ***Activity case-weight per episode*** (for inpatient and outpatient)

Safety

1. ***Infection Rate*** (Out of hospital follow-up)
2. ***Adverse Events***: Medications / Falls / Sentinel events
3. ***Mortality Rate*** (risk adjusted – separately for ICU)

Effectiveness

1. ***AMI Outcomes***

Numerator: Survivors 30 days after presentation

Denominator: All AMI admitted patients

2. ***Unplanned Re-admission Rates***

Numerator: Unplanned re-admission within 28 days of admission via ED

Denominator: All overnight admissions

3. ***Clinical Outcome indicators versus expected outcome for each service***

Numerator: Number of successful outcomes

Denominator: Number for service category of inpatients

Consumer Participation

1. ***Communications survey to measure patient satisfaction***

Numerator: Actual score

Denominator: Possible score

2. ***Involvement in Policy Development and Decision Making***

Numerator: Number attended by at least 2 communication representatives

Denominator: Number of Meetings of Decision Making/Policy Meetings

3. ***Training of consumers***

Numerator: Number of completed accredited training programs

Denominator: Resident population

Appendix 3 - Workshop Participants

ORGANISATION	DELEGATE	POSITION
Central Sydney AHS	Peter Kennedy	Director Health Services
	Gary Miller	A/General Manager, Canterbury Hospital
Department of Health	Deb Hyland	
	Liz Martin	Manager Health System Performance Branch
	Jim Pearse*	
Hunter AHS	Bob McDonald	Manager Performance Improvement Unit
Independent Pricing & Regulatory Tribunal	Liz Livingstone	Analyst
	Steve Lyndon	Analyst
	Alex Oeser	Analyst
Northern Rivers AHS	Chris Crawford	Chief Executive Officer
Northern Sydney AHS	Frank Basik	Executive Director, Northern Beaches Health
	Stephen Christley	Chief Executive Officer
	Mark Parrish	Executive Director, Hornsby Hospital
South Eastern Sydney AHS	George Bearham	Director, Clinical Practice Improvement
	George Jepson	Executive Director, Prince of Wales Hospital
South Western Sydney AHS	Theresa Anderson	A/General Manager, Liverpool Hospital
	Andrew Bernard	General Manager, Bankstown Hospital
	Jennifer Collins	General Manager, Macarthur Health Service
	Stephen Johnson	Director of Planning, Liverpool Hospital
	Colin MacArthur	Director of Health Service Reform
	Ian Southwell	Chief Executive Officer
Sydney Area Health Service (Defence)	Douglas Menzies	Health Business Manager
Western Sydney AHS	Siun Gallagher	Director HSD
Austin Health	Jennifer Williams	Chief Executive Officer
Alfred Hospital	Kim Hill	Director Medical Services
Flinders Medical Centre	Bronwyn Masters	
Inspirit Management Services	David Dean	Workshop Facilitator
	Peter Reeves	Workshop Facilitator

Appendix 4 – Indicators Collected in the Victorian System

The indicators finally selected to monitor clinical and quality standards of care in Victorian Hospitals⁹ were:

Medical

Diabetes - post operative blood glucose monitoring
AMI – therapy times
Asthma – Documented assessment on admission
Colonoscopy - perforation

Surgical

Abdominal Aneurysm Repair – Mortality
Cholecystectomy laparoscopic – bile duct injury
Cholecystectomy open – bile duct injury
TUR - for benign disease – unplanned readmission with clot retention
Colon - anastomosis breakdown
Rectum - anastomosis breakdown
CEA - Stroke/Mortality
Tonsils & Adenoids – return to for bleeding in same admission

Gynaecology

Gynaecology operative procedure - Urinary tract injury
Gynaecology procedure - return to Operating Room

Day Procedures

Day Procedure – Unplanned overnight admission

In addition to this DHS has specified a number of ‘Demand Management Strategy’ measures that all hospitals are expected report on. In some cases ‘performance bonuses’ are applicable:

12 Hour waits
Ambulance By-pass
% Elective Cat 1 Admitted Within 30 Days (monthly)
Average Waiting Time of Cat 2 Elective Patients on Wait List (quarterly)
Number of Patients on Elective Surgery Waiting List (quarterly)
% Elective Cat 2 Patients Overdue On Waiting List (quarterly)
Number of Hospital initiated Postponements per 100 Waiting List Admissions (quarterly)
% CCU Transfers Due To Bed Not Available (6 monthly)
% ICU Transfers Due To Bed Not Available (6 monthly)
Day of Surgery Admission (DOSA) Rate (6 monthly)
Same Day Surgery Rate (6 monthly)

⁹ ibid

Appendix 5: Examples of Indicators collected at The Alfred Hospital

Associated with the objective/strategy of (optimising) patient care, the following Key Performance Indicators are used at the Alfred Hospital:

Performance Drivers:

- ▶ Complaints - % Resolved within 5 Days
- ▶ ED Admission Block by Unit
- ▶ Elective Surgery - Total Patients on Waiting List
- ▶ Elective Surgery - Total Cat 1 Patients admitted within 30 days
- ▶ Elective Surgery - Total Cat 2 Patients admitted within 85 days
- ▶ Elective Surgery - Proportion of Patients with two or more referrals

Performance Outcomes:

- ▶ Ambulance Bypass
- ▶ Elective Surgery - Average Waiting Time for Cat 1 Patients
- ▶ Elective Surgery - Average Waiting Time for Cat 2 Patients

Appendix 6: The indicators collected by the HRT

Group	Indicator	Description	Benchmark
Emergency Department	Triage 1 – Time to be seen	Patients seen immediately as % of all Category 1 patients	100%
	Triage 2 – Time to be seen	Patients seen within 10 minutes as % of all Category 1 patients	80%
	Triage 3 – Time to be seen	Patients seen within 30 minutes as % of all Category 1 patients	75%
	Triage 4 – Time to be seen	Patients seen within 60 minutes as % of all Category 1 patients	70%
	Triage 5 – Time to be seen	Patients seen within 120 minutes as % of all Category 1 patients	70%
	Triage 1 – Time seen to time to ward	Range of time for all Cat 1 patients, highlights median, mean, 25 th and 75 th percentiles	25th percentile
	Triage 2 – Time seen to time to ward	Range of time for all Cat 2 patients, highlights median, mean, 25 th and 75 th percentiles	25th percentile
	Triage 3 – Time seen to time to ward	Range of time for all Cat 3 patients, highlights median, mean, 25 th and 75 th percentiles	25th percentile
	Triage 4 – Time seen to time to ward	Range of time for all Cat 4 patients, highlights median, mean, 25 th and 75 th percentiles	25th percentile
	Triage 5 – Time seen to time to ward	Range of time for all Cat 5 patients, highlights median, mean, 25 th and 75 th percentiles	25th percentile
	Time to Analgesia	Median time of sample of patients receiving narcotic analgesia in ED	25th percentile
	Time from Triage to Admission to Ward	Mean of Medians of time from Triage to Admission to Ward	25th percentile
	Time Triaged to Time Seen	Median, Mean, 25 th and 75 th percentile of the time Triaged to time Seen for admitted patients only by Triage Category	25th percentile
	Time Seen to Time Admitted to Ward	Median, Mean, 25 th and 75 th percentile of the time Triaged to time Seen for admitted patients only by Triage Category	25th percentile
	Waiting List Management	Waiting List Cancellations before admission by Hospital	Number of elective theatre patients on the Waitlist given a planned date (during the survey month) for surgery who had that date cancelled or changed by the hospital BEFORE their admission during the time period per Total number of elective cases actually performed
Waiting List Cancellations after admission by Hospital		Number of elective theatre patients admitted for a procedure, but whose procedure is cancelled (or whose procedure date is changed) by the hospital AFTER their admission during the time period per Total number of elective cases actually performed	25th percentile
Operating Room List Cancellations		Any removal from the Operating Room theatre elective lists during the month for any reason per Final number of patients on Operating Room lists in the month.	25th percentile
Waiting List Cancellations before admission by Patient		Total number of elective theatre patients who cancel, change, alter, or modify their elective procedure date from the date originally agreed with the Hospital PRIOR to admission during the time period	25th percentile

Group	Indicator	Description	Benchmark
Intensive Care Clinical	Waiting List Cancellations after admission by Patient	Total number of elective theatre patients who cancel, change, alter, or modify their elective procedure date from the date originally agreed with the Hospital AFTER to admission during the time period	25 th percentile
	Readmission to ICU	Total number of patients returning to ICU within 72 hours per total discharges for period	25 th percentile
	Deaths requiring Review	All deaths likely to require review by total deaths	25 th percentile
	Inpatient Re-presentation to ED	All patients seen as Cat 1, 2, or 3 in ED within 14 days of discharge from hospital per all inpatient discharges.	25 th percentile
	Urgent Re-presentation to ED	All Triage Cat 1, 2 and 3 patients seen in ED within 24 hours of discharge from the ED per all ED presentations.	25 th percentile
	Returns to Operating Theatre	Number of patients returning to the Operating Theatre during the same admission per total number of operations.	25 th percentile
	Cardiac Arrests	Number of patients experiencing a cardiac arrest in ward areas per total inpatient bed days	25 th percentile
	INR Level < 5	Number of anticoagulation (INR) results found to be above 5.0 per total number of anticoagulation (INR) results	25 th percentile
	Pressure Ulcers Un-graded	Total number of patients found to have a pressure ulcer (raw figures) per total number of inpatient admissions	25 th percentile
	Workforce	Sick Leave Rate - Nursing	Total number of hours of sick leave by all Nursing Staff in pay periods totalling 4 weeks per total hours paid for all Nursing Staff
Sick Leave Rate - Other		Total number of hours of sick leave by all Other Staff in pay periods totalling 4 weeks per total hours paid for all Other Staff	25 th percentile
Resignation Rate - Nursing		Total number of Nursing staff who ceased employment per total number of nursing staff on payroll	25 th percentile
Resignation Rate - Other		Total number of Other staff who ceased employment per total number of Other staff on payroll	25 th percentile
Workers Compensation Claims - Nursing		Total number of new lost time claims received by the hospital from Nursing Staff per total number of Hours paid for all Nursing Staff	25 th percentile
Workers Compensation Claims - Other		Total number of new lost time claims received by the hospital from Other Staff per total number of Hours paid for all Other Staff	25th percentile

Appendix 7: Selection of Indicators from those currently collected

Indicator

Clinical Outcomes

Heart Failure - % Long Stay Outliers
Heart Failure -% In Hospital Mortality
Acute Myocardial Infarction - % Long Stay Outliers
Acute Myocardial Infarction - % In Hospital Mortality
Stroke - % Long Stay Outliers
Stroke - % In Hospital Mortality
Stroke - % Separations to Nursing Home
Pneumonia - % Long Stay Outliers
Pneumonia -% In Hospital Mortality
Asthma - % Long Stay Outliers
Asthma - Unplanned re-admission
Foot Ulcer -% Amputations
Foot Ulcer - % Long Stay Outliers
#Neck of Femur - % In Hospital Mortality
#Neck of Femur - % Complications of Surgery
#Neck of Femur - % Separation to Nursing Home
#Neck of Femur - % Long Stay Outliers
Hip Replacement - % Long Stay Outliers
Hip Replacement - % Complications of Surgery
Knee Replacement - % Complications of Surgery
Knee Replacement - % Long Stay Outliers
Colorectal Cancer Surgery - % Long Stay Outliers
Colorectal Cancer Surgery - % Complications of Surgery
Hysterectomy - % Long Stay Outliers
Hysterectomy - % Complications of Surgery
Hysterectomy -% U 35 Years
Hysterectomy - % Blood Transfusion
Standard Primiparae - % Caesarian Births
Standard Primiparae - % Induced Births
Standard Primiparae - % Severe Perinatal Tear
Maternal Postnatal Stay (Vaginal Births) - % Long Stay Outliers
Maternal Postnatal Stay (Caesarian Births) - % Long Stay Outliers

