Better Choices  Better Health

Final Report of the South Australian Generational Health Review

April 2003

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INTRODUCTION

The South Australian Minister for Health, the Hon Lea Stevens, announced the Generational Health Review (GHR) and appointment of the Review Committee, chaired by Mr John Menadue AO, in May 2002.

The aim of GHR was to develop a framework to guide the South Australian health care system over the next 20 years. The objectives are that the health care system, in partnerships with governments and stakeholders will:

- strive to maintain and improve the health of the population with an emphasis on addressing health inequalities
- ensure safe, accessible, efficient and effective health care.

The principles and values underpinning GHR take into account the South Australian Government’s health and social agenda commitment:

- improving the quality and safety of services
- greater opportunities for inclusion and community participation
- strengthening and reorienting services towards prevention and primary health care
- developing service integration and coordination
- whole-of-government approaches to advance and improve health status
- sustainability in delivery through ensuring efficiency and evaluation.

GHR identified a number of key themes critical to delivering the required health reform agenda. These themes form the basis for the structure of this report:

- promoting a population health approach
- promoting primary health care
- accountability and transparency
- workforce development
- health inequalities and health as a human right.

This summary report needs to be read in conjunction with GHR’s full report, April 2003.
The people of South Australia have a decision to make on what type of health system they want and need.

The implications are clear. System reform is essential.

The present health system is under stress with increasing budget and demand pressures. It is not sustainable into the next generation on grounds of quality of care, efficiency and equity.

GHR’s proposals address this unsustainability. Unless they are addressed, the government will face difficulties in achieving its health and social agenda commitments.

Many argue there is no ‘health system’ at all. Hospitals and health services tend to work independently and compete with each other. The system as it stands is an illness system. It needs to be a health system as it claims to be, with a reorientation towards health promotion, illness prevention and early intervention.

Despite this escalating pressure and demand, a professional, committed and passionate workforce staff South Australia’s health services with many working over and above required working hours. The workforce cannot sustain the pressures for much longer despite the support of dedicated volunteers and family carers.

The directions proposed in this report are not new or world shattering. They are similar to what is happening internationally in health in countries comparable to Australia. It is not the directions that are controversial; it is the act of implementing them.

**Systemic reform**
Real systemic reform is more of a transformation – initially of resources and structures, but more of vision and will. It is vision and will that drives continuous improvement. The ultimate goal of systemic reform is improvement in the health status of South Australians and the provision of a safe, efficient and effective health care system.

All stakeholders, consumers and the community must be involved and work collaboratively towards improved health status. A sustained critical mass of change leaders is necessary to ensure constancy of purpose. It is important for the lead into reform to be well structured, clear and directive in its intention. Wavering or hesitation will be promptly interpreted negatively and a potential constituency for support will be lost.

Systemic reform of the health industry is not easy. However, there are real reasons for optimism. Though there are no guarantees of success the dynamics of change are much better understood. Knowing the challenges and the difficulty of the work will be an advantage and will thwart unrealistic expectations.

Widespread support for reform hinges on creating an informative dialogue between the health system and the public.
**Key systemic reform messages**

Reorientation of the system to enhance the focus on primary care is a significant change. Consumers know that prevention must be the first step. A strong primary care sector will enable consumers to be treated in their homes or as close to their homes as possible.

Primary care tends to be neglected in terms of funding and recognition. Hospitals, while requiring more substantial investment, are also more interesting and ‘sellable’. High technology medical equipment used in microsurgery and transplants tends to be found in hospitals and is newsworthy. The prevention of heart attacks, lung cancer or the prevention of public health outbreaks, such as food poisoning, can not be seen and tend to attract less attention even though the entire community benefits from such activity.

Primary care services and hospital avoidance programs also provide the potential to alleviate pressure on the hospital system. However, if budgets remain tied up with the provision of hospital care it will not be possible to implement such changes.

GHR believes the public will respond very favourably to a government-initiated system reorientation that will strengthen primary care, preventative care and public health.

A thoughtful reform process can develop a constituency of support in the community, creating a natural ally for reform. All community health surveys conducted in South Australia over the last ten years show that when the community realises the health dollars are limited it has very clear views on priorities. Mental health stands at the top of the list, followed usually by childhood services and Aboriginal health. While recognising the important role that hospitals play in the health system, people rank these issues well above acute care.

Unfortunately, the community is largely disempowered in health matters and is typically excluded from decision making. GHR’s recommendations will address new community participation structures and processes such as deliberative polling. The community can become an effective ally in helping redress the imbalance of power in the health system and asserting its priorities and views.

