

9 Better performance through clearer roles and accountabilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.1.1 State-wide planning, direction-setting and guidance

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

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

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In addition, it includes:

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

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

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

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

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

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

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

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

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

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

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

9.1.2 State-wide primary health care issues

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

The Department should be responsible for:

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

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

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

9.1.3 Strategic financial and asset management

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

The Department should be responsible for:

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

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

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

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

9.1.4 Industrial relations and employment issues

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

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

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

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

9.1.5 Strategic performance measurement and monitoring

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

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

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

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

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

9.1.6 Future scope of the Department

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

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

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

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

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

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

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

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

9.2 Make Area Health Services more autonomous and more accountable

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

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

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

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

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

9.2.1 Create a framework for greater autonomy and accountability

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

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

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

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

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

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

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

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

Several other changes should also be made:

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

9.2.3 Aim to achieve a high standard of AHS board members

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

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

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

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

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

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

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

9.2.4 Clarify the role and accountabilities of AHS CEOs

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

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

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

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

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

9.2.5 The number of AHSs and boundary issues

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

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

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

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

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

Box 9.1 Pros and cons of Area amalgamations

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

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

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

9.3 Make statutory corporations and other health entities more accountable

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

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

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

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

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

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

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

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

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

9.4 Improving procedures for ambulances and emergency patients

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

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

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

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

IPART supports this model for a number of reasons:

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

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

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

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

Better performance through clearer roles and accountabilities

Recommendations

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

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

10 More efficient support services

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

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

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

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

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

10.1 Current approaches to providing support services

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

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

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

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

For example, in relation to:

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

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

10.2 Options to improve the efficiency of support services

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

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

10.2.1 Using existing structures

This model would continue to use existing structures and mechanisms.

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

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

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

10.2.2 Central agency and AHSs networks

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

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

This model builds upon and formalises the current approach.

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

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

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

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

10.2.3 Joint venture shared services corporation

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

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

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

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

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

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

10.3 The proposed shared services corporation for NSW Health

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

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

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

Specifically:

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

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

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

10.4 Information Technology

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

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

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

Box 10.1 New England Area Health Service

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

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

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

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

Recommendations

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

II A more integrated performance measurement system

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

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

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

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

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

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

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

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

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

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

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

11.1 Develop an overall framework based on strategic maps

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

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

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

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

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

A more integrated performance measurement system

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

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

11.1.1 Consider using the balanced scorecard model

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

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

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

Box 11.1 Hunter AHS’s balanced scorecard model

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

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

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

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

11.1.2 Involve AHSs and facilities in developing their own KPIs

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

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

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

11.1.3 Ensure indicators can be used for benchmarking

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

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

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

The committee's purpose was to:

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

A more integrated performance measurement system

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

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

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

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

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

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

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

11.2.1 Consider the management dashboard to be dynamic

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

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

11.2.2 Public health indicators should be included on a rotating basis

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

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

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11.2.3 Address appropriate GP referral rates through the proposed national inquiry