Live Singleton Births - % Small for Age
Low/very low birth-weight rates
Apgar score for infants 1000-2500 grams
Relative utilisation rates of targeted procedures (include cardiac-catheterisation, CABG, angioplasty, cholecystectomy, hysterectomy, laminectomy, caesarian section, prostatectomy,

Population Health

% smoking (16 years and over)
% alcohol risk (16 years and over)
% inadequate physical activity
% falls in elderly
% Immunisation risk
% at risk patients targeted for risk reduction

Standardised cardiovascular mortality rate/100,000 (25 - 74 yrs)

Standardised cancer mortality rate/100,000

% asthma morbidity (16 yrs +)

% diabetes (doctor diagnosed) morbidity (16 yrs and over)

Self rated health status (16 yrs and over)

Financial

Network operating Surplus(Deficit) as % of total Revenue (Before and after depreciation)

Surplus (Deficit) on Government Funded Services

Surplus (Deficit) on specified purposes segment

Surplus on capital fund

Return on total assets (Average)

Debt servicing coverage

Current Ratio

Depreciation Coverage

WIES per asset

% General expenditure split across budget programs

Average Casemix cost comparison to State average

Workforce

% Full Time Staffing

% Full Time Staffing - by Category

% Sick Leave

% Sick Leave - by Category

Cost of Sick Leave

Cost of Sick Leave - by Category

Cost of work cover

Cost of lost time injuries

% Resignations by category

Workers Compensation Claims

Hours of overtime

Hours of overtime by category

Cost of overtime

Cost of overtime by category

Activity

Occupancy rate

Length of Stay

Casemix adjusted ALOS

Theatre Cancellation Rate

Surgical WIES per resourced theatre

Average length of stay for top 20 ANDRGs

Discharge home < 56 days of emergency admission from home with stroke

Discharge home < 56 days of emergency admission from home with Fractured Neck of Femur

Access

Waiting times for elective surgery

U1/U2 Med/surg waits >30 days

Med/surg RCF > 12 months

Ratio of elective services

Accident & Emergency waiting times

% ED triage 2 treated within 10 minutes

% ED triage 3 treated within 30 minutes

% ED Triage 4 treated within 60 minutes

Emergency Services as a % of total WIES

Ratio of same-day patients to multi-day patients
Outpatient waiting times
#2624 in hospital awaiting placement
Physical access score (max 100)
% allied health patients first seen for assessment waiting outside of benchmark

Access to critical care beds
Ambulance bypass
Admissions Blocked
Operating Room Cancellations
% Not admitted within 8 hours (access block)
Variation in intervention rates
Separations per 1000 population
% separations of own residences
Waiting times in Emergency Department prior to emergency admission

Patient based reports of elective surgery, emergency and outpatient department waiting times and acceptability of these times to patients

Process

Total cost of catering
Energy consumption per square metre

Capability & Sustainability

Accreditation
Credentialing
% Staff nursing staff retention after one year
% Staff allied health staff retention after one year
Median age of nursing staff
Accurate hospital data submitted to Qld Health
Timeliness of data submitted to Qld Health
How late data submitted to Qld Health
Availability of electronic information
Collection and use of clinical information
Benchmarking in selected clinical areas
Internal benchmarking in selected clinical areas
External benchmarking in selected clinical areas
% Units carrying out regular consultation according to defined criteria

% consumers who perceive they are informed and involved
Partnership satisfaction score(VMOs/GPs)
% Performance agreement targets met

Continuity of Care

Extent of development and use of Clinical Pathways
- in surgical areas
- in medical areas
- in Obstetric and gynaecological areas
Use of pre-admission clinics for elective surgery
Provision of discharge summaries to GPs
Provision of electronic discharge summaries to GPs
Discharge protocols
Shared antenatal and postnatal care
Cardiac Rehabilitation
Usage of Tele-health

Efficiency

Cost per Casemix adjusted separation
Estimated fundable WIES per contracted amount
Cost of acute admitted patient per WIES
Cost of treatment per outpatient
Average length of stay for top 20 ANDRGs
Medical staff cost per WIES
Nursing staff cost per WIES
Non-clinical cost per WIES

Productivity

User cost of capital per Casemix-adjusted separation
Ratio for depreciated replacement value to total replacement value

Total replacement value per Casemix-adjusted separation
Labour costs per Casemix-adjusted separation

Quality

Rate of emergency patient re-admission within 28 days of separation

Rate of unplanned inpatient re-admission within 28 Days
Rate of hospital acquired infection
Surgical site infection by procedure
Rate of unplanned return to theatre
Rate of Patients receiving analgesia within 60 minutes - ED
Stratified mortality rates
Intra hospital mortality within 2 days of specified procedure
Death following AMI, PTC, CABG
Deaths in hospital within 30 days of Fractured Neck of Femur
Neonatal Mortality
Patient satisfaction
Patient Complaints
Proportion of beds accredited by ACHS
Complications within 24 hours of procedures involving Anaesthesia

Post operative LOS for CABG
Timing for thrombolytic therapy for AMI
Cardiac Arrests in Ward areas
INR > 5
Pressure Ulcers ungraded
Congestive Heart Failure
Post operative LOS for PTCA
Ventilated inpatients who develop pneumonia
Surgery for recurrence of hernia after previous surgery
Frequency of D&C in women < 40 years of age
Prosthesis replacement
Immunisation coverage rates 12-15 month olds
Percent of radiotherapy patients treated within targeted timeframe

Safety

Adherence to best practice guidelines
Observed to expected outcome ratios
Incident reports
Adverse events related to drug use in Hospital

Attachment 9 Suggested presentation of KPIs

This attachment provides the reader with an example of how the KPIs proposed by IPART should be presented. The attachment includes a full set of indicators and their presentation (levels 1,2 and 3) at the departmental level. Not all levels are provided for the AHSs and hospitals but their presentation should take the same format.

Please note that the actual performance and the target of the individual indicators do not reflect reality. They have merely been chosen to give the reader an impression of the proposed presentation of the KPIs.

The attachment also includes an example of a cascading indicator. This example shows how the strategic objectives and indicators are aligned across all levels of the organisation.

- 1 User guide to visual mapping

- 2 Strategic map at departmental level
- 3 IPART KPIs, visual mapping presentation—Level 1
- 4 IPART KPIs, trends presentation—Level 2
- 5 IPART KPIs, detailed presentation—Level 3

- 6 Strategic map at AHS level
- 7 IPART KPIs, visual mapping presentation—Level 1
- 8 IPART KPIs, trends presentation—Level 2

- 9 Strategic map at hospital level
- 10 IPART KPIs, visual mapping presentation—Level 1

- 11 Example of a cascading indicator

When implemented the indicators set out below would use colour coding:

- green would indicate that the target has been achieved
- red would indicate that the target has not been achieved
- amber would indicate that the target has almost been achieved

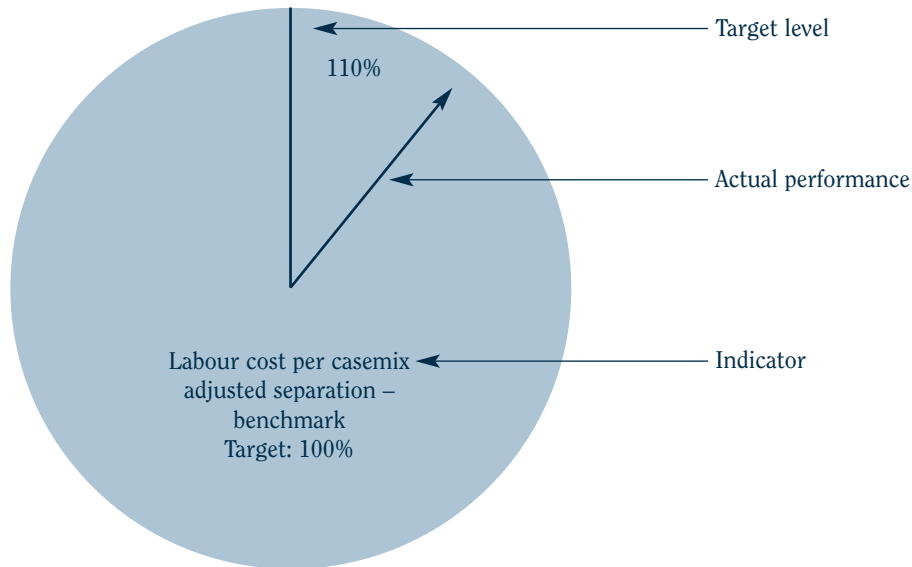
As this report has been printed in one colour, shades of blue have been used to indicate the respective outcomes. Dark blue indicates that the target has been achieved, light blue that it was not achieved, and white with a border that it has almost been achieved.

I User guide to visual mapping

The following examples shows how the visual mapping presentation should be used.

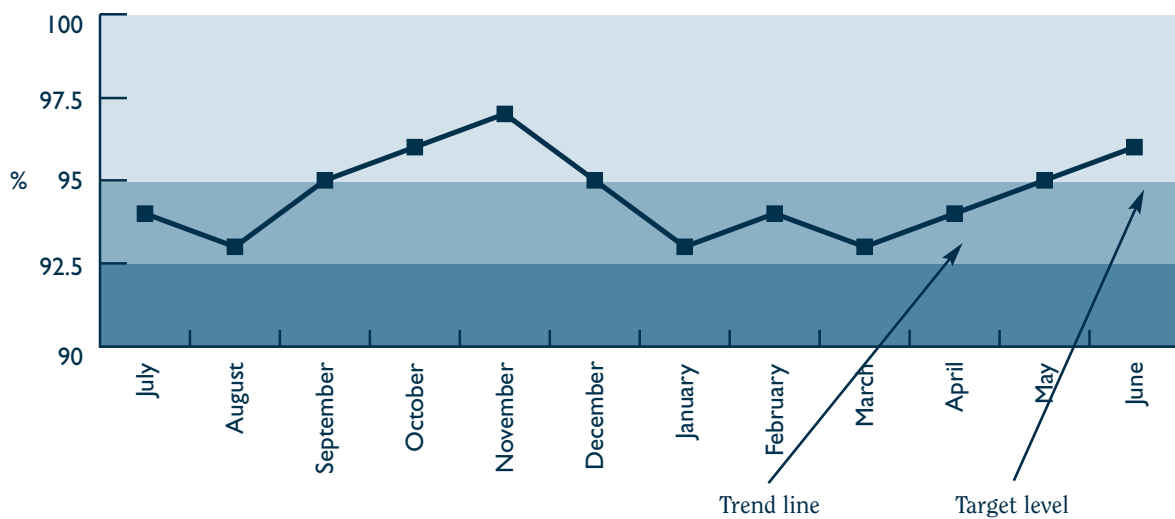
Level 1

The figure below explains how to read the dashboard indicators. The colour indicates if a target has been reached, has almost reached it or missed it. This set of presentations should be used first as the presentation facilitates discussion.



Level 2

This is the second level of presentation. It represents the trend of a particular indicator during the year. The colour scheme used in the graph shows the reader how the trend of the indicator has evolved during the year relative to the target level.