GHR has sought to substantially involve clinicians in its work, which has been inclusive and transparent. The overwhelming sentiment of clinicians is that the present duplication of clinical services wastes resources and in some cases prejudices safety standards. GHR is recommending a clinical senate to manage the process better in the future and make it more difficult for the vocal and the powerful to pre-empt the debate and decide where funding is directed.

The government needs a major information and communications strategy to lead and manage the health debate. The principal issue that must be addressed is that health resources are limited, choices have to be made and the community must be involved. Otherwise the powerless, such as Aboriginal people and other disadvantaged groups in the community, will continue to be marginalised. Unless the government is proactive in this field it will be reactively responding to crisis after crisis and the demands will not stop.

If the implementation process can focus on the above elements, the required reforms have a much greater chance of success.
CHAPTER 1: CASE FOR CHANGE

This is the first review of the entire public health system in 30 years. It presented a rare opportunity to review South Australia’s health system within the context of local, national and global demographic, societal and technological change.

There have been significant demographic, cultural, economic and social changes, and dramatic changes in health care delivery and technology. These trends are not unique to South Australia. Health systems all over the world are grappling with similar issues. The main issues are discussed in this chapter.

A changing population profile
One of the most significant changes is the rapidly increasing ratio of older people. People are living longer than they ever have and South Australia’s population is ageing at a faster rate than other states and territories. By 2051, the median age in South Australia is projected to rise to 49.2 years, compared to 37.1 years in 2000. This profile is not representative of all South Australians. For example in stark contrast, Aboriginal people have a very different demographic structure and much poorer health outcomes than other Australians. If all Australians had the health status of the Aboriginal population, Australia would rank around 140 in the world, equivalent to life expectancy in Bangladesh or similar third world nations.

Social determinants of health
The physical, social and economic environments in which people live impact on health and wellbeing. One of the key social determinants of health is socioeconomic status and the level of disparity between the rich and the poor. In South Australia there is evidence of a widening gap in socioeconomic circumstances and living standards. The rate of poverty in South Australia more than doubled between 1981–82 and 1997–98. Poverty has been linked to inadequate diet, unhealthy lifestyle choices, stress and anxiety. These all impact negatively on health and wellbeing. Health related behaviour such as smoking, dietary habits and physical activity are also associated with socioeconomic status.

Changing burden of disease
Worldwide, the disease burden and what people die from has changed significantly over the last 30 years. The number one disease burden for South Australia is cancer, followed by heart disease, accidents and mental health. A large proportion of the disease burden is preventable. It is estimated that 5.6% of the total number of years of life lost is due to intentional injuries such as suicide, self-inflicted injuries, homicide and violence. Diseases and injuries related to the ageing process have also emerged such as Alzheimer’s disease and osteoporosis. There has also been a growth in the number of people who have multiple, chronic and complex conditions.
**The expectation of cure**

Western culture has promoted an image of medical science that has created unrealistic expectations of health care. Consumers expect and believe they have the right to the best of the latest technology and treatments, despite the uncertain value of some of these interventions. Consumers also have an expectation that they have a right to choice in health care. This choice is being exercised, an example being the rise in the use of complementary therapies, now a significant industry worldwide.

Consumers of health care tend to rely on the advice of providers to determine what services they need and seek to access. The role that providers play is underpinned by the existence of insurance, public or private, which effectively removes the true cost of the service from the point of decision making. There is a potential for providers to influence consumers in such a way that they use more services than they would have if they had made the decision themselves.

**Mix and distribution of services**

The distribution of State Government health expenditure shows that hospitals receive just over two-thirds of the total health budget. However, only a small percentage of the population, approximately 12%, require access to this type of health care. The current split of the health care pie is no longer appropriate given the changing nature of health care, changing population profile and changing health care needs.

On a per capita basis South Australia spends more money, and has higher utilisation rates, more health professionals and more beds than other states and territories.

South Australia has insufficient population to support safe, efficient and effective provision of the current number, range and distribution of clinical services. There is unnecessary duplication of clinical services and the infrastructure that supports them. The fragmentation of services, an under-resourced primary health and community care sector, the lack of information technology and telecommunications connectivity across health care services, system accountability and transparency, and workplace cultures all impact on the quality of care.

The current nature and distribution of metropolitan hospital services is a product of a demographic profile of South Australia that no longer exists. As a consequence there is significant structural inefficiency in the system.