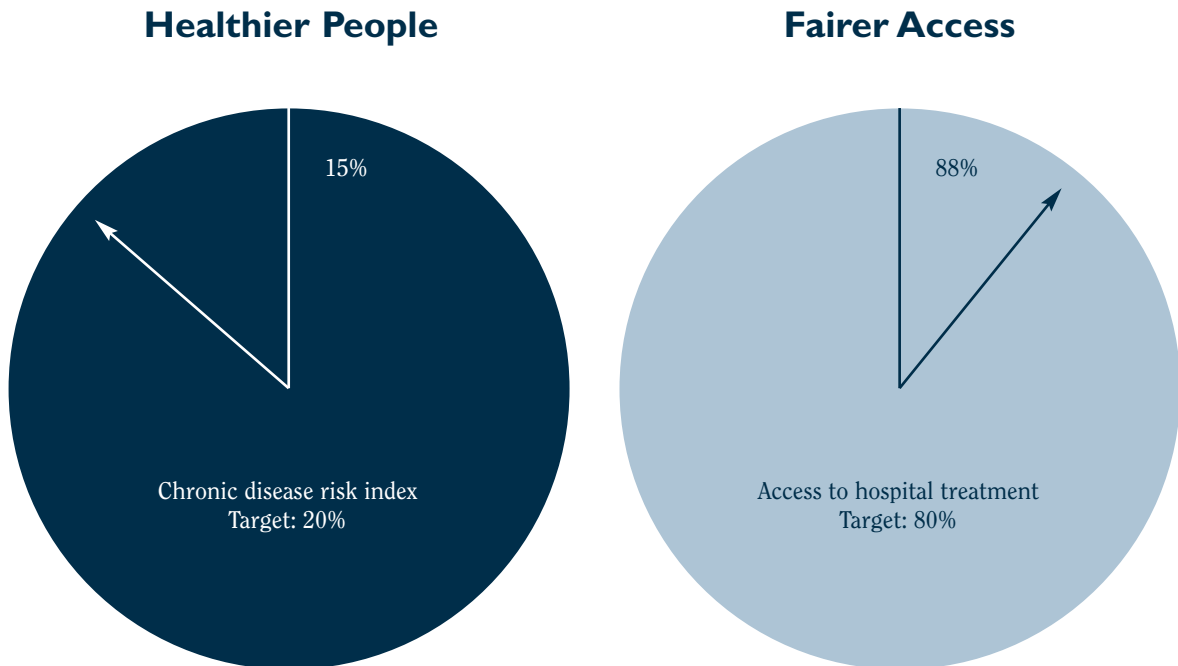
IPART notes that not all factors impacting on the KPIs included in the management dashboard are under NSW Health's control. For example, both GP referrals and post-acute care have a significant influence on potentially avoidable hospitalisation rates and the general demand on the health system, but are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

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

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

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

Figure 11.4 Traffic light presentation of performance indicators



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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.4 Address all levels of governance and include incentives and sanctions

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

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

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

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

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

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

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

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

11.4.2 Link the targets for individual KPIs to incentives and sanctions

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

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

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

Box 11.3 Use of incentives and sanctions in Victoria

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

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

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

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

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Recommendations

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

12 A more sustainable health workforce

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

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

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

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

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

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

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

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

⁴⁷ Source: Chief Financial Officer, NSW Health.

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

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

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

12.1 Establish a single workforce planning unit

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

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

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

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

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

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

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

12.2 Develop an integrated workforce plan

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

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

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

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

12.3 Implement strategies to address shortages and uneven distribution of clinicians

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

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

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

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

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

12.3.1 Address shortages and uneven distribution of nurses

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

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

Table 12.1 Trends in nurse numbers and salaries

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

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

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

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

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

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

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

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

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

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

Increasing the innovative use of casual pools

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

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

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

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

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

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

These more innovative casual pool initiatives would need to be developed and implemented at the AHS or facility level. The Department's role would be to promote the strategy of strengthening casual pools, provide models of best practice, and assist AHSs that struggle to develop effective casual pools.

Providing management skills and support for Nurse Unit Managers

IPART's review identified that filling middle-management nursing positions (Nurse Unit Managers (NUMs)) is particularly difficult. One of the reasons is that the current award structure requires NUMs to be clinical specialists, managers and administrators—a challenging role. In addition, nurses in these positions often don't receive opportunities to improve their managerial skills, or support to manage their administrative workload.

IPART believes that providing NUMs with more management development opportunities and support will help to address nursing shortages:

- NUMs are front-line managers, and therefore have the capacity to directly influence the day-to-day operations of their units and the job satisfaction and morale of the nurses they supervise. Increasing the emphasis on people management skills in the recruitment and development of NUMs, should help to promote a positive work environment, and thus help overcome nurse shortages.
- NUMs also have a significant administrative workload that requires time and additional skills. AHSs indicated to IPART that NUMs spend up to 40 per cent of their time on rostering alone. Providing improved administrative support, such as software that largely automates rostering, would free NUMs for other higher value work. The costs involved should be more than offset by improved productivity.