Attachment 9 Suggested presentation of KPIs

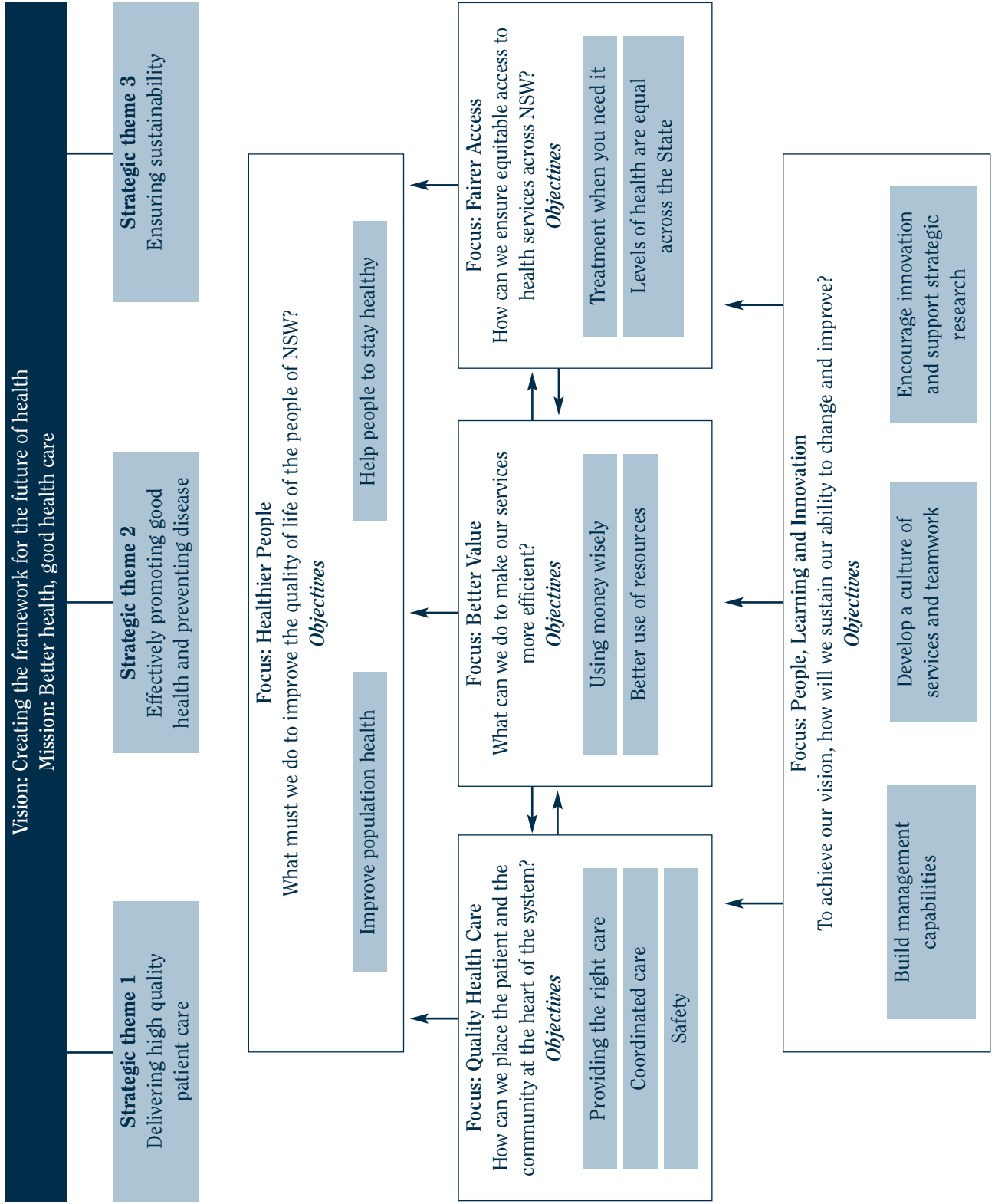
Level 3

The third level provides the reader with the details of the KPIs collected, the trend and, most importantly, it indicates who is responsible for the performance of a particular indicator.

Extract of third level presentation

Dashboard	Measure	Frequency	Actual	Target	Trend	Responsible
Potentially avoidable deaths	Age-adjusted rates of primary, secondary and tertiary avoidable mortality	x	97%	95%	↗	to be defined
Chronic disease index	% of the population with three or more chronic disease risk factors in NSW	x	20%	20%	→	to be defined
Antenatal visits before 20 weeks	% of confinements where first antenatal visit was before 20 weeks gestation	x	89%	95%	↘	to be defined
Self-reported mental health	K10 scores for adults	x	60%	75%	↘	to be defined
Child immunisation rate	Proportion of infants fully immunised at 12 to 15 months	x	96%	95%	↗	to be defined

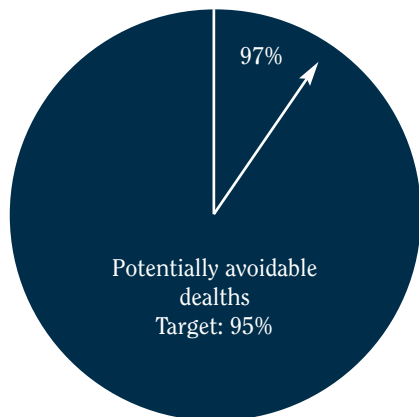
2 Example of a strategic map at the departmental level



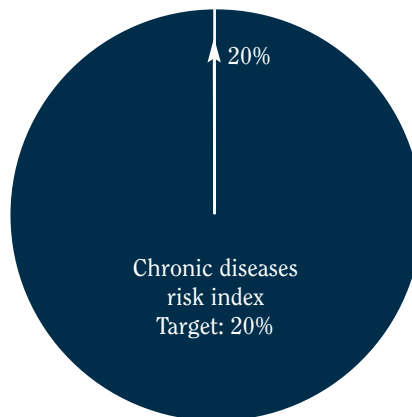
3 KPIs, first level–IPART dashboard indicators—to be used at departmental level

