

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

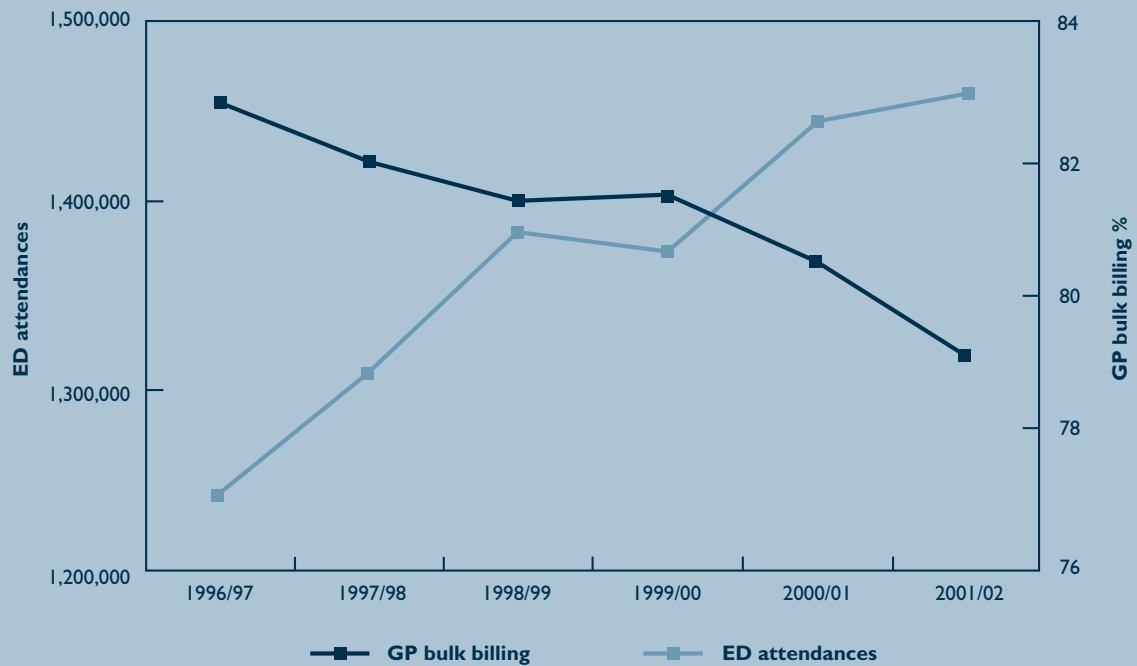
Between 1996/97 and 2000/01 the number of GPs in Australia decreased by nearly 3 per cent,⁶ while their bulk-billing rates fell by 3.6% and the availability of after-hours GP services declined, especially in rural areas. In NSW, this has resulted in:

- 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.

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- 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?