IPART believes NSW Health should consider how it could provide greater support to NUMs—through training, mentoring and the provision of administrative support services—as a high priority.

12.3.2 Address uneven distribution of medical staff

All stakeholders acknowledge there is an overall shortage of medical staff in the NSW Health system. The impact of this shortage is most severe in rural and outer-metropolitan areas, and has a direct effect on these areas' ability to provide services locally. In contrast, some inner-city AHSs are relatively oversupplied with medical staff, largely due to historical patterns of funding and service development.

Robust data on the supply and distribution of NSW Health's medical staff was not available for this review, which highlights the difficulty it faces in sensibly addressing this challenge. The Department did provide estimates of the number of Visiting Medical Officers (VMOs) and staff specialists in the medical workforce in each AHS. These are not FTE estimates, which makes it difficult to interpret the data. However, this data indicates that there were 5,933 VMOs and staff specialists across NSW in March 2003. Of these:

- almost half (45 per cent) were located in three AHSs—South Eastern Sydney, Central Sydney and Northern Sydney
- 19 per cent were in South Eastern Sydney alone
- South Western Sydney, which has about the same population as South Eastern Sydney, had only half as many VMOs and staff specialists.

One of the main reasons for the shortage of medical staff is that there are insufficient places at universities to train the number of specialist doctors required to meet NSW Health's current and future needs. However, as with nursing, there is some capacity for NSW Health to alleviate shortages through strategies aimed at increasing retention rates and improving the distribution of VMOs and specialist staff, to drive more equitable access to medical services across NSW. In particular, IPART believes NSW should:

- work with medical colleges to ensure the fair allocation and distribution of hospital training positions

- streamline overseas recruitment processes
- encourage AHSs to appoint doctors to the Area, or a network of Areas, rather than to a particular facility
- create a more attractive work environment.

Work with medical colleges to ensure fair allocation and distribution of hospital training positions

Medical colleges play an important role in the distribution of medical specialists. For example, the Royal Australasian College of Surgeons is responsible for the processes used to select, train and assess surgeons (including overseas trained surgeons) and accredit hospital training posts. The ACCC's recent draft report on the role of this college proposes a number of changes to ensure its decision-making process is sufficiently independent and to increase the role of Government. The report claims the emerging evidence of a shortage of surgeons in Australia heightens the need for this reform, to ensure competent surgeons are available in rural, regional and metropolitan Australia.

IPART's review supports the ACCC's findings. Many of the stakeholders it consulted within AHSs argued that the barriers created by medical colleges' decision-making processes, which include impeding AHSs recruiting overseas doctors, reinforce the currently inequitable distribution of the medical workforce across NSW. The ACCC's review of the Royal Australasian College of Surgeons has the potential to address many of these concerns and to lead to significant reform.

Some stakeholders suggested the work of the NSW Medical Training and Education Committee (MTEC) could also help to achieve a fairer allocation of training positions. NSW Health established MTEC as a Ministerial Advisory Council in 2001. Its initial focus is to work with its stakeholders to better understand how vocational training and supervision of medical graduates is working. It is currently piloting a project in three AHSs that seeks to understand training at three levels: trainee, trainer and Area/hospital administration. MTEC's long-term goal is to develop an appropriate framework for high quality and sustainable training of the medical workforce. It does not have a direct role in workforce allocation and distribution though its work may have some influence on this in the long term.

MTEC is a new body attempting to work cooperatively with a diverse group of stakeholders with conflicting priorities. IPART believes it is unrealistic to expect MTEC to solve the problems of distribution in the short to medium term. Short-term solutions will probably only be achieved through direct intervention of the Government and the Department.

