Community health: the state of play in NSW. A report for the NSW Community Health Review

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November, 2008

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Suggested citation

Eagar K, Owen A, Cranny C, Samsa P and Thompson C (2008) ***Community health: the state of play. A report for the NSW Community Health Review***. Centre for Health Service Development, University of Wollongong

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Executive Summary

The best of times … the worst of times

> *'It was the best of times and the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way – in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.'*[1]

Solid facts

Based on an audit by NSW Health in 2008, NSW expenditure on community health increased from $1.2 billion in 2004/05 to $1.5 billion in 2006/07. Despite this reported increase, overall expenditure on community health declined as a percentage of total expenditure from 18.0% to 14.5% over the same period. This is due to significant increases in hospital budgets over the same period. Information gathered during our field conclusions suggests that some of this relative decline is due to changes in how services are organised. However, this is not the sole explanation, with evidence to the review suggesting a genuine reduction in community health staff in the three year period.

This pattern was also found when funding for admitted patient services was excluded. Each year community health has been receiving a smaller proportion of funding allocated to non-admitted services, with funding for community health declining by 5.8% relative to other non-admitted services.

There are significant differences in the level of community health investment across areas, with Greater Western spending more money per capita on community health ($375 in 2006/07) than the other areas. At the other extreme, Sydney West spends the least ($187 in 2006/07), with spending in Sydney West representing less than half that spent in the Greater West. While there were some methodological difficulties with the audit undertaken by NSW Health, the overall findings raise serious questions about the balance of health investment in NSW. The results also raise serious questions about equity of access to community services across the state.

The scope of community health

All Areas provide the majority of the community health streams that we outline in Section 7.2 (page 19). The bulk of these services are managed by Primary and Community Health Services with Population Health providing strategic leadership or managing Area-wide health promotion and priority population health programs for Aboriginal Health with some joint service delivery on the ground.

With the exception of the specific issue of hospital demand management, there is a majority (but not unanimous) view both within the Health Department and in the field on the future role of community health - community health should provide the full range of services from prevention to palliation.

Implicit in proposals to define a core role for community health (which was one of our Terms of Reference) is an assumption that at least some of what community health currently does can be either ceased or shifted to other sectors in favour of a set of core services that are more effective. The review of the international evidence commissioned as part of the current Review was

[1] Opening paragraph of Charles Dickens' second historical novel A Tale of Two Cities (1859) set in London and Paris before and during the French Revolution

designed to inform this issue (see our compendium report) and the conclusion there is that there are few solid facts to guide a strategy that involves selective disinvestment. But that does not mean that there are no opportunities to improve the efficiency of community health, an issue which is addressed in our final report.

Models of good practice

The Review received information on good model of cares that are large-scale programs or service redesign initiatives and that have been researched and formally evaluated. But these are in the minority. This reflects the lack of investment in primary health care research and development and in systematic clinical redesign outside hospital or hospital community interface settings. The majority are case studies of local or Area initiatives that have been documented and assessed locally and illustrate a commitment to service improvement, better targeting of priority groups or smarter service delivery.

A key theme throughout the Review has been the growing need for hospital demand management services designed to prevent avoidable admissions, to facilitate early hospital discharge and to reduce the rate of hospital readmissions. There is no consensus on how hospital demand management is best organised and delivered, with some believing that it is best managed by community health and others believing that it is best managed by hospitals.

Service gaps

Short-term hospital demand management services have been increasing at the expense of other services in the community, particularly prevention and early intervention. The Review received consistent feedback on the shortage of psychosocial counselling (particularly in metropolitan areas) and youth health services, as well as the limited capacity to sustain home visiting for high risk families everywhere. There are very limited evidence-based early intervention programs for young people with early onset psychosis and other mental health problems. There is also limited access to allied health treatment, with many people assessed and on long waiting lists.

A further and related issue is the trend to establish more tightly defined micro programs, each with their own eligibility criteria and narrowly targeted recipients that limit the capacity of community health services to flexibly respond to local needs.

The disappearing generalist

The right balance between specialist and generalist primary care was well summarised for the Australian context by Gunn et al (2007) in their recent review of 'generalism' in primary care who describe:

> *'the sense of urgency and alarm in…much of the international literature about the devaluation, loss and downfall of generalism within primary health care systems'.*

A number of submissions to the Review saw no conflict at all between generalist and specialist models, pointing out, for example that:

> *'the local community health centre could provide a very valuable ongoing support service to young people with high support needs and significantly improve their health care and quality of life.'* (Submission to the Review from Dr Carolyn West, Director Spina Bifida Unit, The Children's Hospital at Westmead)
>
> *'This is not an argument for the separate identity and provision of community based health care, but for resetting the balance between hospital and community components of integrated health services, and shifting the centre of gravity of such services towards more accessible community health services.'* (The Future of Community Health Services in Australia, submission to Review from Alan Rosen, Roger Gurr & Paul Fanning)

At least in part, the increasing trend towards establishing specialist teams within community health is due to the inclusion of components of community health services within hospital, sector or area clinical streams. This is particularly the case for community health services located in those areas

that have principal referral hospitals, with the specialist teams in the community reflecting the sub-specialist structures of the hospitals or through the role of population health.

The right balance between community and hospital and between generalist and specialist services cannot be determined in isolation but is part of a set of bigger issues about the role of community health services and where they fit within the broader NSW Health system. This issue is addressed in our final report.

Governance

A key issue for the Review is whether a 'one size fits all' governance model can or should be implemented in NSW, given the size of the current Areas, their different health service architecture and diversity of population needs.

Based on an extensive consultation across NSW, our conclusion is that a single organisation and governance model is unlikely to work across NSW. However the policy environment suggests the need for high profile primary and community health leadership at strategic levels within the system with the authority and levers necessary to drive change and improvements in health services and to build effective primary health care partnerships.

Joint action

A further issue, illustrated in community mental health, is that there is evidence that joint planning, community location and service mobility results in better outcomes than hospital-based ambulatory services. The main issue is how to make these models more sustainable and with wider application. There are numerous examples of pilot studies in selected areas supported by memoranda of understanding and so on in collaboration with Housing NSW, Justice Health, Corrective Services and DADHC.

Workforce flexibility

Many informants believe that community nurses need to fulfil a role similar to District Nurses in the UK National Health Service. These highly skilled primary health care practitioners provide care in partnership with local GPs for families and patients with complex needs and navigate patients to the allied health, hospital and support services that they need. Others spoke of the need for highly skilled rural generalists or primary health care nurses who practice in remote areas without local backup.

Many informants believe that there is a need to reassess and clearly articulate the practice approach, skills and competencies required in the generalist and specialised community nursing and allied health workforce. This would then lead to workforce planning including meaningful workload measures for a variety of community health roles and service settings.

The impediments to greater flexibility are not in a lack of innovation and models to create improvements in efficiency. The key challenges are in the sustainability of these models and in creating the right incentives and opportunities for their wider implementation.

Information and planning systems

In terms of the strategic direction for community health, moving beyond a largely transactional data system is essential. If community health services are to be in a position to demonstrate what they do and the outcomes they achieve, the capacity to capture care goals and outcomes is fundamental at the start and not something that might be built in at a later date.

On the one hand, many executives and managers at both the departmental and area level are critical of community health services because they cannot demonstrate what they do. On the other, neither the data systems nor the information technology are in place that would allow community health services to do otherwise. A major investment is required.

While there are well developed planning tools and models for acute hospital services, there is a dearth of equivalent tools for the planning of community health services in NSW. Investments are needed in a service planning, classification and decision support tool to assist plan the best service mix in each location.