Healthier People

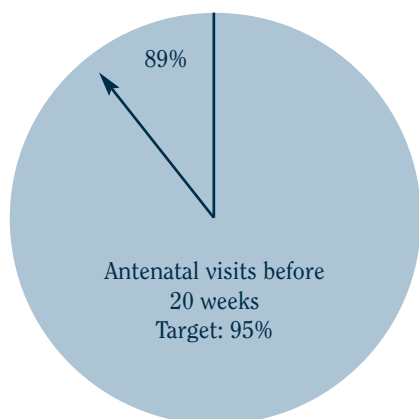
Objective: Improve population health



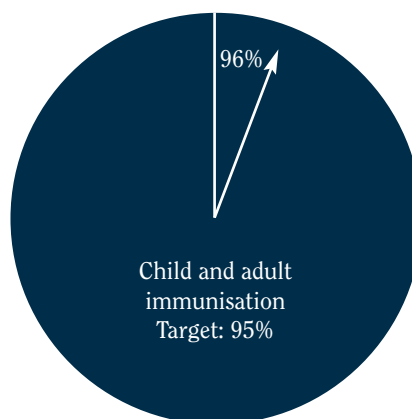
Objective: Help people to stay healthy



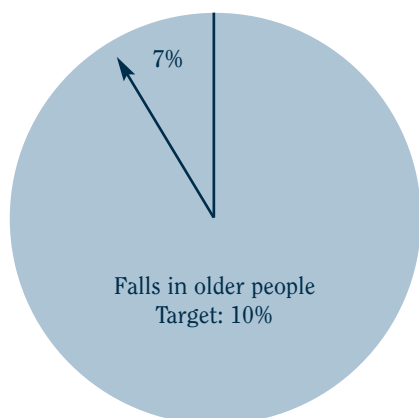
Objective: Help people to stay healthy



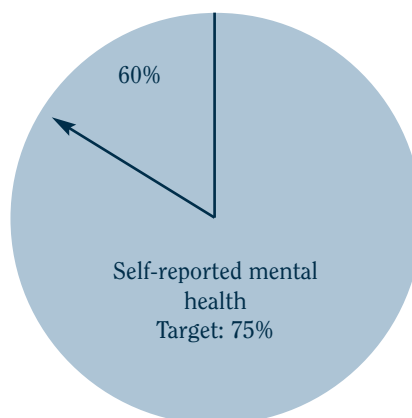
Objective: Improve population health



Objective: Improve population health

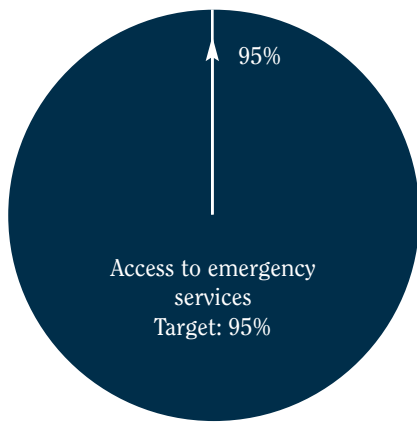


Objective: Help people to stay healthy



Fairer Access

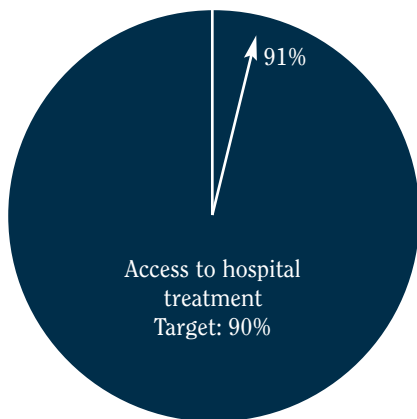
Objective: Treatment when you need it



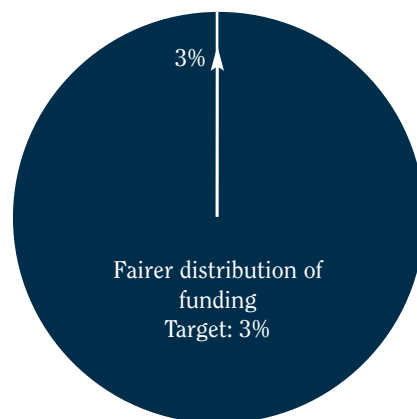
Objective: Treatment when you need it



Objective: Treatment when you need it



Objective: Levels of health are equal across the State

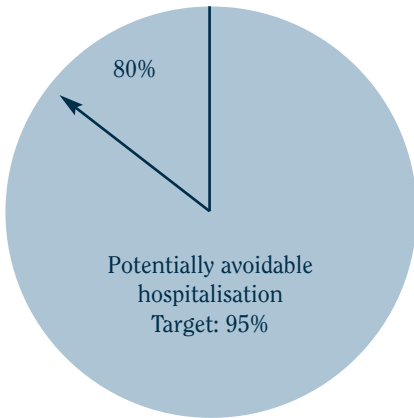


Quality Health Care

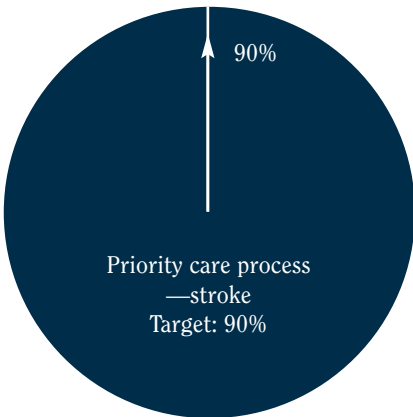
Objective: Safety



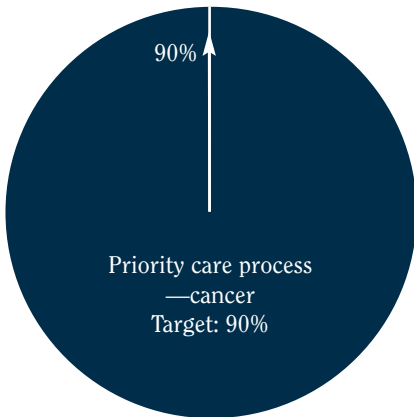
Objective: Coordinated care



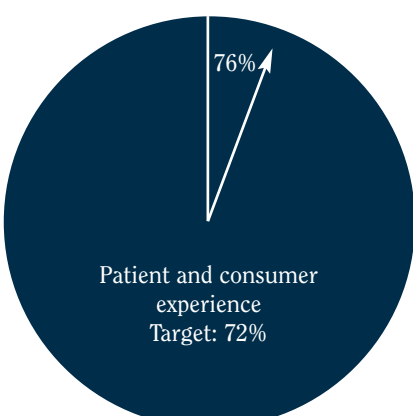
Objective: Providing the right care



Objective: Providing the right care

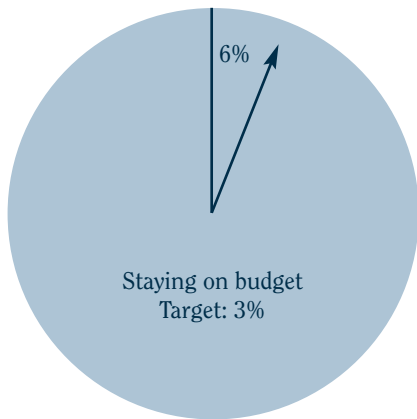


Objective: Providing the right care

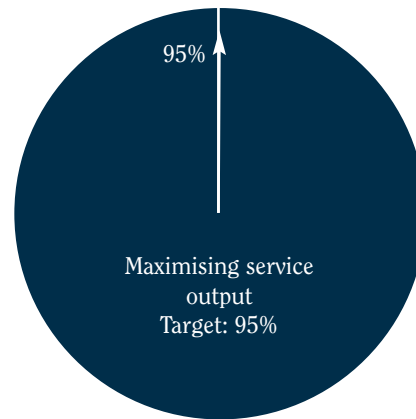


Better Value

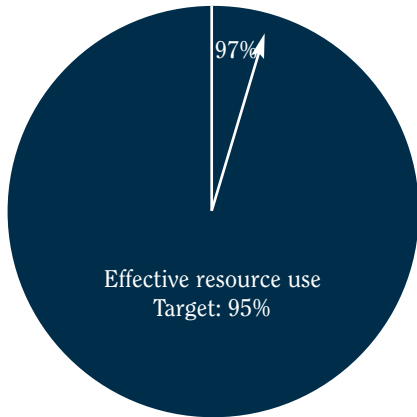
Objective: Using money wisely



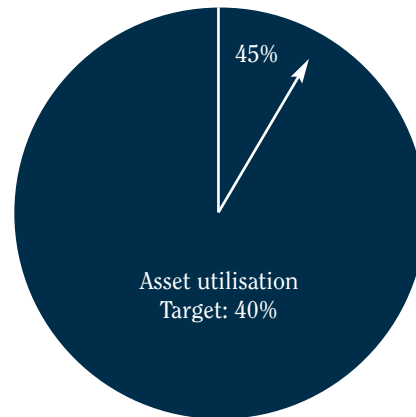
Objective: Better use of resources



Objective: Better use of resources

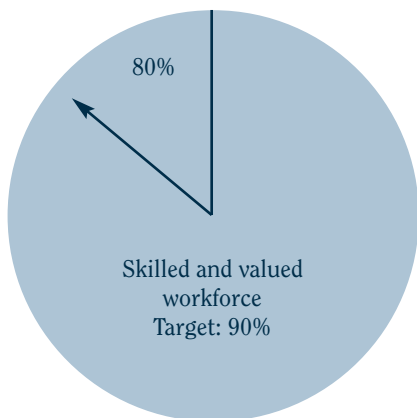


Objective: Better use of resources



People, Learning and Innovation

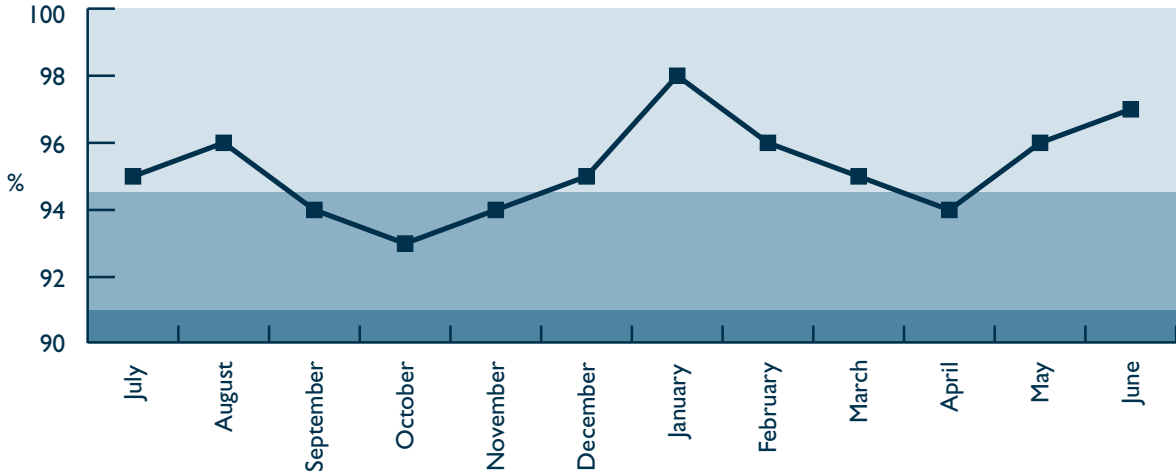
Objective: Develop a culture of service and teamwork



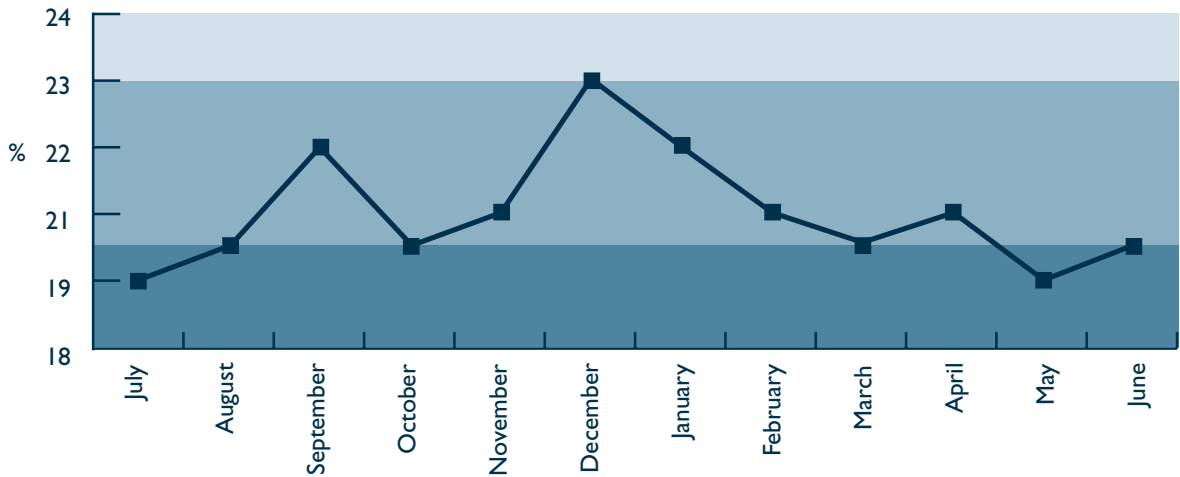
4 KPIs—second level presentation of IPART KPIs—to be used at departmental level

Healthier People

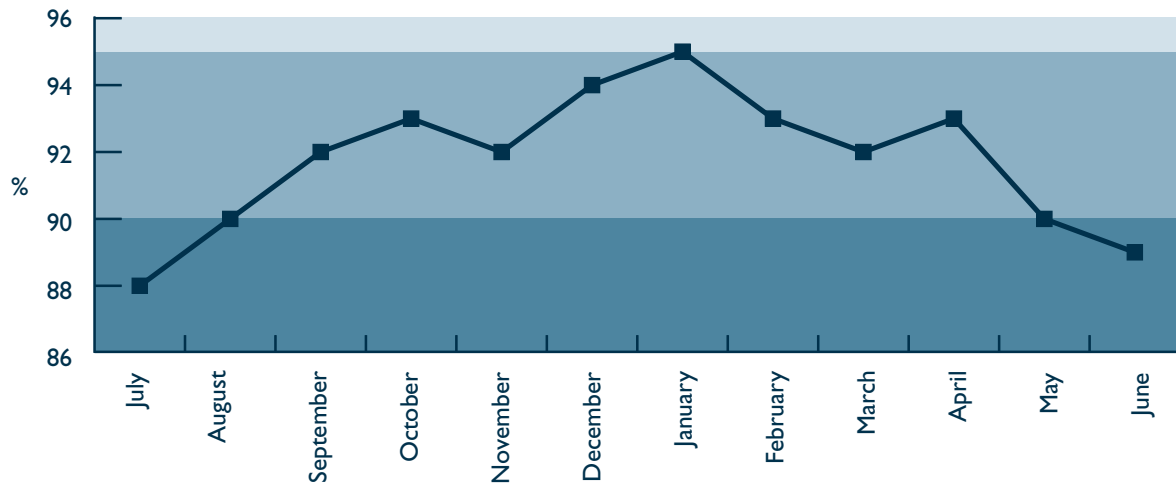
Objective: Improve population health
Potentially avoidable deaths



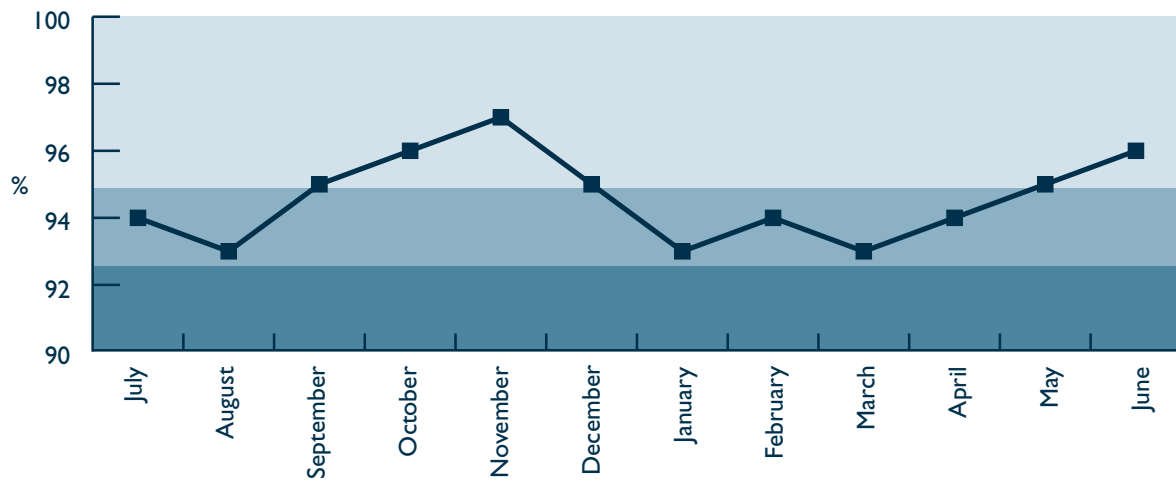
Objective: Help people to stay healthy
Chronic disease risk index