Streamline overseas recruitment processes

Many AHSs argue that there are too many barriers to attracting and retaining overseas doctors. Several hundred Registrar positions are occupied by overseas recruits. Many of these trainees stay for several years, but are then forced to return home because of restrictive requirements imposed by the Commonwealth Department of Immigration, the Australian Medical Council and medical colleges.

Other AHSs are frustrated at the hurdles they need to jump to get a position declared an 'Area of Need'. The Department's Area of Need Program grants special status to particular positions on a temporary basis while efforts to attract a medical practitioner with general registration on a permanent basis continue. The program was developed as a short-term strategy rather than a long-term solution to medical workforce shortages.

The main barriers to overseas recruitment need to be addressed at the national level and in the context of global shortages. If they were removed, anecdotal evidence suggests that there is a pool of qualified doctors willing and able to fill vacancies across Australia.

Within NSW, there appears to be some scope for NSW Health to streamline its overseas recruitment processes. IPART believes that this should be pursued. NSW Health should also consider coordinating overseas recruitment efforts. It believes efficiency benefits could be gained by making one AHS with proven experience responsible for overseas recruitment, rather than individual AHSs sending their own staff overseas to recruit a small number of specialists.

Encouraging AHSs to appoint doctors to the Area or network of Areas

Some AHSs have begun to appoint doctors to the Area rather than to a particular facility, to allow them to perform procedures at any of the facilities within the AHS's boundaries. This approach parallels the clinical stream structures some AHSs have adopted, and provides the flexibility to move clinicians to where they are most needed.

IPART believes this concept could be broadened, to allow the appointment of clinicians to a network that cuts across AHS boundaries. To be effective, this approach would require the cooperation of AHSs and willingness of clinicians. However, it may be feasible in some cases, particularly where a cooperative relationship between a metropolitan and rural AHS already exists.

Create a more attractive working environment

Some AHSs will always have more difficulty in attracting doctors than others because of their location or other factors. However, the experience of organisations such as the Post-graduate Medical Council and MTEC is that AHSs and hospitals can increase their attractiveness by creating a more attractive working environment. Regional hospitals that previously had poor reputations and high staff turnover rates have been transformed by adopting strategies such as:

- providing study leave to Junior Medical Officers
- establishing mentoring programs
- upgrading accommodation facilities
- making it easier for staff to be involved in extracurricular activities, both within the health system and in social contexts.

AHSs in which doctors have productive and cooperative relationships with the administration are also favoured over those where there is persistent conflict. Several stakeholders suggested better relationships could be facilitated by improving performance management systems so that staff are more accountable but also have more opportunities for two-way communication with management and for development.

In addition, there is some scope to introduce additional incentives to attract medical practitioners to AHSs where there are shortages. For example, the CEO of one rural AHS suggested that allowing doctors to accumulate long service leave at a faster rate than usual after they have been employed for a minimum period could encourage doctors to stay longer in rural areas. However, other stakeholders were concerned that this kind of incentive would place AHSs in competition with each other for vocational groups in short supply, and could set precedents that have State-wide ramifications. Ideally, the industrial relations environment should allow AHS-specific agreements that do not flow on to other AHSs. If flow-on effects aren't restricted, specific agreements would become ineffective and high risk.

12.3.3 Address barriers to the recruitment and retention of allied health staff

Some of the most severe shortages in NSW Health's workforce are of allied health staff. There are critical shortages of pharmacists in public hospitals and shortages of radiographers and radiation therapists across the State. In rural and regional areas, there are shortages of physiotherapists, speech therapists, psychiatrists and other allied health professionals.

A significant barrier to the recruitment and retention of allied health staff is created by the rates of pay NSW Health offers them. Allied health professionals across nearly all streams can earn substantially more in the private sector. For example, a pharmacist with a private business is likely to earn two to three times more than one working in a public hospital.

Another barrier is that the training of some allied health professionals better prepares them for establishing a private business than for providing services in the public health system.