Work towards a standard classification of community health services and interventions and routinely collected data that can be used to inform future planning requires central support. While these problems will not be resolved in the short-term, there is no reason why work to develop a much-needed 'Guide to Community Health Role Delineation' could not begin in 2009.

Research and development

There are many examples of community health staff undertaking their own service evaluations and documenting what they do in reports. However, there is no systematic investment in R&D and not a strong R&D culture. Further, there is no central repository of best practice information on community health and no central community health knowledge management strategy. There are models in the literature of population-based research that include researchers working in collaboration with their communities, with research findings being incorporated into daily practice to better meeting immediate care needs and to directly influence popular expectations.

Revitalising community health

Despite the range of community health services being offered, many informants feel that community health had become 'invisible' in their Area and that the focus on promotion, prevention and early intervention is being overwhelmed by hospital demand. Many community health centres are run down and services are being increasingly relocated back to hospital campuses, with implications for reduced access for those clients most in need of publicly funded community health services.

There are mixed views on how best to re-vitalise community health, what the best governance and structural options for the future are, and about the best way to make progress. However, several themes have been consistent throughout the consultation process:

- Primary and community health services need to be at the table and to 'have and be seen to have' a clear role in supporting hospital demand management and avoidance to be relevant in this environment and to provide continuity of care for their existing clients.
- Without clearly defined primary and community health structures and effective leadership, the 'episodic illness' model will continue to overwhelm prevention and early intervention services for children, families and young people and will continue to reduce interagency partnership programs targeting at risk or vulnerable groups.
- Many acute hospital managers and clinicians, particularly in urban areas, are perceived to have limited understanding of the role and operation of community health and the service issues or models of care that have been developed to respond to the full range of population. This is especially the case in relation to community health activity targeted to clients who do not encounter the acute care system.
- Numerous examples were provided to the Review of hospital-based managers wanting to redeploy community nurses and community midwives to backfill hospital vacancies, with little concern for the impact on community workloads and models of care. These examples were interpreted as essentially cost shifting from hospitals to other areas of the NSW government's human services and to Commonwealth-funded services.
- Models in urban, regional and rural environments are different by necessity. Most senior executives and local managers in rural and regional areas support an integrated model as the only pragmatic approach for workforce reasons. This is especially the case in smaller health services where a primary health care approach is core business.
- There is a pervasive sense of weariness and fatigue, with restructuring in many Areas being unresolved. There is also widespread frustration that competing models of care and

administrative systems have still not been reconciled and that organisational structures that have been evolving since the last restructure in 2005 have not been finalised.

The starting point is where NSW is now

The majority of community health services in NSW are now managed at a local level as part of an integrated health service system with shared operational management and funding arrangements with hospital services. However, the seniority and responsibilities of community health managers vary widely.

The current policy settings in NSW and nationally (and internationally) suggest the need for a vibrant community health service at the heart of the health system. There seems to be a strong majority view (if not consensus) on the desirability of that direction. But there are few coherent strategies in place on how best to practically achieve a community health and primary care-driven system.

This *State of Play* report has described community health in NSW in 2008 and a series of strategic issues are described. Our compendium report (*Community health: the evidence base*) synthesises the international and national evidence on community health interventions and services. These two reports inform the final report (*Community health at the crossroads: which way now?*) that sets out a proposed strategic direction for the future of community health in NSW.

1 Introduction

This is the second of three reports on the 2008 Review of Community Health in NSW (the Review) undertaken by the Centre for Health Service Development (CHSD), University of Wollongong.

The NSW Community Health Review is a strategic review that has three major components and eleven terms of reference. The major components are:

1. An audit of the scope of activity and existing investment in community health services undertaken by NSW Health. This audit was undertaken by NSW Health.
2. Analysis of gaps in current provision of community health services with a focus on service delivery, governance, linkages and referral pathways with other parts of the health system including general practice, other providers of primary care services and acute and population health services.
3. Development of a vision for the future role and operation of a revitalised community health service sector with a focus on core services to be provided by community health services, best buys and areas for investment and disinvestment and a staged pathway for reform.

The purpose of this second report is to summarise the current state of play in NSW. This report describes current clinical and management structures and identifies current gaps in service provision. It also addresses issues such as linkages and referral pathways with general practices and other community based health services and with the acute and population health sectors.

The first report (*Community health: the evidence base*) provided a definition of community health and primary health care and includes a brief history in the Australian context. This compendium report includes an overview of current pressures and drivers for change and places these in an international context as well as contemporary national developments. It summarises the local and international evidence for community health interventions within a population planning framework.

The final report in this series (*Which way now?*), builds on these first two reports. It is strategically focussed and designed to inform future planning and resource allocation decisions in NSW.

2 Scope

This is a strategic, not an operational, review. Its purpose is to inform the next stage of the Review, which will identify options for the future, rather than to review or evaluate how community health services are operating now.

For pragmatic reasons, the NSW Health Department limited the scope of the NSW Community Health Review to community health services provided by NSW Health Area Health Services. This decision was made on the basis that the strategic role of Non-Government Organisations (NGOs) may be considered at a later time.

In the context of the current Review, NGOs are key stakeholders rather than the subject of the Review, as are general medical practitioners and their allied health colleagues in the private sector and other government departments and central agencies.

While the scope of the review is limited to government managed community health services, it is important to recognise that community health is part of a broader primary care sector that includes general medical practitioners, private allied health providers and NGOs. As such, while the focus is on community health, community health cannot be considered in isolation.

3 Methods

Information from a range of sources has been analysed to address the Terms of Reference and strategic issues for the Community Health Review.

The component of the Review that was used to focus the content for this second report was the analysis of submissions and consultations mainly undertaken within the health system and to a limited extent with other parts of government and groups with an interest in policy and the strategic issues for community health.

Meetings, regular teleconferences, correspondence and workshops with the steering group and other key informants were used to get feedback on the issues raised by the consultations and discussion focused on the drafts of the strategic options.

3.1.1 Baseline audit

A baseline audit of community health service activity, resources and investment was prepared by the Primary Care and Partnerships Branch in NSW Health to provide background information for the Review. The data have been analysed and used in this report to provide a snapshot of trends in investment in community health services across NSW.

3.1.2 Stakeholder consultation and key informant interviews

Consultations were undertaken with a range of stakeholders to obtain information on the current role and focus of community health services, governance and partnership arrangements, gaps in service delivery and support systems and to elicit views on the key strategic issues and future priorities for Community Health Services.

The scope of these 60 days of consultations was not comprehensive. Rather, the goal was to consult with key stakeholders and informants who were identified as having views that reflect wider perspectives and who could contribute to the analysis of the strategic issues and themes emerging from the Review.

Consultations were undertaken in each Area Health Service and at Westmead Children's Hospital. Review team visits were organised by each Area Health Service and the format varied across the state, but typically involved key informant interviews with the Area Executive team and the senior Area Community Health Manager, as well as a range of informants. Each Area was asked to select the most appropriate methods for consultation and the key participants. The result in each Area was a series of scheduled interviews and meetings, forums and videoconferences with community health team leaders, hospital general managers, Area program directors and senior clinicians from across the Area, plus non-government organisations, carer and consumer representatives.

In relation to consultations with the Areas, it was necessary to emphasise that the aim was a strategic and not a comprehensive survey and not an operational review. Some participants had difficulty with that distinction, perhaps because of the plethora of organisational reviews and surveys that are ongoing in the system.

The issues and content covered at the consultations varied somewhat across the Areas, and between groups of participants, but remained focussed on the key strategic issues for the future. These strategic issues were identified relatively early in the life of the Review, and these were used for introductory remarks and setting the expectations of the consultations, allowing participants to focus on particular issues and themes, depending to some extent on where and when each consultation session was held.