Objective: Help people to stay healthy
Indicator: Antenatal visits before 20 weeks

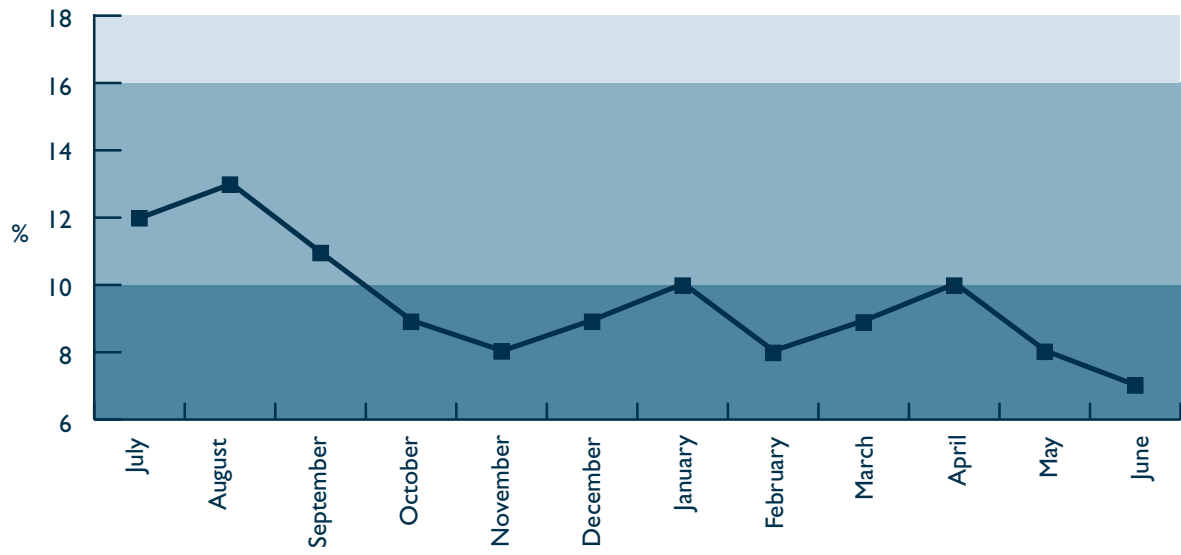


Objective: Improve population health
Child immunisation rates

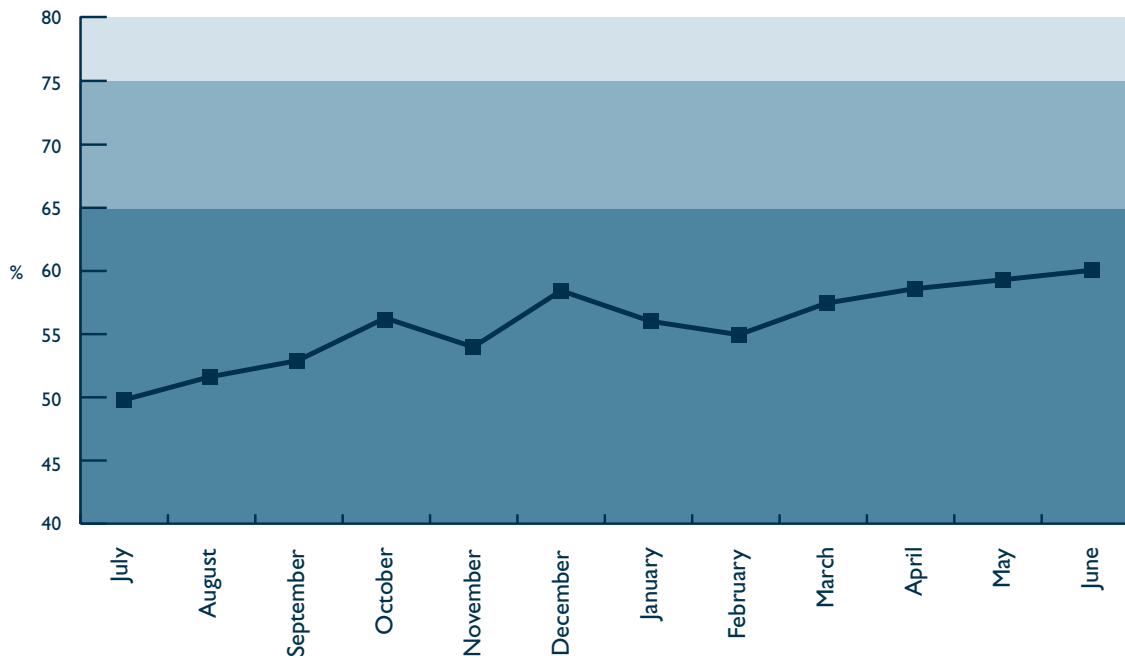


Attachment 9 Suggested presentation of KPIs

Objective: Improve population health
Falls prevention in older people



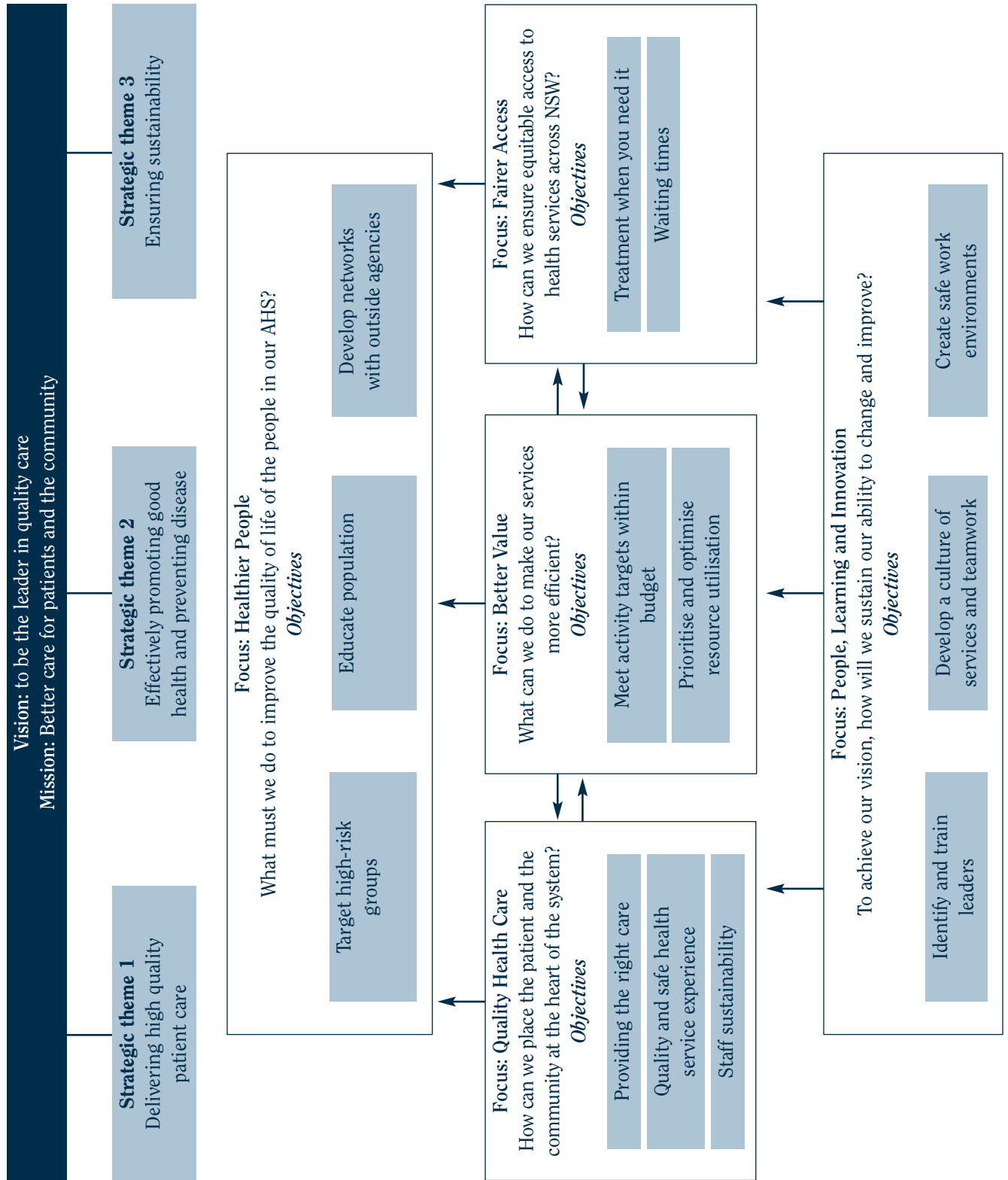
Objective: Help people to stay healthy
Self-reported mental health



5 Level 3—Dashboard indicators at departmental level

Focus	Objective	Dashboard	Measure	Frequency	Actual	Target	Trend	Responsible	
Healthier People	Improve population health	Potentially avoidable deaths	Age-adjusted rates of primary, secondary and tertiary avoidable mortality	x	97%	95%	↗	to be defined	
	Help people to stay healthy	Chronic disease risk index	% of the population with three or more chronic disease risk factors in NSW	x	20%	20%	→	to be defined	
	Help people to stay healthy	Antenatal visits before 20 weeks	% of confinements where first antenatal visit was before 20 weeks gestation	x	89%	95%	↗	to be defined	
	Improve population health	Child and adult immunisation rate	Proportion of infants fully immunised at 12 to 15 months	x	96%	95%	↗	to be defined	
	Improve population health	Falls in older people	Age-standardised hospitalisation rates for fall injuries in people aged 65+	x	7%	10%	↗	to be defined	
	Help people to stay healthy	Self-reported mental health	K 10 scores for adults	x	60%	75%	↗	to be defined	
	Fairer Access	Treatment when you need it	Access to emergency services	% of patients treated within benchmark times	x	95%	95%	→	to be defined
Treatment when you need it		Access to targeted treatments	Treatment rates for coronary revascularisation, hip replacement and radiotherapy waiting times	x	86%	90%	↗	to be defined	
Treatment when you need it		Access to hospital treatment	% of ready-for-care patients waiting for booked treatment	x	91%	90%	↗	to be defined	
Levels of health are equal		Fairer distribution of funding	Average distance from RDF target for AHSs	x	3%	3%	→	to be defined	
Quality Health Care		Safety	Safety	Incidence rates for acute separations	x	11%	5%	↗	to be defined
		Coordinated care	Potentially avoidable hospitalisations	Rates and associated bed days of potentially avoidable admissions	x	80%	95%	↗	to be defined
		Providing the right care	Priority care process—stroke	Snapshot analysis of stroke patients analysed across each aspect of the dashboard	x	90%	90%	→	to be defined
	Providing the right care	Priority care process—cancer	Snapshot analysis of cancer patients analysed across each aspect of the dashboard	x	90%	90%	→	to be defined	
Better Value	Providing the right care	Patient and consumer experience	Patient satisfaction survey	x	76%	72%	↗	to be defined	
	Using money wisely	Staying on budget	Net cost of services variance from budget	x	6%	3%	↗	to be defined	
	Better use of resources	Maximising service output	Health service output measure	x	95%	95%	→	to be defined	
	Better use of resources	Effective resource use	Effective resource use index—comparison against benchmark	x	97%	95%	↗	to be defined	
People, Learning and Innovation	Better use of resources	Asset utilisation	Asset depreciated value/weighted output measure of service	x	45%	40%	↗	to be defined	
	Develop a culture of service and teamwork	Skilled and valued workforce	Staff motivation score (job satisfaction)	x	80%	90%	↗	to be defined	