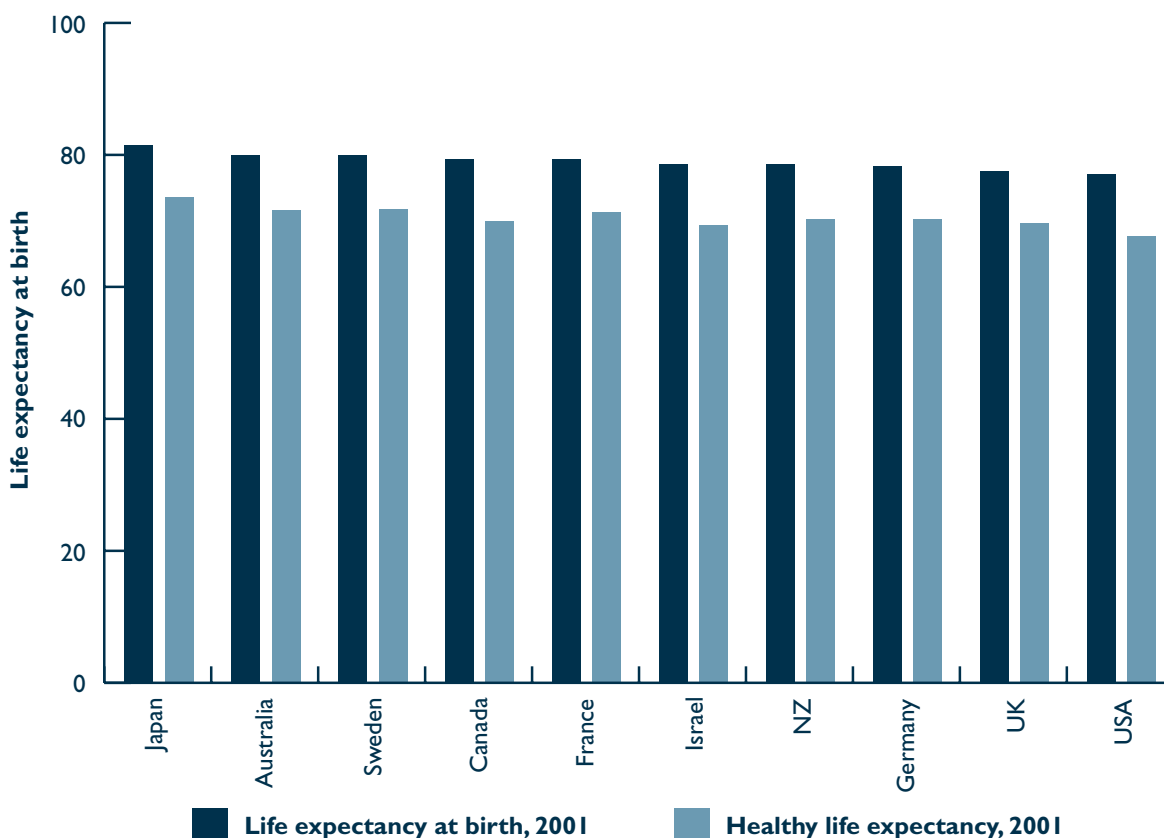
Health outcomes in NSW compare favourably with those for Australia as a whole and other countries. The life expectancy at birth in NSW is marginally lower than the national average (eg female life expectancy in 2000 was 82.6 years for NSW and 82.8 for the nation). Male and female life expectancies in 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