Interviews were conducted in NSW Health with the Deputy Directors General, branch heads, program managers and key policy analysts, the NSW Community Health Directors' Forum and selected Health Priority Taskforces to obtain information on strategic issues, relevant state and

national policy directions and developments in relation to workforce, support services and information systems.

Briefings with general practitioners and Divisions of General Practice, non government organisations and representatives of other government departments and inter-agency groups were also scheduled in several Areas, as well as separately with peak organisations. Separate briefings and consultation sessions were held with General Practice NSW and representatives from 15 rural and urban Divisions of General Practice. Representatives of peak non government organisations including the Aboriginal Health and Medical Research Council, NSW Council of Social Service (Health Policy Advisory Group and the HACC Issues Forum), the Aged and Community Services Association of NSW and the ACT, Barnardo's, the Benevolent Society of NSW, the Men's Health Network and the Network of Falls Coordinators were also consulted.

The State Offices of the Commonwealth Departments of Health and Ageing and Families, Housing, Community Services and Indigenous Affairs were consulted and asked about heir strategic views on current service gaps and ways of developing community health. Researchers and academics with expertise in primary health care and relevant officials in NSW departments and other states were contacted by phone and email and their various reports, evaluations and policy documents were accessed by email postings or through websites.

Consultations with other NSW human service departments and government agencies (Departments of Aboriginal Affairs, Ageing Disability and Home Care, Justice Health, Community Services, Police, Corrective Services) were scheduled to occur at a time that will be useful to inform the third and final report.

3.1.3 Submissions, examples of good practice and innovation and related information

Community health staff and interested individuals and organisations were encouraged to contribute examples of good practice and innovation through the Review website and to provide submissions and recommendations to the Review. A list of submissions and links to examples of good practice were maintained on the Review website.

Area Health Services also provided a range of background information including service and strategic plans, evaluation reports, information on models of care and examples of partnership arrangements. These are included in Section 9.3 on quality and safety initiatives and in Attachment 2 under Table 4, which summarises the range of models presented to the Review. It is not a comprehensive listing.

3.1.4 On-line survey

Community health staff and interested individuals were also invited to comment on the key strategic issues for the Review via an on-line survey. At the time of writing, 75 individuals have taken up this invitation so far and their views are discussed in this report. While this survey was not designed as a representative sample, the survey was an open opportunity for feedback on the strategic issues that the Review is considering.

3.1.5 Assessing the strength of the qualitative evidence

The mix of methods summarised above was used to assess the context of the current system and the viability of a range of options for reform and to give due weight to the strategic considerations derived from the Terms of Reference.

The strength of the evidence in this report has been assessed based on standard methods of triangulation. Information received during the Review was classified as 'qualitative evidence' if it became a theme that recurred across several consultations. One-off comments made in a single consultation did not meet this criterion. The evidence was regarded as strong if it was assessed as "dependable" or "consistent" (corresponding to the notion of "reliability" in quantitative research)

and "valid" . Consistency or reliability was assessed by verification of the information through examination of raw data, themes and process notes. Validity was assessed by reference to the international evidence, as well as to the broader context in which community health in NSW operates (see our first report).

4 Policy context

The *NSW State Plan* (NSW Government 2006) and the *NSW State Health Plan* (NSW Health 2007a) identify strengthening primary and continuing health care in the community as a key strategic direction for the state health system. Both plans focus on prevention and early intervention, integrated primary health care, GP access and services and programs targeting hospital avoidance, mental health, aboriginal health, chronic care and disability support and support for carers.

The *NSW Integrated Primary and Community Health Policy 2007–2012* outlines six priority areas for reform and development in the sector including integrated service planning, integrated service delivery, improved models of care, stronger partnerships, improved workforce capability and enhanced information management and research (NSW Health 2006). The accompanying *Policy Implementation Plan* outlines the major projects and service development strategies being implemented by Area Health Services, branches within the NSW Health Department and key partners such as the NSW Alliance to progress the policy (NSW Health 2007b).

NSW is rolling out and evaluating the HealthOne initiative as one model to promote integration between primary health care providers. HealthOne provides capital funding to establish real or virtual multidisciplinary primary health teams that combine the resources of general practice, community health and allied health services in shared facilities in rural and selected urban and regional areas. HealthOne has similarities to the South Australian Health Plus model, Queensland Health Precincts and GP Super Clinics where capital is being provided to collocated community health and private sector services.

The NSW Health Services Act 1997 (Section 10) defines the role of an area health service. Area Health Services have 15 functions as specified in the Act:

> *(a) generally to promote, protect and maintain the health of the residents of its area,*
>
> *(b) to conduct and manage public hospitals, health institutions, health services and health support services under its control,*
>
> *(c) to give residents outside its area access to such of the health services it provides as may be necessary or desirable,*
>
> *(d) to achieve and maintain adequate standards of patient care and services,*
>
> *(e) to ensure the efficient and economic operation of its health services and health support services and use of its resources,*
>
> *(f) generally to consult and co-operate (as it considers appropriate) with any one or more of the following:*
>
>> *(i) the Health Care Complaints Commission constituted under the Health Care Complaints Act 1993 ,*
>>
>> *(ii) health professionals practising in its area,*
>>
>> *(iii) other individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the promotion, protection and maintenance of health,*

(g) to investigate and assess health needs in its area,

(h) to plan future development of health services in its area, and, towards that end:

(i) to consult and plan jointly with the Department of Health and such other organisations as it considers appropriate, and

(ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services, and

(iii) to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister,

(i) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services,

(j) to provide services to persons with whom it has contracted or entered into an agreement under section 37 (2),

(k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129,

(l) to provide training and education relevant to the provision of health services,

(m) to undertake research and development relevant to the provision of health services,

(n) to make available to the public information and advice concerning public health and the health services available within its area,

(o) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.

As this brief overview of the policy context highlights, community health services in NSW are being provided within a policy framework that, if translated into practice, should be resulting in a vibrant community health service that sits at the centre of NSW health services. However, as discussed below, this Review has identified a significant gap between the policy and the practice. This is a fundamental issue and is discussed throughout the remainder of this report.

5 Organisational context

NSW Health is one of many agencies that have responsibilities for the health and well being of the people of NSW and for the delivery of primary and community health related services. At the national level, the Department of Health and Ageing and Medicare Australia have responsibility for funding and the payment of subsidies for general practice, medicines and a range of community aged care services.

At the state level, a range of government agencies have responsibilities that interface with community health. These include, but are not limited to, the departments of Ageing, Disability and Home Care, Community Services, Aboriginal Affairs, Police and Corrective Services.

NSW Health comprises the NSW Department of Health, Area Health Services, statutory health corporations and affiliated health organisations.

There are eight Area Health Services that are responsible for providing health services in designated geographic areas.

There are also a number of public health organisations that provide statewide functions or specialist health services:

- Ambulance Service of NSW
- Justice Health
- Children's Hospital at Westmead
- Clinical Excellence Commission
- The NSW Cancer Institute.

The Department of Health is organised as six main functional areas, with four Deputy Director Generals:

Strategic Development

- Primary Health and Community Partnerships
- Mental Health and Drug and Alcohol Office
- Inter-Government and Funding Strategies
- Statewide Services Development

Population Health

- Centre for Aboriginal Health
- Centre for Health Advancement
- Centre for Epidemiology and Research
- Centre for Health Protection
- Centre for Oral Health Strategy
- Office of the Chief Health Officer

Health System Performance

- Clinical Quality and Patient Safety
- Clinical Services Redesign
- Demand and Performance Evaluation
- Health Services Performance Improvement
- Strategic Information Management

Health System Support

- Asset and Contract Services
- Corporate Governance and Risk Management
- Corporate Personnel Services
- Employee Relations
- Finance and Business Management
- Legal and Legislative Services
- Nursing and Midwifery
- Shared Services
- Workforce Development and Leadership

Several sections within the department have responsibilities for various aspects of community health. The Primary Health and Community Partnerships section within the Strategic Development Division has a policy responsibility for community health but not an operational role. While it administers some special initiatives, it is not responsible for community health financing. Other key branches include the Mental Health and Drug and Alcohol Office and the Centre for Aboriginal Health.