IPART believes NSW Health should explore strategies for overcoming these and other barriers to attracting and retaining allied health staff, including considering substantial pay rises.

12.4 Engage with health care professionals and unions to enable new models of patient care

Despite the major changes and advances in health care, there has been little fundamental change in the roles and responsibilities of the different health care professionals, the way they are organised, and the way they have interacted with each other for the last 30 years. However, the challenges NSW Health faces in overcoming shortages in health care professionals, meeting increasing demand for health care services, and controlling the burgeoning costs of providing these services mean that it has no choice but to find new ways to deliver health care services and seek alternative providers for some services.

This inevitably means that the roles of the doctors, nurses and allied health professionals and their scopes and patterns of practice, will need to change to match new models of delivering patient care. Indeed, the emergence of new health care providers and the roles they eventually play is expected to result in more drastic changes to the health care landscape over the next 10 to 15 years than we have seen in the past 30 years. In many ways, these changes will determine how quickly NSW Health can develop new service delivery models in the future, and what shape these models will take.

IPART identified a strong view that there should be a broad-based review of the skills needed to deliver health services across the system. This review should not be based on existing professional boundaries, but on the needs of patients. The professions should then model their work practices on the needs of patients, rather than on these boundaries.

Such broad-based reform will be difficult to achieve—it is a complex task and there may be strong resistance from some groups. However, IPART believes NSW Health should engage with health care professionals and their unions to address the need for change in scope of their roles and responsibilities and patterns of practice. The unifying goal of delivering better patient care could be used to drive a change program.

This kind of change is likely to occur incrementally at first. NSW Health has already begun to develop and implement strategies to begin this change, and this should continue. IPART's review also identified some potential first steps in creating new models of service delivery that are already occurring in other jurisdictions and are achievable—employing non-nursing staff for some roles currently performed by nurses, and employing non-medical specialists in roles currently performed by medical staff. These approaches are discussed below.

12.4.1 Employ non-nursing staff for some roles currently performed by nurses

Registered nurses (RNs) are highly qualified specialists. After their graduate year, nurses generally elect to work and train in a specialty field, such as emergency, cancer, and mental health. Specialisation results in improved patient outcomes but less flexibility. Enrolled nurses (ENs) and Assistants in Nursing (AINs) have a more generic role that complements the skills and work of RNs.

Since IPART's 1999 review, NSW Health has focused on developing the clinical role of nurses. For example, it has introduced two new nursing roles—Nurse Practitioners and Clinical Initiatives nurses—which provide advanced practice in a number of care settings. The new roles have improved patient care in a range of settings, from rural hospitals to metropolitan Emergency Departments. They have also improved job satisfaction and career opportunities for nurses. NSW Health anticipates it will have more than 150 Nurse Practitioners by 2006.

Health departments in other jurisdictions, however, have gone a step further, by beginning to employ 'non-nursing' staff for specific 'non-clinical' roles. For example, in Victoria, the increasing demand for care for people with dementia has resulted in the employment of 'sitters' whose main role is to watch patients at risk of falling out of bed or wandering away, particularly at night when fewer nurses are on duty. The need for sitters will increase as Australia's population ages and life expectancy increases.

Also in Victoria, a nursing shortage crisis in dialysis units was alleviated by advertising for technicians rather than nurses. Initially, nurses resisted this strategy but it has been largely successful. The specialist skills required are now provided by trained technicians. In the USA, technicians rather than theatre nurses also provide many of the support services required by surgeons in operating theatres.

IPART believes NSW Health should evaluate the potential for employing non-nursing staff in positions that don't require all the specialist clinical skills of nurses, such as sitters and dialysis technicians. The first step might be to focus on the non-clinical tasks currently performed by nurses, including administrative functions. The benefits of implementing this strategy would include:

- alleviating nurse shortages
- making nursing roles more rewarding roles by making optimal use of their skills
- improving patient care by ensuring adequate staffing and treatment by the most appropriately qualified staff.