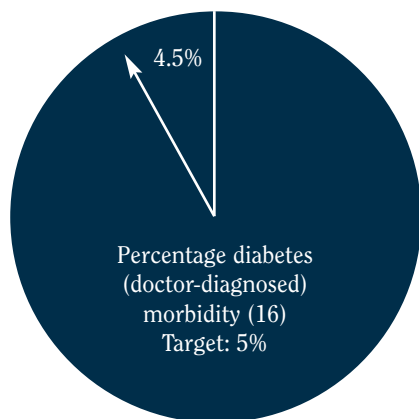
6 Example of a strategic map at AHS level



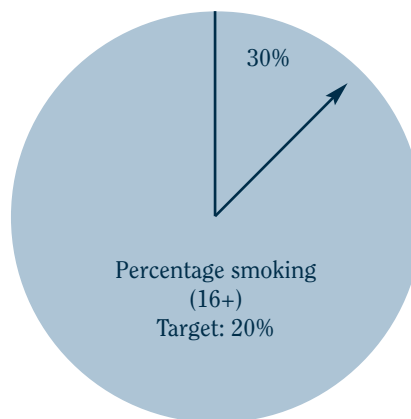
7 KPIs—IPART dashboard indicators—to be used at AHS level (developed at an AHS level)

Healthier People

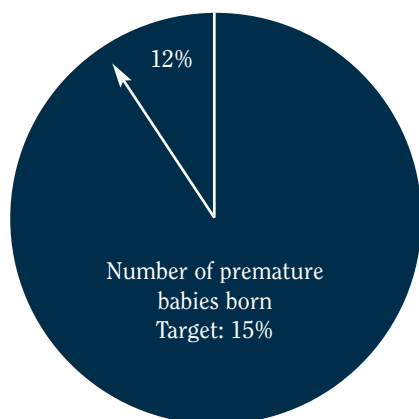
Objective: Target high-risk groups



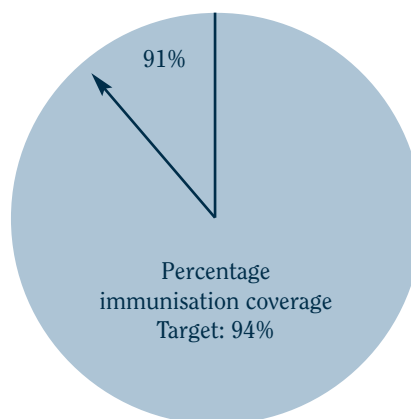
Objective: Educate population



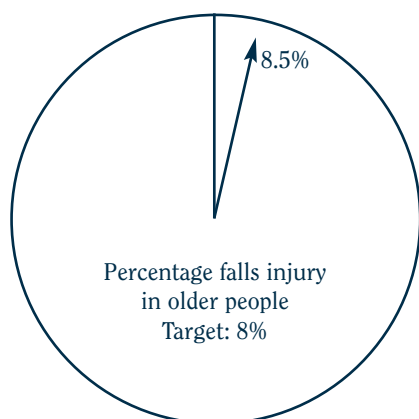
Objective: Educate population



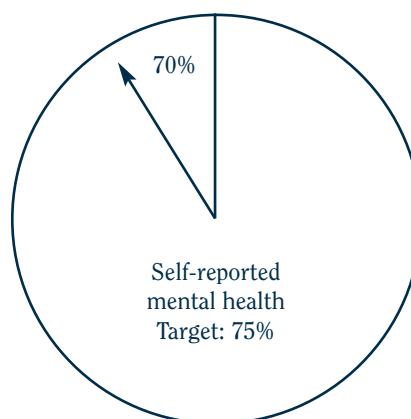
Objective: Educate population



Objective: Target high risk groups

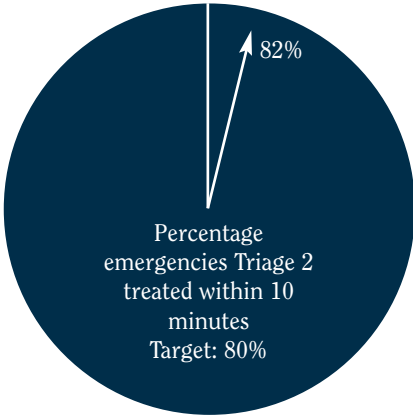


Objective: Develop networks with outside agencies

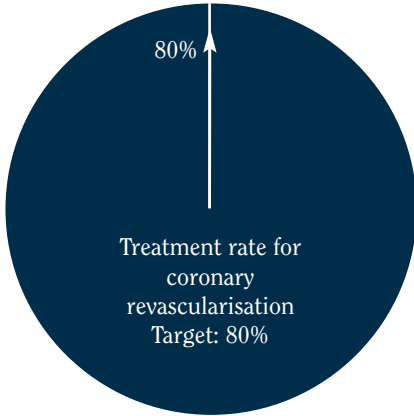


Fairer Access

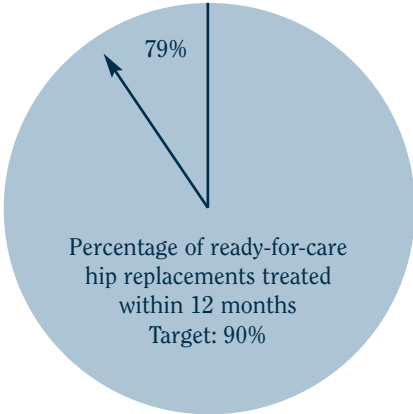
Objective: Waiting times



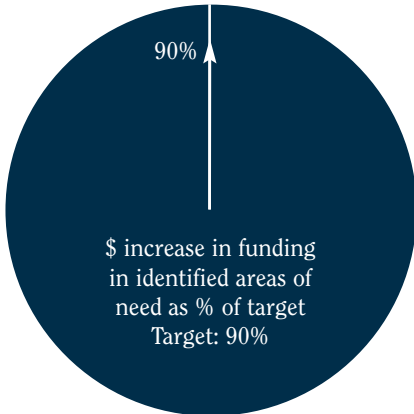
Objective: Treatment when you need it



Objective: Waiting times

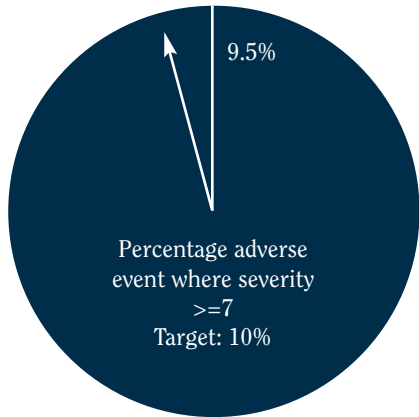


Objective: Treatment when you need it

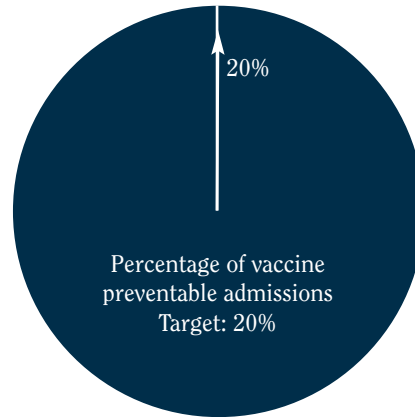


Quality Health Care

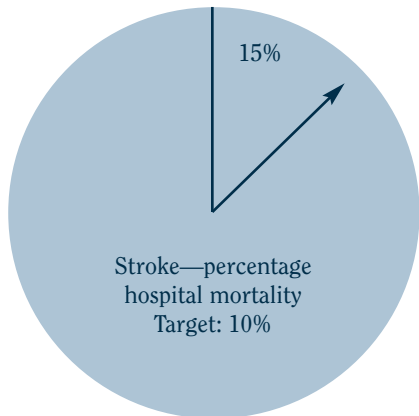
Objective: Quality and safe health care experience



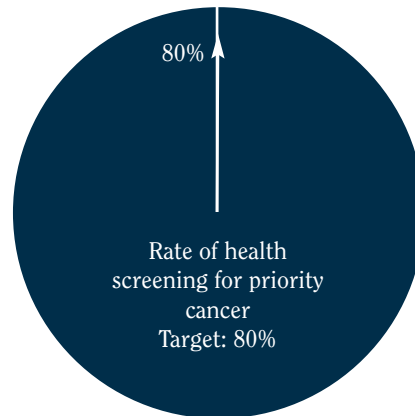
Objective: Providing the right care



Objective: Providing the right care



Objective: Providing the right care



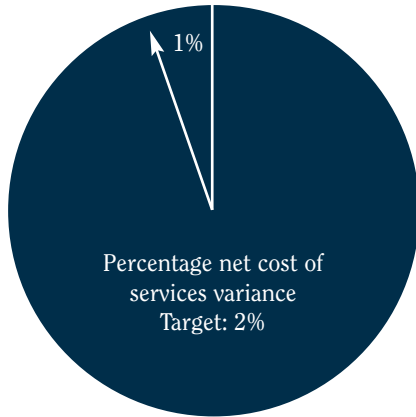
Objective: Quality and safe health care experience



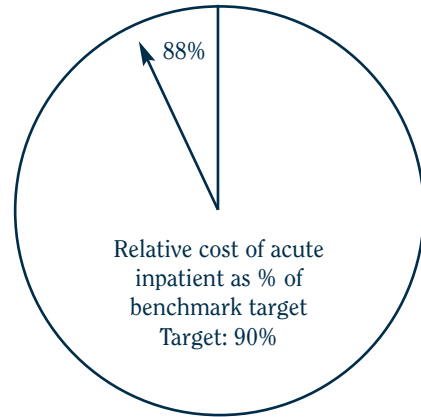
Attachment 9 Suggested presentation of KPIs

Better Value

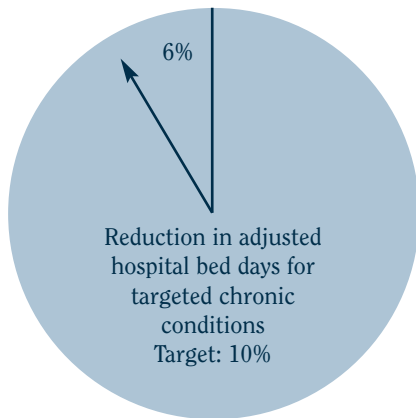
Objective: Meet activity targets within budget



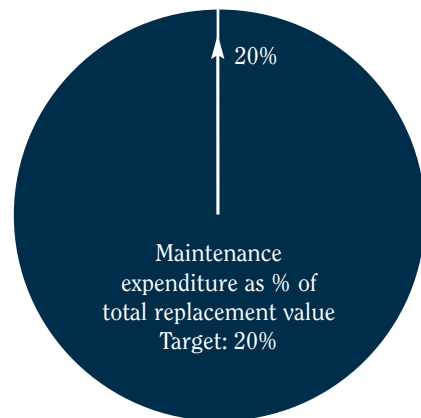
Objective: Prioritise and optimise resource utilisation