The Area Health Services were last restructured in terms of their boundaries in 2005. Each of the new Areas was established with a standard management structure consisting of a Chief Executive and six executive directors (Clinical Operations, Population Health and Planning, Corporate Services, Clinical Governance, Nursing and Midwifery, Workforce). No standardised structure was established for community health. However, the Department requested Chief Executives to ensure that the management of primary/community health and chronic care functions be effectively incorporated into clinical operational management in the third tier of each Area Health Service. Since the establishment of the Areas, some variations in management structures have developed and the management structure of each Area as at October 2008 is included in Attachment 4.

In addition to Area Health Services, the Department of Health provides grants to a range of NGOs for the provision of community health services. As discussed in Section 2, these are outside the scope of the current Review.

6 Contemporary national developments

This Review is being undertaken at a time when significant initiatives are occurring at a national level. Not only is the next Australian Health Care Agreement (AHCA) under negotiation, there are also a number of national reviews in place. This section briefly summarises key developments that are expected to have an impact on community health.

6.1 National Health and Hospitals Reform Commission

In February 2008, the Prime Minister and the Minister for Health and Ageing announced the establishment of the National Health and Hospitals Reform Commission (NHHRC). Its role is to provide advice to the Commonwealth on performance benchmarks and practical reforms to the Australian health system that can be implemented in both the short and long term.

The Commission is due to report in June 2009 on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:

(a) “reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;

(b) better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;

(c) bring a greater focus on prevention to the health system;

(d) better integrate acute services and aged care services, and improve the transition between hospital and aged care;

(e) improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;

(f) improve the provision of health services in rural areas;

(g) improve Indigenous health outcomes; and

(h) provide a well qualified and sustainable health workforce into the future”.

Its first report, '*Beyond the Blame Game: accountability and performance benchmarks for the next Australian Health Care Agreements'* was delivered in April 2008.

That report flagged the intention of the Commission to recommend the assignment of specific accountabilities to each tier of government. Specifically, the Commission proposed that states be accountable for public hospitals, mental health, maternal and child health and public health. The Commonwealth would be accountable for primary care ('all other aspects of care in the community, primary medical care and community health care', NHHRC 2008, page 4), prevention, aged care and indigenous health.

> *The assignment of accountabilities for performance benchmarks does not mean that we are suggesting that there should be an immediate transfer of functions between governments where they differ from the current situation. The accountable government does not have to be directly involved in service delivery and there are likely to be advantages in retaining mixed provision of services by public, private and non-government agencies. Nor are we suggesting that any financial support for a function should only come from one government: support for public hospitals (or primary care services) could still come from both Commonwealth and states, but the contributions of each would be clearly specified (for example, as a share of funding or the volume of services purchased).*
>
> *What we are suggesting is that one government should be held accountable by the public for overall service performance in each area. Australians want to move beyond the blame game with each level of government blaming the other for system failings. Patients and the public need to know to whom they can turn for accountability and redress.*
>
> *Importantly, we are signalling our view about the desirable direction of the Commonwealth taking a more active role in ensuring adequacy of the full range of primary health care services. This would involve moving beyond general practice to allied health, district nursing, community mental health services and community health services, for example. We believe that there needs to be significant investment in primary health care infrastructure, an objective that the Commonwealth Government has partially set out to address through the establishment of GP Super Clinics. State governments have also responded to this challenge through major programs such as GP Plus in South Australia, HealthOne in New South Wales and Primary Care Partnerships in Victoria. But there is no integrated plan for the development, resourcing and networking of state-based primary health services, general practice and other private or non-government primary health services.* (NHHRC 2008 page 22).

In arguing for a more structural approach to reform, Dwyer and Eagar (2008) challenged this proposal, as others are now doing (albeit for different reasons):

> *The Commission's proposal that the nominated level of government accept accountability for the relevant sectors without the matching authority is an expedient but we think unsustainable arrangement, requiring the development and maintenance of sophisticated monitoring and financial incentive systems. As the Commission acknowledged, the other problem is that it is technically difficult to separate some of the identified sectors. For example, how can responsibility for maternal and child health not be part of primary care? And how can mental health be separated from community health? While the Commission's proposals would no doubt solve some problems, others would inevitably be created and new blame- and cost-shifting possibilities would be opened up. This is consistent with Leutz's third law – 'Your integration is my fragmentation' (Leutz 1999:91)* (Dwyer and Eagar 2008, p. 8)

By November 2007, the NHHRC had commissioned 14 discussion papers on possible areas of reform. The target audience for these papers is the Commission itself, with each paper outlining various options for the NHHRC to consider. Seven of these papers deal with primary and community health and are of direct relevance to this Review, as is the paper on structural options for the reform of Commonwealth State governance arrangements. There are a further five papers

that deal with various aspects of prevention and health promotion that are also of relevance to this Review plus one paper on public private mix.

The issues covered in this series can be inferred by their titles:

Commonwealth State governance

Options for reform of commonwealth and state governance responsibilities for the Australian health system

Prevention

A national agency for promoting health and preventing illness

A Preventative Priorities Advisory Committee and Prevention Benefits Schedule for Australia

Financial incentives, personal responsibility and prevention

Funding policy options for preventative health care within Australian primary health care

New and emerging nurse-led models of primary health care

Primary and community health

New models of primary and community care with a focus on rural and remote care

New models of primary and community care to meet challenges of chronic disease prevention and management

Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform

Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020

A vision for primary care: funding and other system factors for optimising the primary care contribution to the community's health

Primary care reform options

Models of primary and community care in 2020

Public private mix

A mixed public private system 2020

The content of relevant papers in this series is considered in our compendium report on the literature. In terms of workforce issues and themes about reform options and service gaps in the field, the NHHRC commissioned consultations with health workers at the frontline and an outcomes report was produced (Elton Consulting 2008).

6.2 National primary care strategy

In June 2008, the Minister for Health and Ageing announced that a National Primary Health Care Strategy will be developed. The Strategy will 'look at how to deliver better frontline care to families across Australia', with priorities including:

- Better rewarding prevention.
- Promoting evidence-based management of chronic disease.
- Supporting patients with chronic disease to manage their condition.
- Supporting the role GPs play in the health care team.
- Addressing the growing need for access to other health professionals, including practice nurses and allied health professionals like physiotherapists and dieticians.
- Encouraging a greater focus on multidisciplinary team-based care.

A review of the Medicare Benefits Schedule enhanced primary care items is also being undertaken alongside development of the Strategy with a focus on reducing red tape for doctors, simplifying the Medicare schedule, and giving more support to prevention. An External Reference Group is

supporting the development of the Strategy, which (like the NHHRC strategy) is expected to be completed in June 2009.