The strategy would complement NSW Health's existing approach of shifting nursing roles towards increased clinical responsibility and specialisation. Experience in other jurisdictions suggests it can be implemented quickly.

12.4.2 Employ more non-medical specialists in roles currently filled by medical staff

Over the last decade, NSW Health has increasingly involved other health professionals in services traditionally provided by doctors. For example, Nurse Practitioners now perform some medical procedures previously only performed by doctors. These practitioners have not replaced doctors, but in certain instances, involving them rather than doctors achieves both optimal patient care and better use of available resources.

Experience in the US suggests there is potential for other health professionals to undertake more of the tasks previously undertaken only by doctors. For example, midwives could be trained for a broader role in maternity services, and Nurse Practitioners could be trained for work in labour-intensive neonatal care wards.

A further example is physician assistants. This role was first created in the USA in the 1960s, with the aim of improving access to health care for people in areas under-supplied with medical services. Today, physician assistants are interdependent, semi-autonomous clinicians who practise in partnership with physicians in most medical and surgical specialties. They perform many tasks previously only done by physicians including examination, diagnosis, treatment and prescribing.

Studies have shown that the quality of care given by physician assistants is equal to that given by physicians in comparable situations, and results in high levels of patient satisfaction.⁵⁰ Most physician assistants practise in primary care, where they are estimated to have the capacity to provide 80 per cent or more of the type of services previously provided only by physicians.

There are many similarities between physician assistants and nurse practitioners. However, physician assistants receive generalist training modelled on medical school curriculums whereas nurse practitioners are usually trained in a nursing specialty. The setting for care and the specialty usually determines how these two professions practise, rather than legislative or professional regulations.⁵¹

⁵⁰ Mittman DE, Cawley JF, Fenn, WH. Physician assistants in the United States. *British Medical Journal* 2002; 325:485–7.

⁵¹ Ibid.

IPART believes NSW Health should examine whether it is feasible and desirable to make greater use of non-medical specialists in roles currently filled by medical staff—for example, by establishing the role of physician assistant. The US experience illustrates the potential for alternative models to improve patient access to services.

12.5 Establish a comprehensive management training program to strengthen the administrative workforce

IPART's review identified concern at both the Departmental and AHS levels about the adequacy of the training and development provided to managers and administrators across NSW Health. The turnover rate for AHS CEOs and hospital administrators is reported to be high relative to other industries, and there is concern that managers of the next generation are not being adequately prepared for their future roles. IPART observed, through its consultation process, that the highest levels of NSW Health's management workforce are highly professional, motivated and dedicated. However, their concerns about the need for better planning for future management needs are valid.

All parts of the health system should be developing workforce initiatives that promote excellence and innovation and recognise talent regardless of experience or employment status. This requires a well-funded and planned training and development program.

Potentially, such a program could include the following elements:

- a centrally coordinated graduate program that exposes graduates to a range of experiences within the Department and across AHSs and that fosters a culture driven by curiosity and innovation
- proactive identification of potential managers at all levels of the system for whom development pathways are planned, incorporating a comprehensive program of management training and concurrent work experience
- a coordinated exchange program that allows staff to apply for fixed short-term secondments in other parts of the system, to promote cooperative relationships and help staff develop a system-wide view
- a targeted program of voluntary redundancies in the context of promoting cultural change in the system.

This program should be incorporated into the integrated workforce plan, as strong management is vital to delivering nearly all components of such a plan and ultimately to delivering better patient care.

12.6 Implement strategies to control workforce costs

Staff salaries are the most significant pressure on NSW Health's budget. In recent years, health care professionals' salaries have increased rapidly, partly in recognition of their qualifications and skills.

In the long term, the kind of changes in roles, responsibilities and patterns of practice discussed in section 12.4 should deliver a more cost-effective mix of skilled staff. For example, some of the tasks currently performed by nurses do not require four years of university training. Other appropriately trained staff could perform these tasks at lower cost while also freeing university-qualified nurses for tasks that better match their skills.