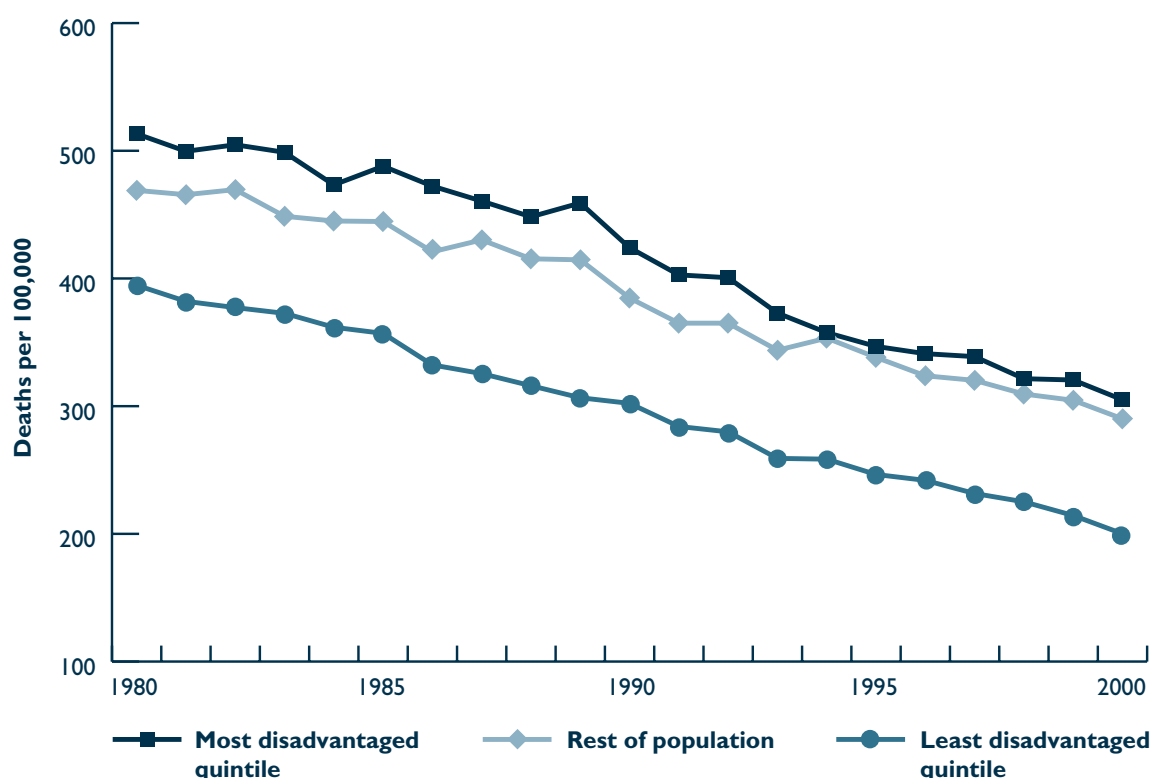
Source: WHO, *World Health Report 2002*

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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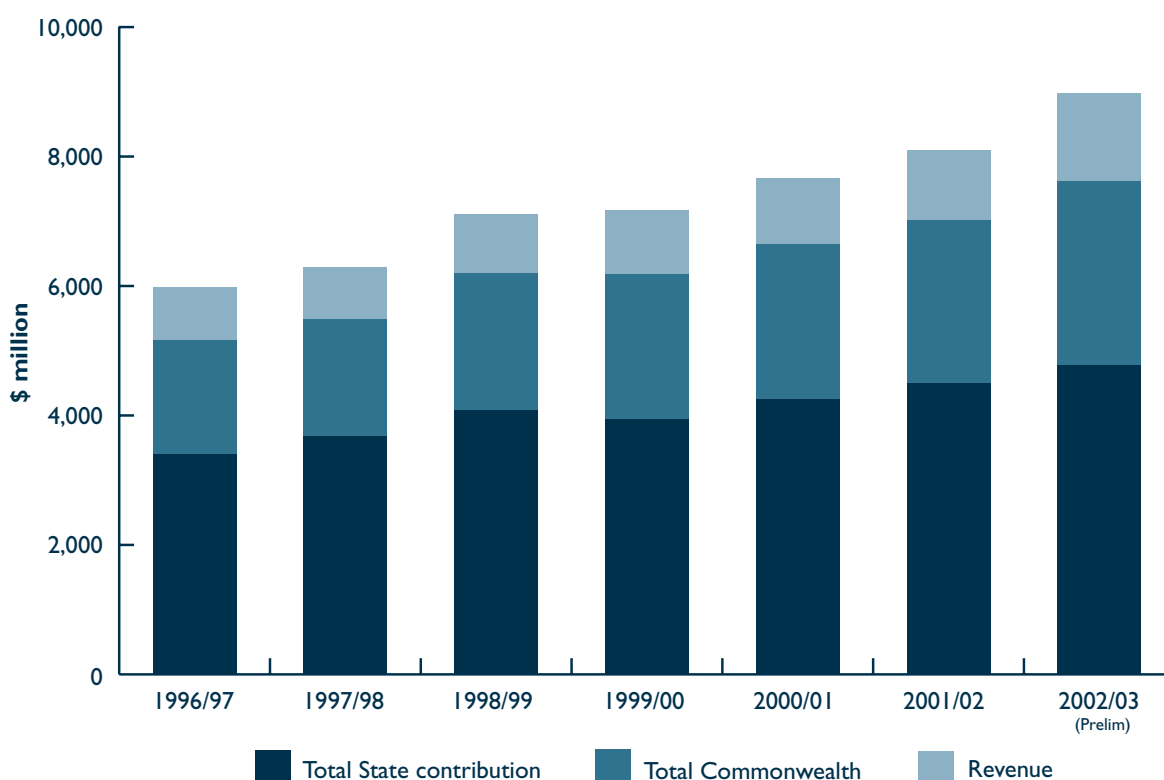
In terms of the underlying causes of illness, tobacco smoking is the leading preventable cause of disease and death. Hospitalisation rates associated with smoking-related illness continue to rise. However, deaths attributable to long-term smoking have declined by 34 per cent over the last 10 years.²⁰ 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.