A discussion paper (*Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government)* was released on 30 October 2008 (Commonwealth of Australia 2008). It proposes ten key elements that *'could underpin a future Australian primary health care system'*:

> ***All Australians should have access to primary health care services which keep people well and manage ill-health by being**:*
>
> *1. Accessible, clinically and culturally appropriate, timely and affordable;*
>
> *2. Patient-centred and supportive of health literacy, self-management and individual preference;*
>
> *3. More focussed on preventive care, including support of healthy lifestyles;*
>
> *4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing, and complex conditions.*
>
> ***Service delivery arrangements should support:***
>
> *5. Safe, high quality care which is continually improving through relevant research and innovation;*
>
> *6. Better management of health information, underpinned by efficient and effective use of eHealth;*
>
> *7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.*
>
> ***Supporting the primary health care workforce are:***
>
> *8. Working environments and conditions which attract, support and retain workforce;*
>
> *9. High quality education and training arrangements for both new and existing workforce.*
>
> ***Primary health care is:***
>
> *10.Fiscally sustainable, efficient and cost effective.*

This discussion paper does not include specific proposals. However, there is a discussion under each element asking the question 'where could changes be made?

6.3 National prevention taskforce

In April 2008, the Minister for Health and Ageing announced the establishment of a new National Preventative Health Taskforce. In announcing the Taskforce, the Minister also announced that the Commonwealth was committed to ensuring that preventative health measures become a key part of health funding agreements between the Commonwealth and state and territory governments.

The taskforce is to provide evidence-based advice to governments and health providers on preventative health programs and strategies, focusing on the burden of chronic disease currently caused by obesity, tobacco and alcohol.

By July 2008, the Taskforce is to provide advice on the framework for the Preventative Health Partnerships to be included in the Australian Health Care Agreements between the Commonwealth and the states and territories.

6.4 National maternity services review

This Review is intended as the first step in developing a comprehensive plan for maternity services into the future and to inform the development of a National Maternity Services Plan. It is being led by the Commonwealth Chief Nurse and Midwifery Officer, Ms Rosemary Bryant. The Review covers antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the peri natal period. A report to the Minister for Health and Ageing is expected by the end of 2008.

6.5 National performance indicators

In June 2008, the Australian Institute of Health and Welfare (AIHW) proposed 40 national performance indicators for inclusion in the next Australian Health Care Agreement (AIHW 2008). In many ways, these suggested indicators reflect the range of issues on the current national agenda.

In summary, the AIHW has proposed:

- 15 performance indicators that are relevant to public hospitals and 14 to private hospitals
- 24 performance indicators that are relevant to primary care and community health
- 7 performance indicators that relate to public health activities
- 10 performance indicators that relate to aged care.
- 6 performance indicators that relate to maternal and child health services.
- 7 performance indicators that relate to mental health services.
- 6 performance indicators that relate to dental heath services.

In some cases, there are multiple measures for the one indicator, resulting in 68 measures in total. These measures are summarised in Attachment 1.

While most indicators relevant to public hospitals are already being collected, the adoption of this performance indicator set would have significant implications for community health in NSW and for the community health information system development that is currently being planned.

6.6 Conclusion

As the above summary highlights, this Review is being undertaken against a very fluid environment at the national level. The key aspects of the next AHCA are expected to be agreed at around the same time as our final report in December 2008, with the results of the various national reviews/strategies expected in mid-2009. The net result is that proposals in our final report will need to be considered in the context of subsequent recommendations and commitments made at a national level.

7 Range of community health services and current investment

7.1 Findings from the 2008 audit of community health services

In early 2008, NSW Health conducted an audit of its community health services (NSW Health 2008). Key findings from that audit are described in this section.

In 2004/05, NSW residents received almost 61 million primary and community health services, compared to 2.2 million hospital services. Of these 61 million services, 60% (36.2 million) were provided by General Practitioners and 40% (24.5 million) were provided by community-based services and hospital outpatient departments provided through the public health system NSW Health 2008).

As shown in Table 1, community health provides around eight to nine million occasions of service a year. Total services increased by 8.2% between 2004/05 and 2005/06 before decreasing slightly in 2006/07.

Table 1 Community health occasions of service 2004-2007

Year	Community health occasions of service
2004/2005	7,968,188
2005/2006	8,622,748
20060/2007	8,619,186

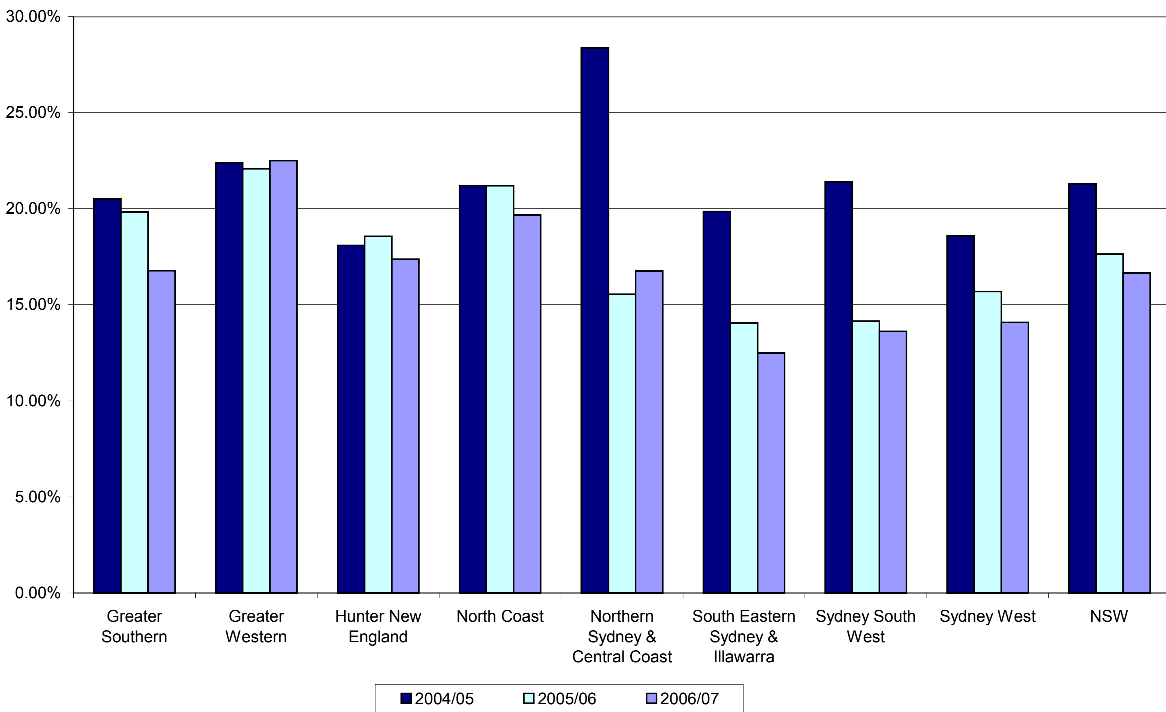
Source: NSW Health 2008

The eight million community health services in 2004/05 were provided by 12,739 FTE staff. In 2006/07, a total of 13,584 community health FTE staff were employed, a 7% increase in the two year period.

Nevertheless, the audit found that the number of staff employed in community health declined as a percentage of total staff from 21.3% in 2004/05 to 16.7% in 2006/07 (see Figure 1). This decline occurred across most areas. In 2004/05, more than 18% of staff employed in all areas worked in community health. By 2006/07, only two areas (Greater Western and North Coast) employed more than 18% of total staff in community health.