However, there is also potential for NSW Health to achieve savings in the short to medium term. IPART has identified several strategies which should be a high priority—these include:

- controlling the costs of salaried medical staff by optimising the ratio of visiting medical officers (VMOs) to salaried medical practitioners (SMPs) in hospitals, and establishing redeployment or, if necessary, targeted redundancy programs for SMPs in inner-city AHSs
- restricting the use of agency nurses.

12.6.1 Controlling costs of salaried medical staff

Despite an overall shortage of medical staff, the total number of salaried medical staff employed by NSW Health has increased by 10 per cent since 1996/97. Salary costs per FTE have increased by 33 per cent, and total costs have increased by 46 per cent (Table 12.2). Clearly, salaried medical staff costs have become a major cost driver for NSW Health.

Table 12.2 Trends in salaried medical staff numbers and salaries

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Salaries (nominal \$'000)	424,815	479,141	525,528	554,874	588,752	622,178
FTE staff	5,613	5,720	5,751	5,969	6,140	6,175
Salary cost per FTE (\$)	75,684	83,766	91,380	92,959	95,888	100,758
Index of salary cost per FTE	100	111	121	123	127	133
Average weekly earnings index*	100	103	106	107	113	118

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

One of the factors that may be influencing the increase in SMP staff costs is that NSW Health is increasing its use of SMPs and decreasing its using of VMOs. This trend was identified in IPART's 1998 review and is more pronounced in 2003. Time-in-lieu and rostering requirements have added significantly to the cost of using SMPs. The Department of Health indicated that in some locations, particularly for emergency physicians, SMPs may receive a full-time staff specialist salary for working only two weekend shifts. IPART believes NSW Health should evaluate the relative cost-effectiveness of employing VMOs compared to SMPs. IPART believes this evaluation is likely to show that resources will be optimised by employing more VMOs in preference to SMPs.

Another factor may be that some inner-city AHSs are oversupplied with staff specialists in some clinical streams, which is lowering their productivity and reinforcing the uneven distribution of specialists across the State. NSW Health should consider whether a targeted redundancy and redeployment program is justified in these areas. Such a program would provide an opportunity to drive cultural change in those areas, may reduce the pressure on salary increases across the State, and could potentially increase the attractiveness of AHSs with shortages of medical staff, encouraging a better distribution of staff.

12.6.2 Restrict the use of agency nurses

Although most agency nurses receive equivalent rates of pay to other nurses, the agencies charge commission rates of up to 42 per cent which makes agency nurses much more expensive than other nurses. NSW Health's payments to agencies are a small but rapidly growing proportion of its overall nursing staff costs, and place an increasing pressure on some AHS budgets. Since 1996/97, these payments have increased by 376 per cent (Table 12.3). As a proportion of total nursing costs, they have increased from 0.7 per cent in 1996/97 to 2.4 per cent in 2001/02.

The use of agency nurses varies from Area to Area, and reflects the pattern of nurse shortages. For example, the New Children's Hospital Westmead, Central Coast AHS and several rural AHSs don't use agency nurses at all or use them at a negligible rate. South West Sydney, Central Sydney and Far West use agency nurses at relatively high rates, and South Eastern Sydney is the highest user and accounts for nearly one-third of NSW Health's total payments to nursing agencies.

Table 12.3 Trends in nursing agency payments

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	Change
Nursing agency payments (\$'000)	9,564	19,733	24,050	27,379	36,180	45,529	376%

The main benefits for AHSs of using agency nurses are that they are a highly flexible workforce, and can be used as a 'stop gap' measure when faced with shortages. However, they may not be the most cost-effective way to obtain these benefits. In addition, there are several disadvantages to using agency nurses. As well as their higher costs, agency nurses are less likely to be familiar with a particular work place, resulting in increased dependence on assistance from other nurses and increased risks to patients.