Objective: Prioritise and optimise resource utilisation



Objective: Prioritise and optimise resource utilisation



People, Learning and Innovation

Objective: Develop a culture of service and teamwork

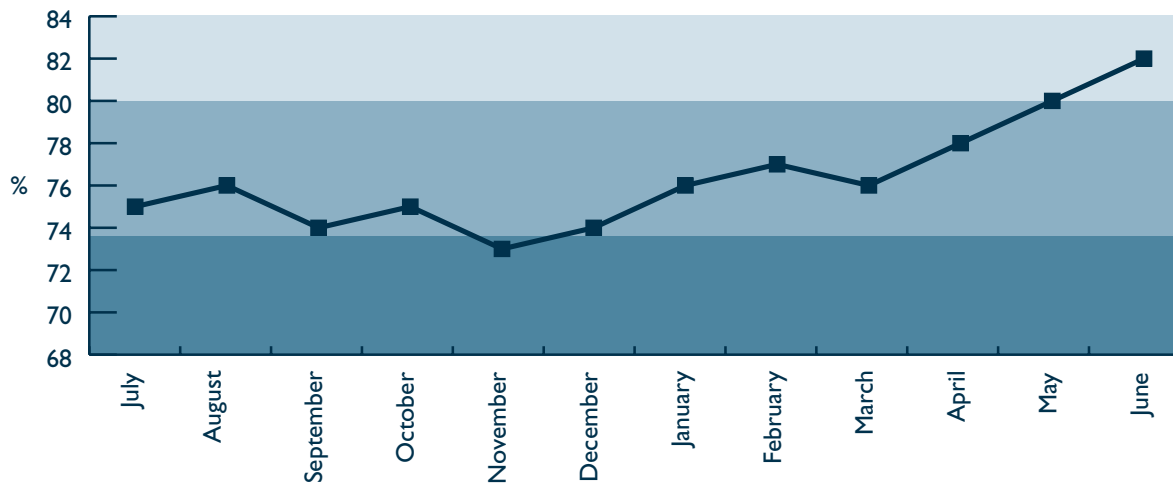


8 KPIs—second level presentation of IPART KPIs—to be used at AHS level

Fairer Access

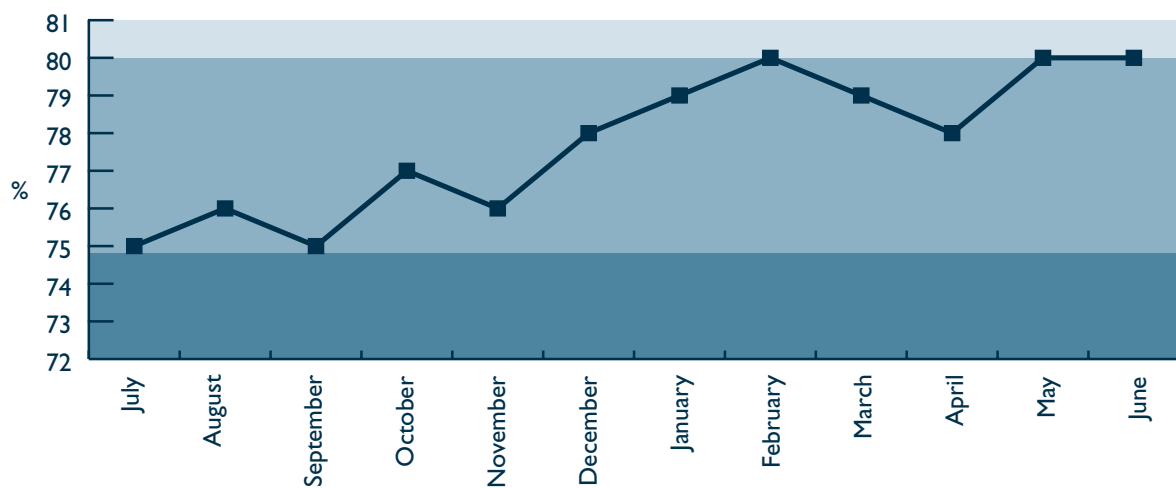
Objective: Waiting times

Percentage emergencies Triage 2 treated within 10 minutes



Objective: Treatment when you need it

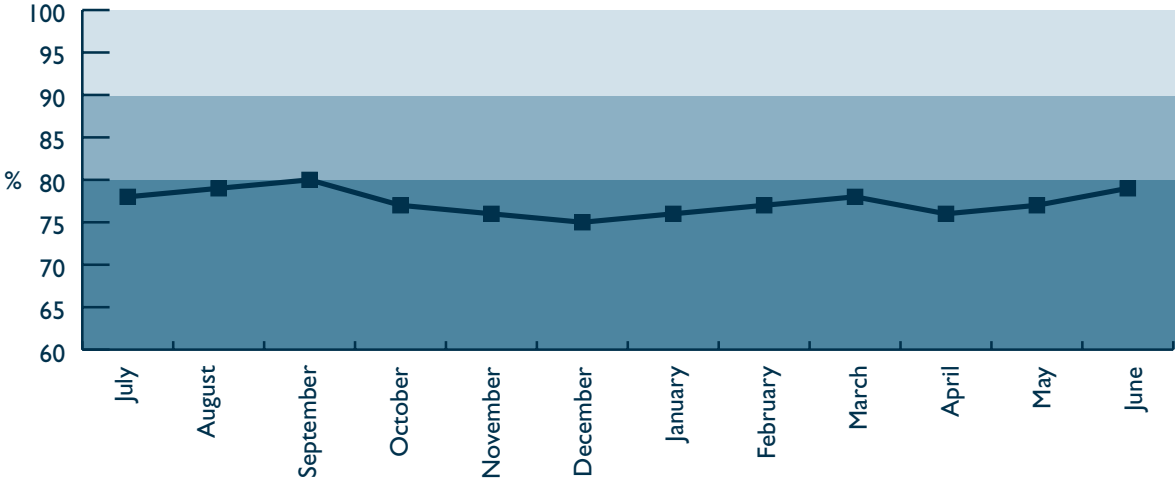
Treatment for coronary revascularisation



Attachment 9 Suggested presentation of KPIs

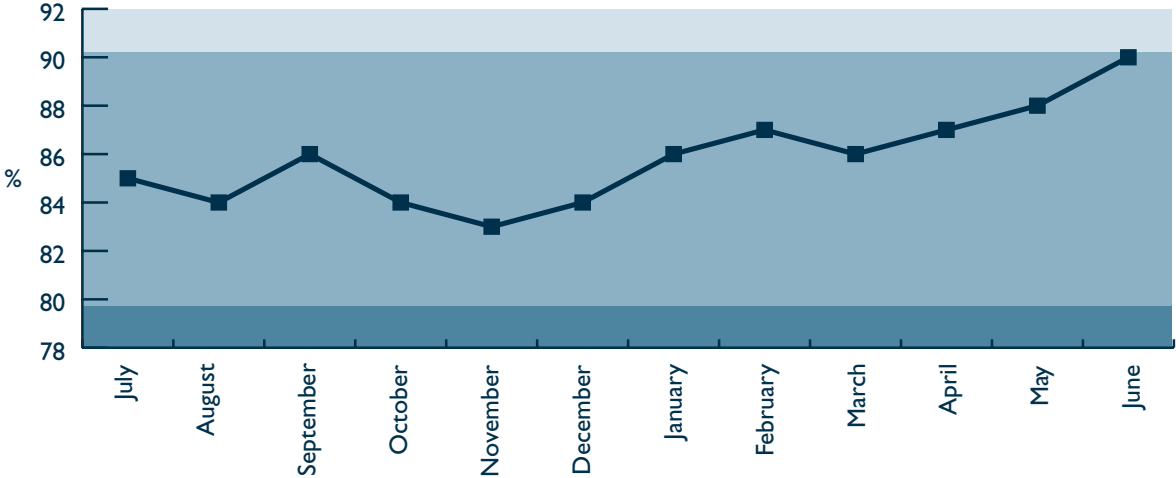
Objective: Waiting times

Percentage of ready-for-care hip replacements treated within 12 months



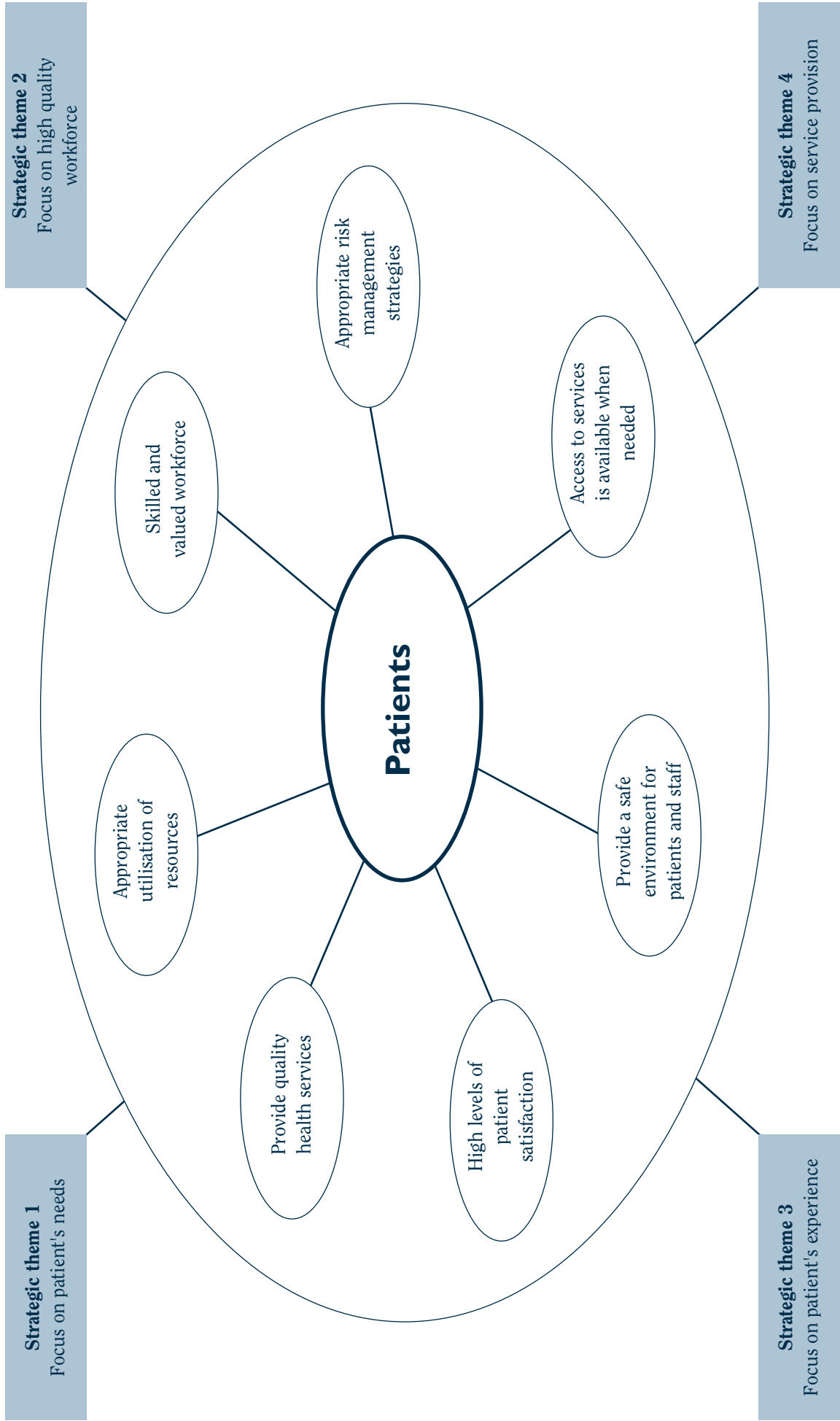
Objective: Treatment when you need it

\$ increase in funding in identified areas of need as % of target



9 Example of a strategic plan at the hospital level

Vision: Creating a culture of best quality care
Mission: To ensure best possible health outcomes in a safe environment