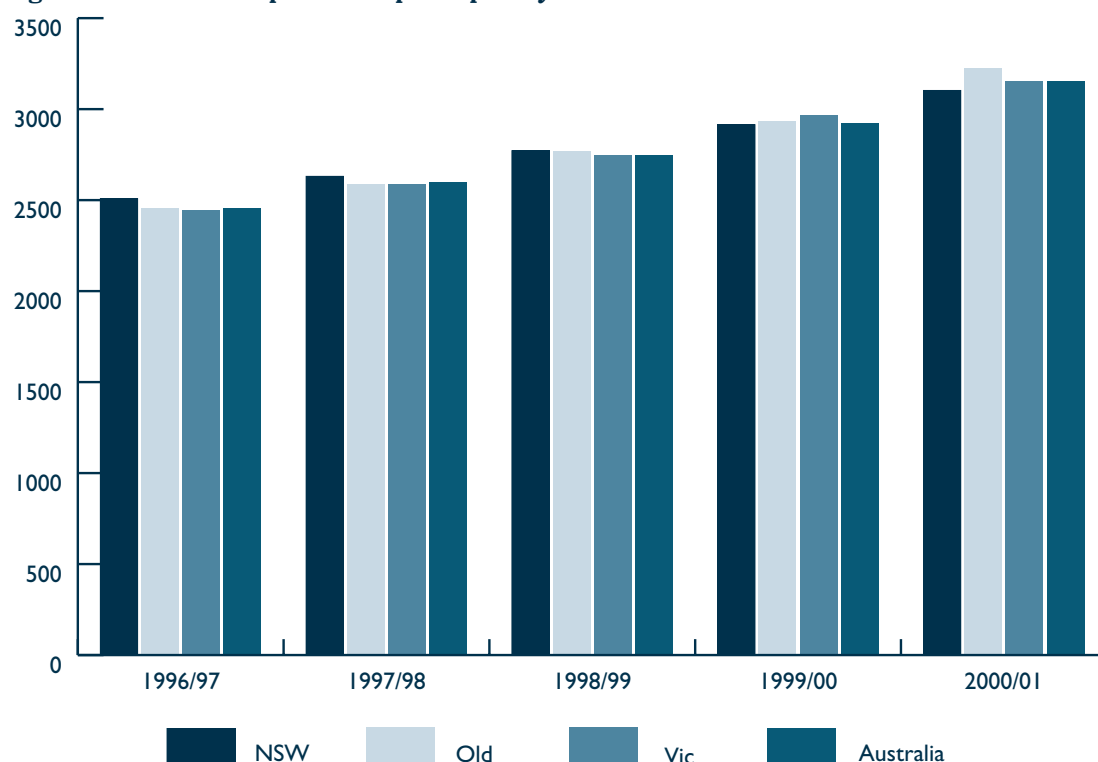
Health is also a growing part of the budget. Over the last five years, State Government funding for the health system increased by 13 per cent in real terms. NSW Health's expenditures increased by 16 per cent in real terms over the five years to 2002/03. Over the five-year period, hospital admissions 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.

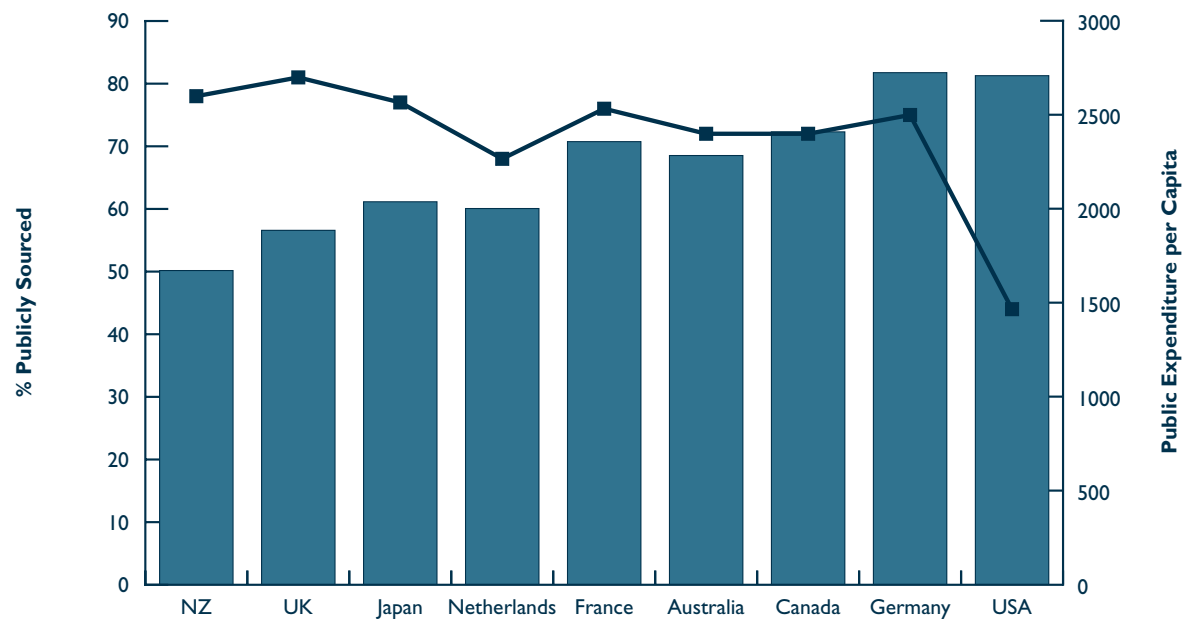
Figure 3.5 Expenditure per capita by country, 2000