In Victoria, the Department of Human Services has responded to concerns about public hospitals' increasing use of agency nurses by issuing a directive in March 2002 requiring hospitals to limit the use of agency nurses. The four major elements of the directive were:

- 1 Agency nurses should only be used for unplanned absences unless an exemption is gained from the Department of Human Services.
- 2 Hospitals were instructed on the amount they can pay for agency nurses (based on an hourly casual rate as per the award rate plus a component for salary-related costs plus a 'management fee' for the cost to the agency).
- 3 Hospitals were to restrict their own nursing staff from working as agency nurses in their own organisation.
- 4 Hospitals were directed to provide flexibility through the provision of nurse banks (known as casual pools in NSW).

Provisions were made to enable hospitals to apply for exemptions from the directive to minimise risks to the continuity of service. The initiative was also supported by a proposal by Health Purchasing Victoria (HPV) to issue one tender for nurse agency services for all Victorian public hospitals in an attempt to stabilise prices and competition. The tender was intended to result in exclusive use of a small number of preferred providers for the duration of the tender period.

The HPV proposal was considered by the ACCC which concluded in December 2002 that the public benefit likely to result from the arrangements would outweigh any anti-competitive detriment that may arise. However, the authorisation process is not complete as at least one nursing agency has requested a review of the determination. The tender cannot proceed until the review process is complete.

The Department of Human Services' initial estimates suggest that expenditure on agency nurses by metropolitan health services in 2002/03 will be at least \$20 million less than it would have been if the nurse agency directive had not been issued. The decrease in demand for agency nurses has resulted in many nurses opting to be included in nurse banks. The banks are operated by facilities and designed to provide nurses with similar flexibility to agency nursing, but nurses are paid casual award rates.

Considerable savings have been achieved relatively quickly in Victoria, even without a central contract for use of agency nurses. There are few barriers to applying a similar directive in NSW. NSW Health will need to decide if it is appropriate for the Department to play such a role; however, the Victorian experience suggests that the needs of nurses who require flexibility can be met by appropriately structuring casual pools for facilities or Areas. If these are well managed, nurses have little incentive to register with an agency.

Recommendations

- 81 The Department should establish a single strategic workforce planning unit to coordinate the development of this workforce plan, and to substantially improve the base of information about NSW Health's workforce.
- 82 The Department should develop an integrated workforce plan designed to ensure a skilled, flexible and adaptable workforce that meets changing patient needs into the future.
- 83 The Department should engage with health care professionals and their unions to address the need to change these professionals' scopes and patterns of practice to enable the development of new models of service delivery and provide more satisfying work environments for employees.
- 84 NSW Health should establish a comprehensive management training program aimed at identifying potential managers and equipping them with the skills necessary to fulfil future management needs.
- 85 AHSs, assisted by the Department, should invest in the development and training of casual nurses to optimise the use of skills and experience available in casual pools. AHSs should accommodate the need of some nurses for high levels of flexibility, perhaps by developing a two-tiered casual pool structure.
- 86 The Department, together with the AHSs, should develop and implement a policy that limits use of agency nurses.
- 87 AHSs should improve the productivity of front-line nurse and other managers by providing more training in managerial skills and additional administrative support.
- 88 The Department should work towards streamlined and centrally coordinated procedures for overseas recruitment of medical staff.
- 89 AHSs should consider appointing more doctors to the AHS rather than individual facilities. This could be extended to clinical network appointments with the cooperation of other AHSs.
- 90 The Department and AHSs should develop strategies to control the increase in salaried medical staff costs. This should include an evaluation of the optimal ratio of VMOs to salaried staff. The Department and AHSs should develop coordinated strategies to achieve greater equity in the distribution of medical staff across Areas.
- 91 The Department should consider strategies for attracting and retaining allied health professionals to the public health system including allowing them to work in both the private and public health sector.