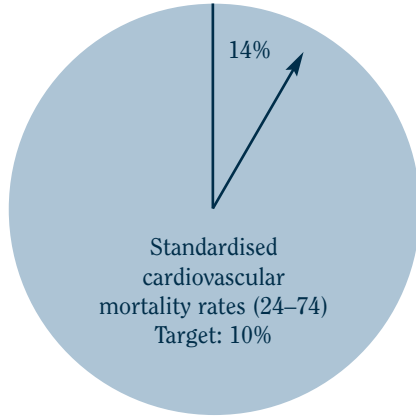


Attachment 9 Suggested presentation of KPIs

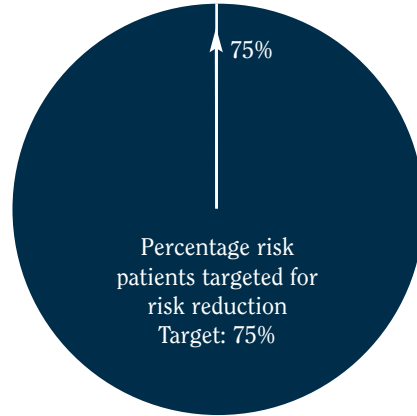
10 KPIs—IPART dashboard indicators—to be used at hospital level (developed at a hospital level)

Focus on Patient's Needs

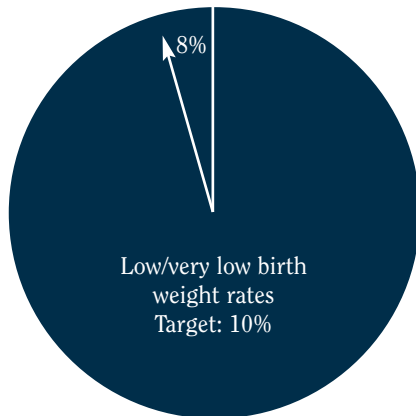
Objective: Provide quality health services



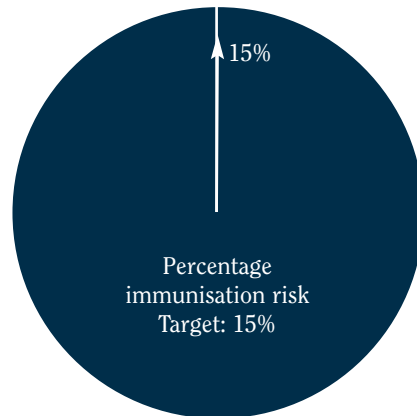
Objective: Provide quality health services



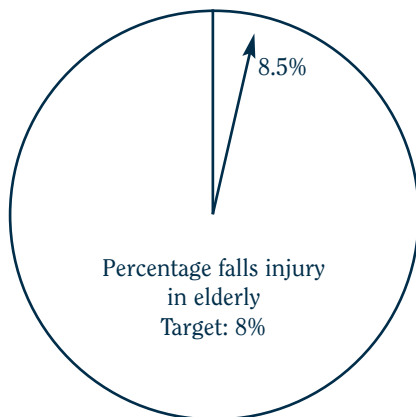
Objective: Provide quality health services



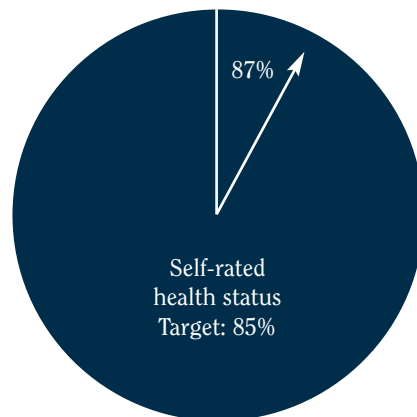
Objective: Provide quality health services



Objective: Provide quality health services

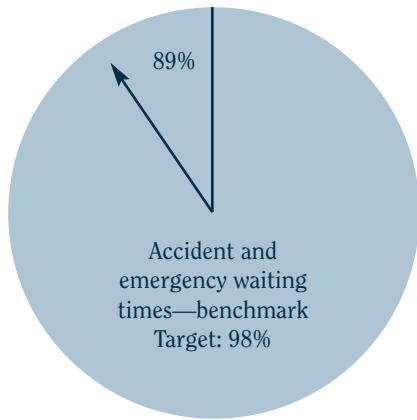


Objective: Provide quality health services

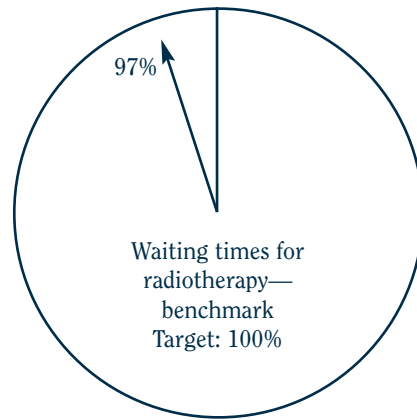


Focus on Patient Experience

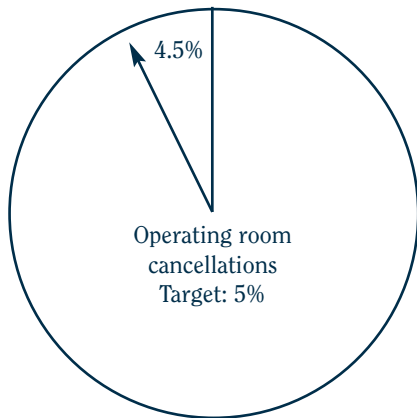
Objective: Access to services is available when needed



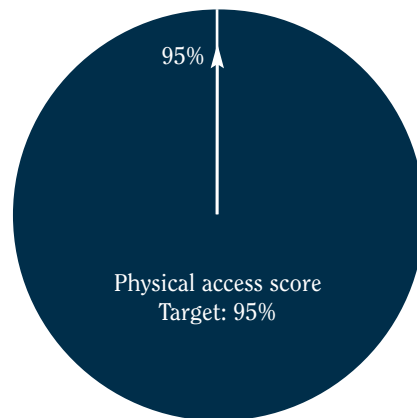
Objective: Access to services is available when needed



Objective: Access to services is available when needed



Objective: Access to services is available when needed



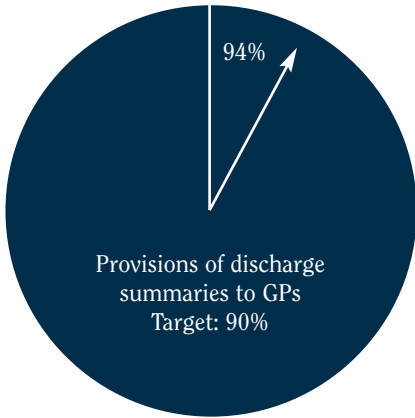
Attachment 9 Suggested presentation of KPIs

Focus on Quality

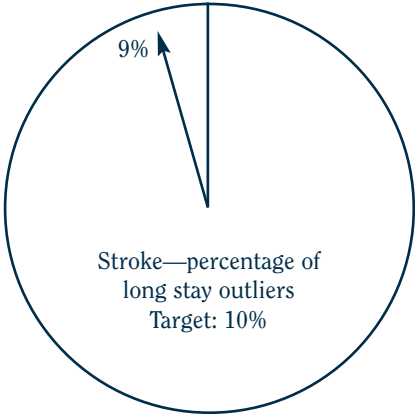
Objective: Provide a safe environment for patients and staff



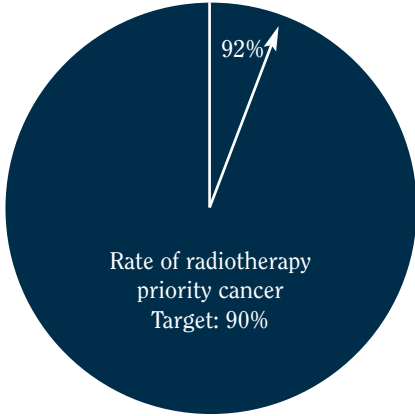
Objective: Provide quality health services



Objective: Provide quality health services



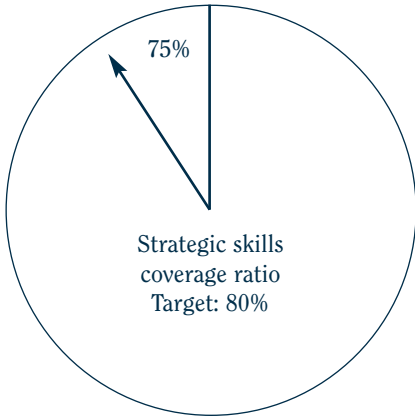
Objective: Provide quality health services



Objective: High levels of patient satisfaction

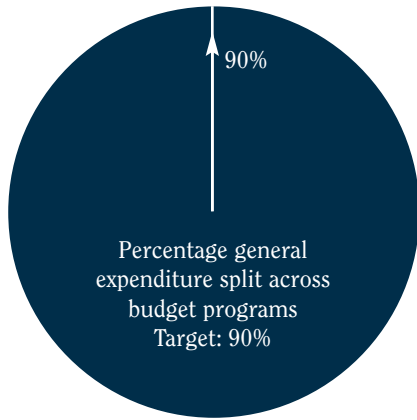


Objective: Provide quality patient services

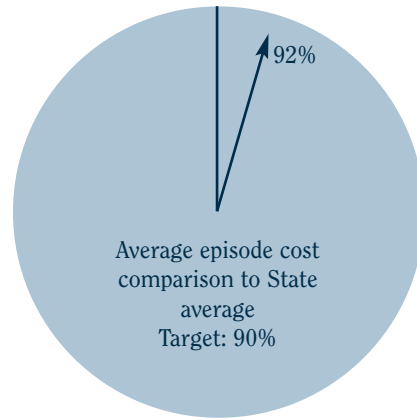


Focus on Service Provision

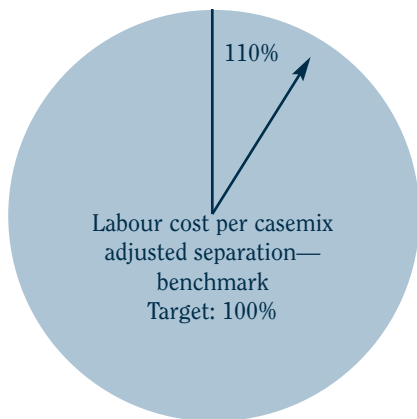
Objective: Provide quality patient services



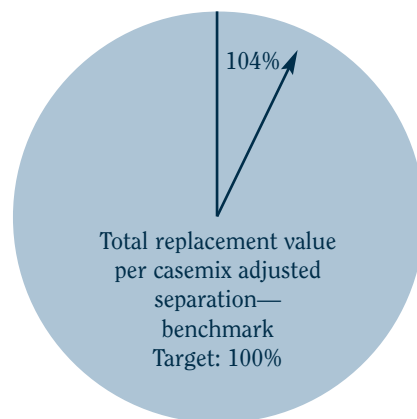
Objective: Appropriate utilisation of resources



Objective: Appropriate utilisation of resources



Objective: Appropriate utilisation of resources



II Example of a cascading indicator