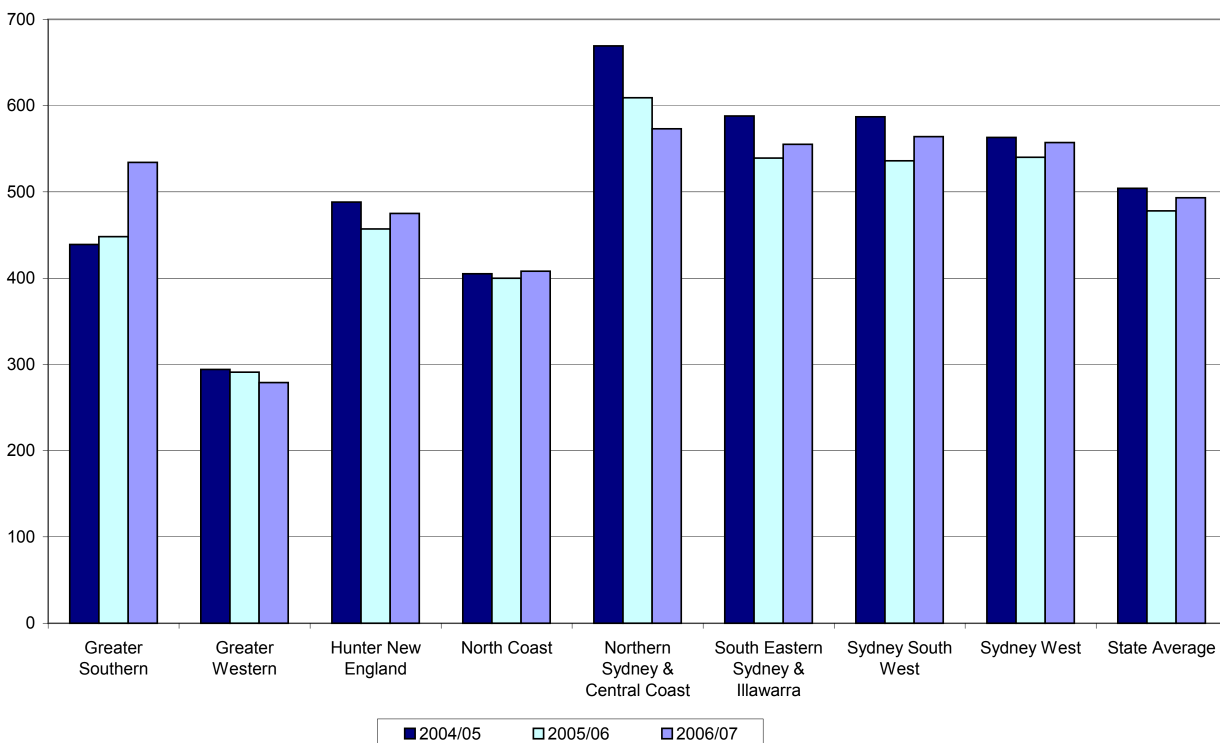
The field consultations indicated that some of this decline is due to changes in how services are organised. Specifically, we have been informed that some services have been moved from community health to either population health or to various clinical streams. That said, evidence from the consultations also suggests that this is not the sole explanation for the decline in staff numbers, with some of the decline reflecting a genuine reduction in community health staff in the three year period.

Figure 1 Percentage of staff employed in community health by Area Health Service



With the exception of two areas (Greater Western and North Coast), the number of community health staff also declined on a per capita basis (see Figure 2). The biggest decline (14.3%) occurred in Northern Sydney and Central Coast.

Figure 2 Community health staff per capita



This finding is consistent with patterns of financial investment in recent years. NSW expenditure on community health increased from $1.2 billion in 2004/05 to $1.5 billion in 2006/07. Despite this reported increase, overall expenditure on community health declined as a percentage of total

expenditure from 18.0% to 14.5% over the same period. This is due to significant increases in hospital budgets over the same period.

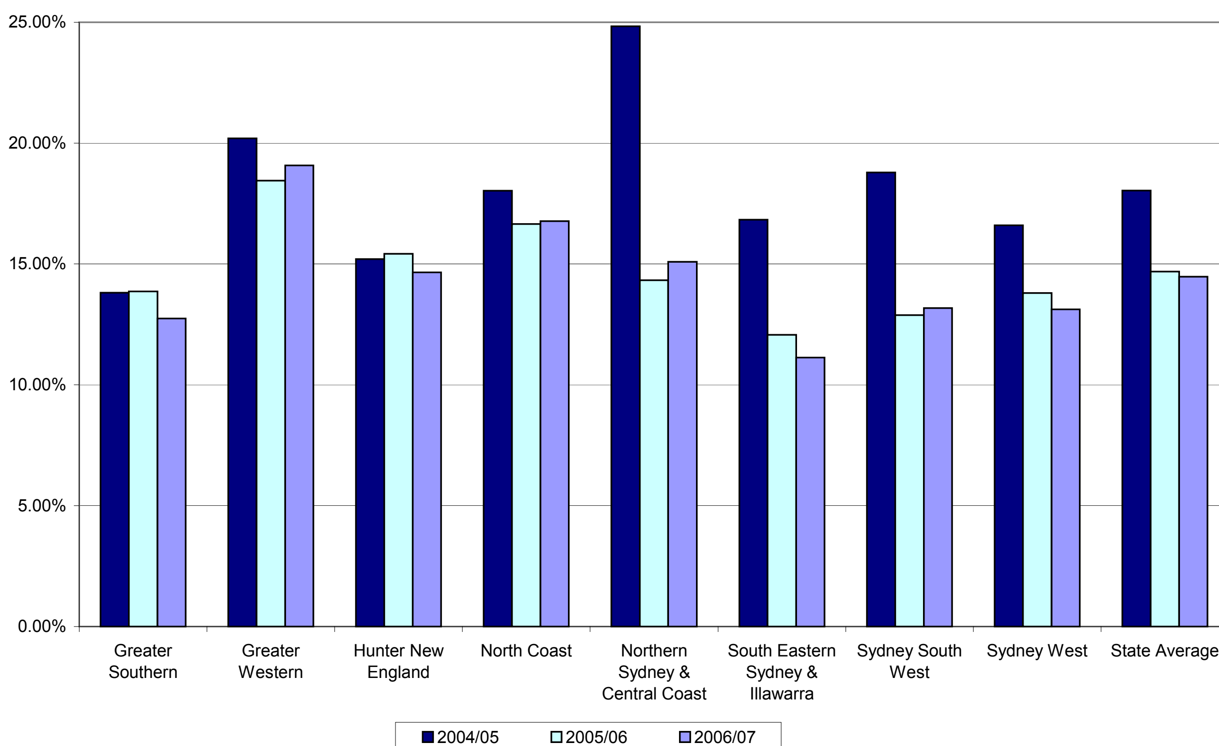
This pattern was also found when funding for admitted patient services was excluded. Each year community health has been receiving a smaller proportion of funding allocated to non-admitted services, with funding for community health declining by 5.8% relative to other non-admitted services.

In 2004/05, all areas except for Greater Southern spent more than 15% of their total budget on community health. By 2006/07, only three areas (Greater Western, North Coast and Northern Sydney and Central Coast) spent more than 15% of their budget on community health. The lowest levels of community health expenditure are in Greater Southern, South Eastern Sydney and Illawarra and Sydney West.

The audit found significantly different levels of community health investment across areas, with Greater Western spending more money per capita on community health ($375 in 2006/07) than the other areas. At the other extreme, Sydney West spends the least ($187 in 2006/07), with spending in Sydney West representing less than half that spent in the Greater West.

While there were some methodological difficulties with the audit, the overall findings raise serious questions about the balance of health investment in NSW. The results also raise serious questions about equity of access to community services across the state.

Figure 3 Community health as a percentage of total Area Health Service expenditure



7.2 Range of community health services currently provided in NSW

Figure 4 below summarises the range of services typically provided in the community. However, not all of these services are provided in all Areas and, as discussed in Section 8 (page 28) there are differences between Areas in terms of how these services are organised and governed.