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 Harde 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 Harde 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.

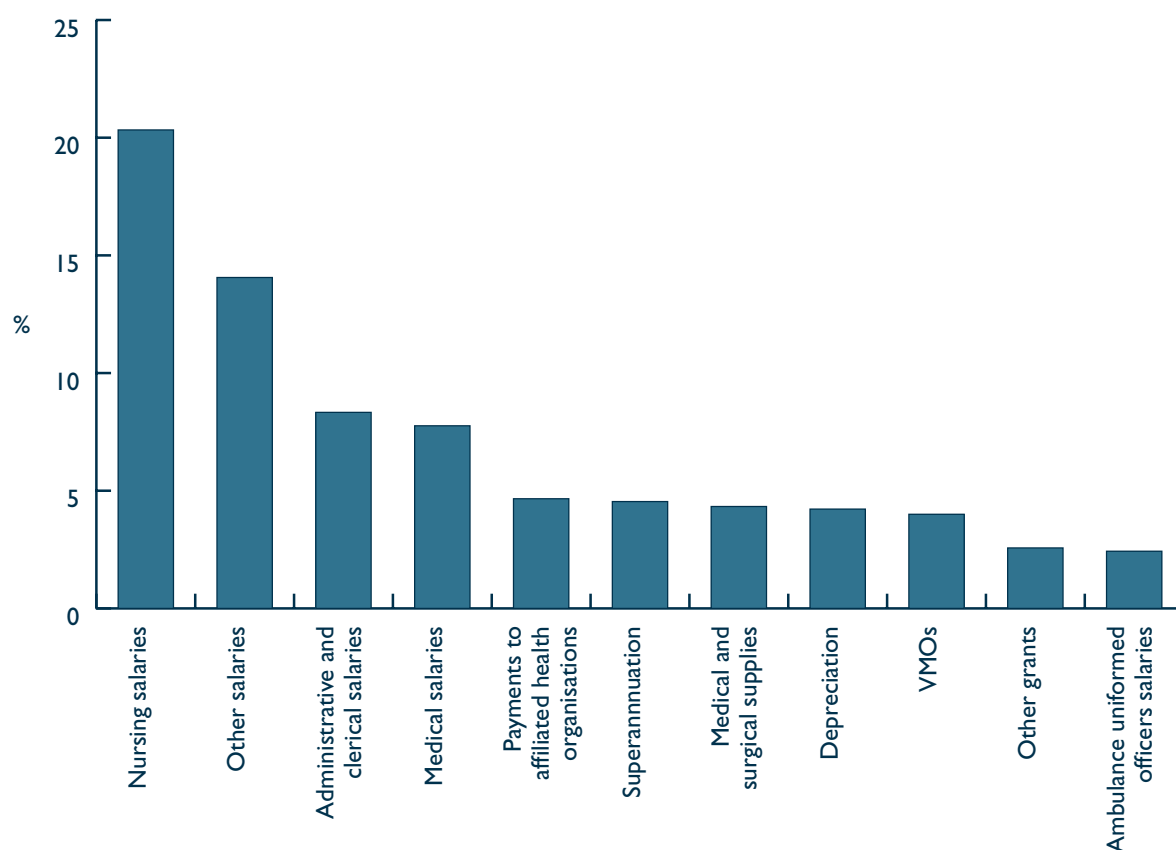
²² This does not include patients previously treated as admitted patients who are now managed on an outpatient basis.

²³ In the current study by Harde 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 Harde 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.