

5 Better quality care and patient safety

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

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

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

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

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

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

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

5.1 What are systems to ensure quality care?

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

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

5.1.1 Developing and implementing guidelines and support systems

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

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

5.1.2 Monitoring and reporting clinical care performance

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

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

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

5.1.3 Implications for clinicians

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

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

5.1.4 Implications for the cost of health care

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

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

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

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

5.2 Current clinical governance structures and initiatives in NSW

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

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

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

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

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

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

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

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

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

5.3 Proposals to strengthen clinical governance

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

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

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

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

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

5.3.1 Developing and implementing guidelines and support systems

Developing guidelines for care

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

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

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

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

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

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

Implementation and system development

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

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

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

5.3.2 Monitoring and reporting clinical care performance

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

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

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

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

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

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

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

Box 5.1 National service frameworks in the United Kingdom

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

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

Recommendations

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

6 More integrated service delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.2 Improve coordination at higher levels of government

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

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

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

6.3 Focus integration and coordination efforts on high-priority issues

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

6.3.1 Whole-of-government response to mental health problems

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

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

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

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

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

6.3.2 Need for better integration and provision of transport services

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

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

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

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

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

Box 6.1 Recent transport initiatives in NSW Health

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

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

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

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

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

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

6.3.3 Coordinate delivery of health care services across agencies

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

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

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

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

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

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

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

Box 6.2 Community-driven initiatives in post-acute care

Mid North Coast

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

Darlinghurst Community Health Centre post-acute care team

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

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

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

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

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

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

Recommendations

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

7 Stronger structures for clinician and community participation

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

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

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

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

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

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

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

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

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

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

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

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

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

The HCAC's role would be to:

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

Stronger structures for clinician and community participation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Some of the functions of the groups are to:

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

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

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

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

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

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

Stronger structures for clinician and community participation

Recommendations

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

8 More equitable health outcomes and more effective funding arrangements

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

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

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

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

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

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

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

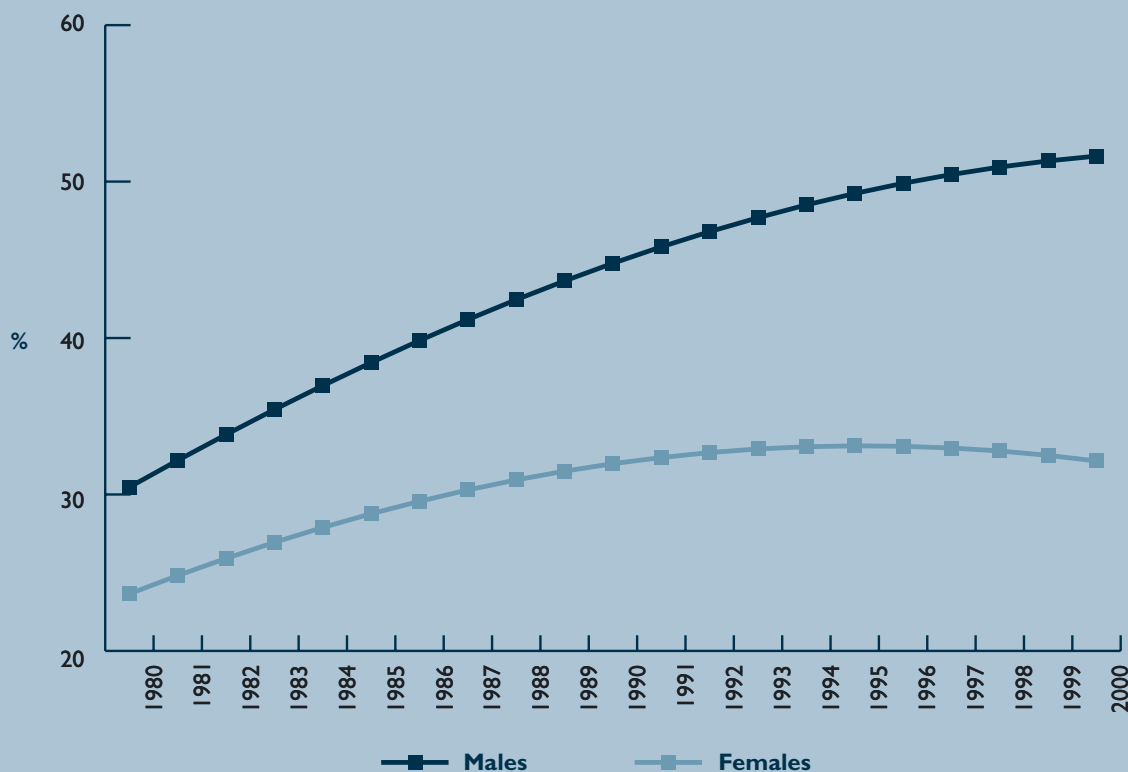
Box 8.1 Socioeconomic status and health

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

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

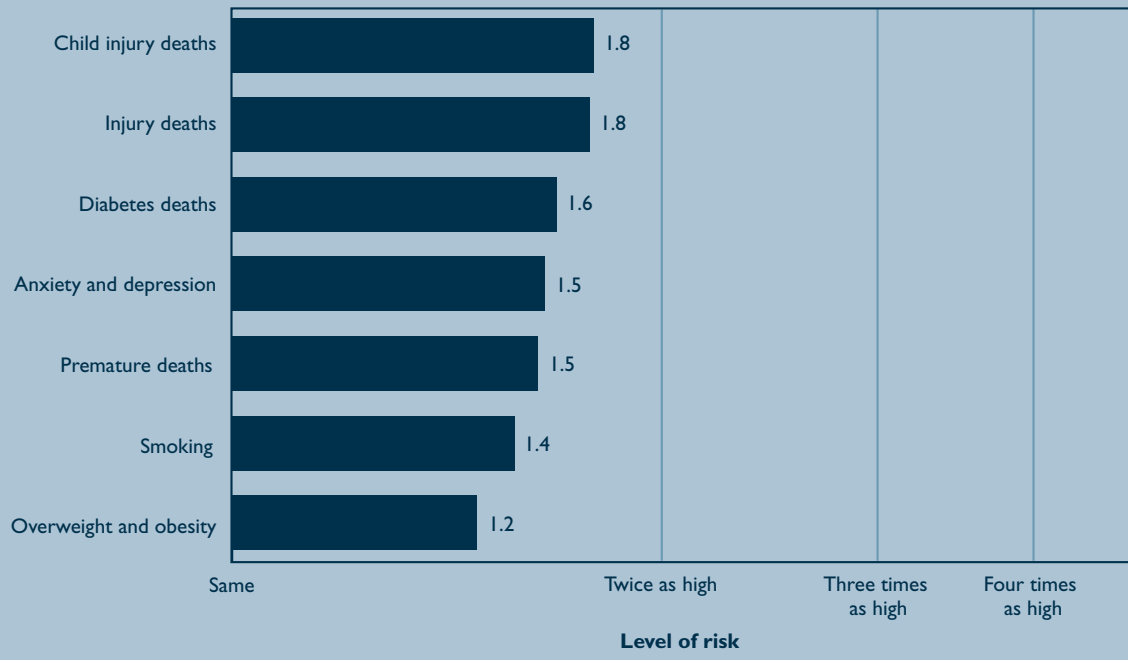
Between 1980 and 2000, the percentage difference in premature death rates for the highest and the lowest SES groups increased for both males and females (Figure 8.1). The gap for males has increased more than the gap for females. In 1980, the premature death rate in the lowest SES group was 24 per cent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

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



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

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

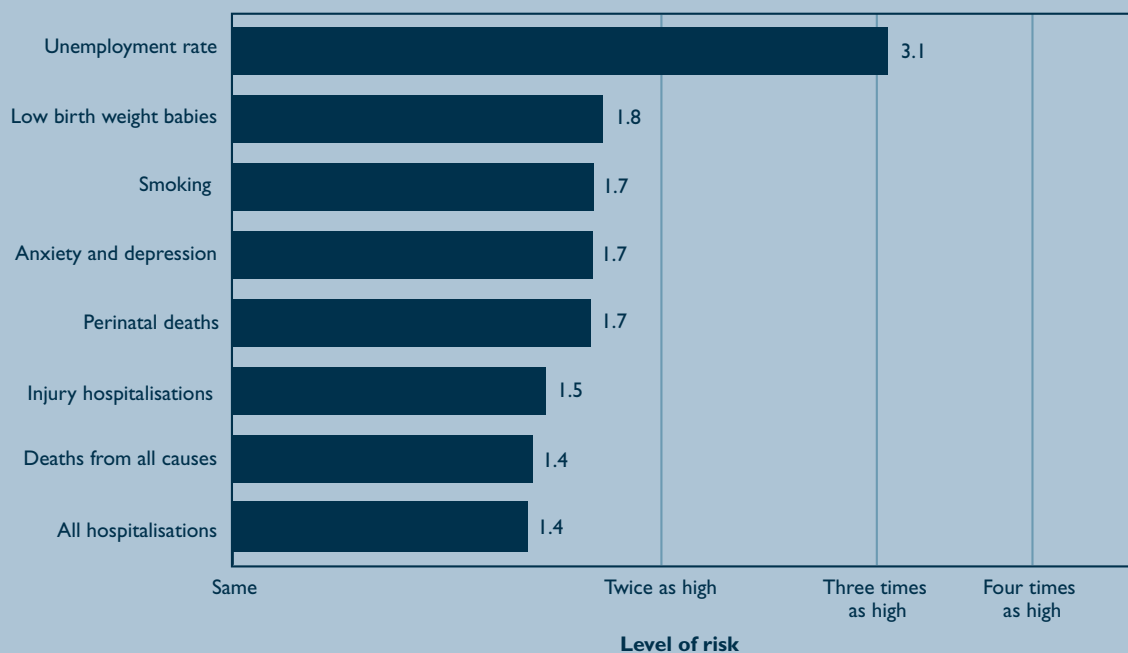


Box 8.2 Health outcomes for indigenous people

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

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

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



8.1 Develop more specific strategies for health and equity priorities

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

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

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

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

8.2 Reform funding arrangements

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

More equitable health outcomes and more effective funding arrangements

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

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

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

8.2.1 Introduce four-year rolling budgets

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

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

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

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

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

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

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

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

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

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

8.2.2 Revise the Resource Distribution Formula

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

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

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

³³ And its predecessor, the Resource Allocation Formula.

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

More equitable health outcomes and more effective funding arrangements

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

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

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

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

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

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

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

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

Box 8.3 Department's review of RDF

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

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

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

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

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

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

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

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

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

More equitable health outcomes and more effective funding arrangements

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

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

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

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

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

8.2.4 Adopt episode costing as a management tool

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

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

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

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

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

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

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

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

8.2.5 Capital charging and other capital funding issues

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

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

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

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

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

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

8.2.6 Address other funding issues

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

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

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

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

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

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

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

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

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

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

More equitable health outcomes and more effective funding arrangements

Recommendations

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