A final issue in considering this table is that there is no standard classification of community health services and no standard nomenclature. For the purposes of convenience, we classified services into five broad program types, each of which consists of a number of streams:

- Intake and initial assessment
- Child and family health services
- Rehabilitation, aged care and chronic disease
- Community and population services
- Services for priority population groups

It is important to stress that these are services that a client/patient may need, not different specialist teams. While some services may be provided by specialist teams, many are delivered by generalist community and primary health staff within a multidisciplinary model.

However, just as acute care has its own classification systems such as Diagnosis Related Groups, there is a need for a standard classification of community health. This is discussed further in Section 9.4.

All of these are core issues for this Review and are discussed further in the remainder of this section and in Section 12.

Figure 4 Summary of community health services provided in NSW

Stream	Examples of services typically provided by community health
Intake and initial assessment	
Intake and initial assessment	Intake
	Initial needs identification and referral
Child and family health services	
Child and family	Early childhood health
	Families NSW
	Family Care Cottages
	Community midwifery
	Paediatric therapy services
	Disability diagnosis and assessment
	School health
	Immunisation
	Genetic counselling
Physical Abuse and Neglect of Children	Therapy, counselling and casework services
	Education and training
Rehabilitation, aged care and chronic disease	
Aged & Extended Care	ACAT
	Dementia support
	Falls prevention
	Day programs
	PADP
	Home assessment
	Medication review
	ASET and hospital liaison
Community Nursing and Domiciliary Care	Domiciliary care
	Wound management

Stream	Examples of services typically provided by community health
	Health assessment
	Health maintenance
	Primary palliative care
	Specialist nursing services in areas such as breast care, renal care, stoma and continence
Community Rehabilitation	Such as brain injury, cardiac, stroke and orthopaedic
Hospital Demand Management	Community Acute/ Post Acute Care
	Hospital in the home
	Discharge planning & coordination
	ComPacks
	Transition care
Multidisciplinary Chronic Disease Management	Examples of which include cardiopulmonary and diabetes education and control
Palliative Care	
Community and population services	
Counselling & psychosocial services	
Drug and Alcohol	Assessment and counselling
	Home detoxification
	Opioid replacement programs
	Needle and syringe
	Drug Court
Health Promotion	Disease prevention and risk factor programs
	Injury prevention
	Community nutrition
	Health promoting schools
	Mental health promotion
	Community development
Mental Health	Child and adolescent
	Adult mental health
	Older people's mental health
	Special needs
Oral Health	School Dental Program
	Adult Dental Services
	Specialist Services
	Dentures
Sexual Assault	Crisis care and medical examinations
	Counselling
	Court support and advocacy
	Education and training
Sexual Health	HIV/AIDS programs
	Clinical services
	Contact tracing

Stream	Examples of services typically provided by community health
	STI education and awareness
Services for priority population groups	
Aboriginal Health	Aboriginal Health Workers
	Priority programs – otitis media, eye health, maternal and infant health, renal etc
Multicultural Health	Ethnic Health Workers
	Interpreter services
	Refugee health
	Torture and trauma services
Women's Health	Cervical cancer screening
	Reproductive health information and education
	Priority target group programs and capacity building
Youth Health	Youth health services
	Education and support programs
	Interagency and capacity building

7.3 Sufficiency of community health services currently provided in NSW

This issue is inherently linked to the issues of allocative efficiency and the role of community health discussed later in Section 11 (page 50). As already stated, this is a strategic and not an operational review and our Terms of Reference do not include reviewing the adequacy of existing services. However, we received extensive comments in the consultations about the insufficiency of existing services and many of these are of strategic importance.

As discussed elsewhere, short-term hospital demand management services have been increasing at the expense of other services in the community, particularly prevention and early intervention. The Review received consistent feedback on the shortage of psychosocial counselling (particularly in metropolitan areas) and youth health services, as well as the limited capacity to sustain home visiting for high risk families everywhere. There are very limited evidence-based early intervention programs for young people with early onset psychosis and other mental health problems. There is also limited access to allied health treatment, with many people simply assessed and put on long waiting lists.

A further and related issue is the trend to establish more tightly defined micro programs, each with their own eligibility criteria and narrowly targeted recipients that limit the capacity of community health services to flexibly respond to local needs. These issues and their related themes are consistent with finding reported about national concerns under consultations with frontline staff commissioned by the NHHRC (Elton Consulting 2008).

These strategic issues are considered in the final report of the Review.

7.4 Good practice models in the field

Contributors to the Community Health Review were invited to provide examples or case studies of good practice in the field to inform the Review. Numerous examples were provided including models for specific services or programs and examples of service or system redesign to improve access or efficiency.

A sample of these case studies that provide a snapshot of the kind of innovation and practical problem solving that is occurring in the field is reported in Attachment 2. This is not a comprehensive audit of innovative primary and community health activities. Models across NSW and further examples are included in this report in the section on quality and safety (Section 9.3).

Some of the models or services in scope are large scale programs or service redesign initiatives that have been researched and formally evaluated. But these are in the minority. This reflects the lack of investment in primary health care research and development and in systematic clinical redesign outside hospital or hospital community interface settings. The majority are case studies of local or Area initiatives that have been documented and assessed locally and illustrate a commitment to service improvement, better targeting of priority groups or smarter service delivery.

7.5 Hospital demand management

A key theme throughout the Review has been the growing need for hospital demand management services and how these are best provided. We consulted the Review Steering Group on this specific issue. There was no support among the Steering Group for community health to be defined as primarily a short term hospital demand management strategy. That said, there was no consensus on how hospital demand management is best organised and delivered, with some members believing that it is best managed by community health and others believing that it is best managed by hospitals.

There is clear evidence and agreement from all quarters, including the NSW Auditor-General (2008), on the increasing need for more effective hospital demand management that is designed to prevent avoidable admissions, to facilitate early hospital discharge and to reduce the rate of hospital readmissions. But that does not mean that this role is best undertaken by community health.

The mixed views of the Steering Group on this issue are consistent with our broader field consultations. As one example of this, of 72 respondents to the on-line survey, 47% believed that hospital demand management is best undertaken by community health, 17% by hospitals and 36% were not sure.

Those advocating for this role to be the responsibility of community health argue that community health already has the expertise and the necessary linkages with general practitioners and other community care providers who are essential partners in effective hospital demand management. A further argument supporting this position is that, at least at present, the role of community health in hospital demand management is the only lever that community health has to engage with area management and clinical networks.

Those advocating the alternative position point to recent history where the requirement for hospital demand management has resulted in a disinvestment in prevention and early intervention. In the absence of a circuit breaker, there is a view that the only way to maintain any real investment in prevention and early intervention is to quarantine it from hospital demand management. Giving hospitals the responsibility for managing their own demand is a way to quarantine funding for services that have a longer term agenda.

This is a key issue that will be addressed in our final report.

7.6 The balance between specialist and generalist services

There has been an increasing trend towards the establishment of specialist teams within community health in recent years and a strategic issue for the future is the balance between primary and specialist services. The majority view of the Steering Group was that community health should have a strong generalist core supplemented by a small number of specialist programs.

There is no consensus in the field on this issue. While many people shared the view that there needs to be a strong generalist base, many of the examples of best practice we received came from small specialist teams that have established their own data collection and evaluation

systems. They pointed to the good outcomes that they are achieving and the need to expand such programs.

In its submission, the Council for Intellectual Disability (CID) pointed out that the numbers of people requiring rehabilitation because of their intellectual disability are very low. However as they live their lives and age like everyone else, they may have rehabilitation needs. CID stated that these needs should be met as part of mainstream services, and the requisite speciality input is about intellectual disability as well as rehabilitation. CID proposed that a multidisciplinary intellectual disability Health Resource Team should be established in each Area Health Service with a network of clinical nurse consultants focused on the health of people with intellectual disabilities.

> *'One issue we should comment on further is the possible role of rehabilitation services in the health care of people with intellectual disabilities. For reasons set out in our response to the NSW Health Discussion Paper (NSW Health 2007a), we are very clear that we do not support the suggestion that these services should become the base for the state-wide network of intellectual disability specialist health services*. (Submission to the Review from the NSW Council for Intellectual Disability.)

The Review received a number of submissions calling for the establishment of more specialist teams. While the following is not a comprehensive list, it illustrates the range of specialist services that have been proposed:

- Multidisciplinary intellectual disability 'Health Resource Teams' in each Area Health Service
- Specialist teams for very low prevalence disorders such as Spina Bifida
- Specialist domestic violence services throughout NSW in a similar manner to the introduction of Sexual Assault Services.
- Specialist resources for psychosocial services in community health centres
- Specialist services for survivors of domestic violence and child abuse
- Specialist falls prevention teams to target at-risk groups.
- Community Aged Care and Chronic Disease Services led by a Community Geriatrician / Physician that would work closely with local GPs.
- Specialist HIV services with an emphasis on chronic disease management
- Mobile facilities for specialist services in rural and remote areas to treat chronic diseases and to support generalist workers
- Specialist men's health services to address psychosocial, domestic violence and intergenerational issues.

At least in part, the increasing trend towards establishing specialist teams within community health is due to the inclusion of components of community health services within hospital, sector or area clinical streams. This is particularly the case for community health services located in those areas that have principal referral hospitals, with the specialist teams in the community reflecting the sub-specialist structures of the hospitals or through the role of population health.

> *'The multidisciplinary community health team provides community health care services for people living with HIV/AIDS (PLWHA) across the geographical area of SESIH. The service reports to the HIV and Related Programs (HARP) Unit1 under the Population Health Stream with clinical governance provided through the Clinical Stream Director Population Health and Primary Health Care. Strategic alignment is also provided through the Area Director of Primary and Community Health.'* (Submission to the Review from the Area-wide HIV Community Team, South Eastern Sydney Illawarra Health)

The other argument in favour of increasing the number of specialist services is essentially industrial. Recent award changes have favoured specialist clinicians over generalists in their

criteria for promotion. Many staff perceive that they need to become a 'specialist' for reasons of both career development and remuneration. This is not an issue that is easy to solve and is similar in many ways to the situation with general practice.

That said, the arguments in favour of maintaining a strong generalist model are equally strong and they are not restricted to NSW. As our accompanying evidence report demonstrates, there is good evidence to suggest that generalist primary care services can effectively deliver a wide range of services (but not all) along the full spectrum from prevention to continuing care. General practitioners and other referral agencies have pointed to the difficulty they have in attempting to navigate a community system that is increasingly specialised. For rural communities, a strong generalist service can deliver a range of services locally without the need for consumers to travel long distances to access specialist services. From an efficiency perspective, the generalist model is more cost effective in cases where it can be demonstrated that health outcomes are similar.

Contemporary debates about the role of generalist teams versus specialist services internationally emphasise the origins of the apparent dominance of the specialist models.

> *'Primary health care was declared the model for global health policy at a 1978 meeting of health ministers and experts from around the world. Primary health care requires a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services. Considered too idealistic and expensive, it was replaced with a disease-focused, selective model. After several years of investment in vertical interventions, preventable diseases remain a major challenge for developing countries. The selective model has not responded adequately to the interrelationship between health and socioeconomic development, and a rethinking of global health policy is urgently needed.'* (Magnussen et al. 2004)

This debate of comprehensive versus selective primary care was well summarised for the Australian context by Gunn et al (2007) in their recent review of 'generalism' in primary care who describe *'the sense of urgency and alarm in…much of the international literature about the devaluation, loss and downfall of generalism within primary health care systems'*.

> *'Some of these (issues) relate to the way in which generalism has always been measured in opposition to specialism with specialists being seen as advanced or more expertly trained. Others relate to political and economic forces which have pushed technical focus and specialism over generalism. It is striking that generalists, the people who provide first contact, continuous care in relation to the social context of individuals and communities have had to justify and define their roles so much.'* (Gunn et al 2007 p.21)
>
> *'The values and kind of care delivered through generalism do provide the basis for an equitable, accessible and affordable health care system.'* (Gunn et al, 2007, p.33)

In determining the right balance between specialist and generalist services, there are a number of issues to consider:

- The allocative and dynamic efficiency of the overall health system (see the compendium evidence report for a discussion on this issue)
- Projected workforce shortages
- Career development and promotion opportunities for staff
- How best to deliver services to consumers with commonly occurring chronic and complex conditions whose needs cross more than one speciality
- How best to deliver services to consumers with high needs but with very low prevalence disorders or disabilities
- The interface between community health speciality programs and key partners such as general practitioners
- The different needs in urban and rural areas.

A number of submissions to the Review saw no conflict at all between generalist and specialist models, pointing out that:

> *'the local community health centre could provide a very valuable ongoing support service to young people with high support needs and significantly improve their health care and quality of life… A health worker in each community health centre with a special interest in young people could develop some expertise in these areas, network with primary and tertiary health providers, provide some case work and run support groups.*' (Submission to the Review from Dr Carolyn West, Director Spina Bifida Unit, The Children's Hospital at Westmead)
>
> *'This is not an argument for the separate identity and provision of community based health care, but for resetting the balance between hospital and community components of integrated health services, and shifting the centre of gravity of such services towards more accessible community health services.'* (The Future of Community Health Services in Australia, submission to Review from Alan Rosen, Roger Gurr & Paul Fanning)

The right balance between community and hospital and between generalist and specialist services cannot be determined in isolation but is part of a set of bigger issues about the role of community health services and where they fit within the broader NSW Health system. This issue is addressed in our final report.

7.7 Summary of issues and tensions

The evidence from the Review is that community health investment has decreased on a relative basis over the last several years while the need for hospital demand management has increased. At the same time, the consultations received the consistent message that community health staff perceive that they are expected to provide a comprehensive range of services that they are not resourced to provide. In practice, this dilemma has been addressed by meeting the requirement for hospital demand management at the expense of prevention, early intervention and psychosocial services.

With the exception of the specific issue of hospital demand management (see Section 7.5), there is a majority view among the Steering Group on the role of community health. Almost all members agree that community health should provide the full range of services from prevention to palliation.

This is consistent with views of many key stakeholders consulted both in interviews and in the on-line survey, as well as consultations undertaken in the national context and commissioned by the NHHRC:

> *'To reduce the burden on hospital infrastructure and resources, a 'big picture' re-think about the role of hospitals and role of primary health centres/clinics is needed. Such a re-think should set out to move services out of hospitals and integrate community-based primary care and acute care services to provide a more holistic healthcare system. It could result in new or reshaped healthcare providers located at schools, GP clinics or visiting the patient at home ... This approach would require an increase of funding for community and home-based care.'* (Elton Consulting 2008, p.22).

However, a recurring theme in the consultations has been the need to reach agreement on a set of core programs that are evidence based and measurable with key performance indicators that Chief Executives can own and be judged by. In the same way that key performance indicators for emergency department access performance and surgery have given resource priority to emergency departments and elective surgery, key stakeholders have identified this as a key strategy to drive the future role and resourcing of community health.

Implicit in proposals to define a core role for community health is an assumption that at least some of what community health services currently do is of low priority, and can be abandoned for other sectors address, in favour of a set of core services that are more effective. The review of the

international evidence commissioned as part of the current Review was designed to inform this issue and the conclusion there is that there are few solid facts to guide a strategy that involves selective disinvestment. The future role of community health is discussed further in Section 11 and the final report in this series addresses this issue in some detail.