Should no reform occur and the system continues to function as it currently does, the following scenario is likely to ensue:

- Demands on emergency departments will continue and waiting times will increase.
- Delays in admissions from emergency departments to hospital wards will continue and perhaps worsen.
- Pressures on hospitals beds will increase resulting in a demand for additional beds requiring additional capital investment.
- Additional beds will be difficult to open because of workforce issues.
- Workforce availability and morale will probably decline even further.
- The reduction in some populations would result in trying to maintain multiple service sites with specialist clinical staff spread so thinly there would be insufficient critical mass of staff and patients to maintain safe and efficient services.
- Length of stay is likely to increase as the number of long-stay patients increases.
- Waiting times for elective surgery will be extended significantly.
• Insufficient community support for people with multiple diseases and chronic conditions will place further pressure on GPs.
• People will continue to be inappropriately admitted to hospitals because of lack of community support services.
• The inequities in accessing services closer to home will not have been addressed.

All of the above will have the combined effect of further reducing standards of care and compromising safety and quality of health services. At the same time they will prevent any opportunity for investment in primary care services — a focus on health promotion, illness prevention and early intervention would not be possible.

The results of a modelling exercise commissioned by GHR show that — if there is no change in clinical practice; no change to patient flows (ie the distribution of clinical services); continued investment in current hospital configuration; and no investment in community support services and the demand management strategies recommended by the GHR — by 2011:

• total hospital admissions will increase by 10% (population driven)
• total beds (same-day and overnight) required will increase by 16% or 472 beds
• total cost per annum will increase by 9% or $87.9 million at 2001 prices.

This does not include the capital cost required to maintain the current infrastructure. The result would be an increase in the existing structural inefficiencies in the system, a failure to address the issue of equity of access to services for the people of the northern suburbs and a decline in the quality and safety of services.

The key to achieving structural efficiency, equity of access and maintenance of safe, quality clinical services is to:

• adopt the planned change in patient flows incorporated into the modelling exercise
• implement the Strategy for managing metropolitan hospital workload begun by the Department of Human Services (DHS) and supported by the GHR, and provide the necessary investment for it to be rolled out as a matter of urgency
• plan the removal of overnight beds as same day beds are increased and community support services are put in place, and provide the necessary capital investment to drive this reform
• support clinical practice changes by continuing to develop and review clinical plans to reflect changing practice.

The effect of these actions by 2011 will be:

• total admissions increasing by 7% instead of 10%
• total beds (same-day and overnight) required decreasing by 7% (216 beds) instead of the increase of 16% (472 beds) if the status quo prevails
• total cost per annum decreasing by 13% or $117.5 million instead of an increase of 9% or $87.9 million (2001 prices).

Clearly by adopting these strategies the South Australian health system should be able to manage demand better and more appropriately. This should provide an opportunity to maximise efficiency gains as well as provide funds for further investment in health development and reform. GHR considers that
more detailed modelling needs to be done to identify costs as well as savings from implementing these strategies over the next ten years.

The dollars made available can be invested in primary care services including early intervention programs for infants and young children, people with a mental health problem, Aboriginal people and people with developing chronic diseases such as asthma and diabetes.

**Fragmentation and duplication of planning, funding and governance arrangements**

The current fragmentation of health services in South Australia and how services are planned, governed and funded are major inhibitors to the development of a coordinated health system to achieve improvements in population health status.

Many argue that there is no health ‘system’. Consumers repeat their story every time they visit a different health service. Information technology systems are not connected and even if they were, software would not allow them to ‘talk to each other’. Metropolitan systems do not ‘talk’ with country systems because many rural services do not have the infrastructure.

There is a range of planning, advisory and governing bodies across various portfolios and all are funded separately. They all make decisions on behalf of and with their communities, which directly or indirectly affect health status at a regional and local level. There is duplication of planning processes, needs assessments and community consultations, often with very little impact or demonstrated improvement in health outcomes.

There are numerous regional boundaries for planning and service delivery at different government levels (local, state and commonwealth). There are different processes and systems within the State Government and within individual departments.

There is an unacceptable number of short-term, unsustainable and duplicated projects due to the way programs and health services are funded. Short-term grant funding creates competition rather than cooperation. The majority of program funding is often based on population numbers, not on need or capacity. A decline in population equates to a decline in funding. The reasons behind a population decline usually equate with a poorer socioeconomic profile that demonstrates a greater health need.

As at 1 July 2002, there were 76 health units incorporated under the *South Australian Health Commission Act 1976* (SAHC Act) including 46 country health units, seven regional boards, two metropolitan community health services, eight metropolitan hospitals, three disability services, and statewide drug and alcohol, dental, and child and youth health services.

There are a number of common issues that should be resolved and the GHR has sought to address them at a preliminary level, including the:

- number and nature of regions in Adelaide and country areas
- needs of Aboriginal communities in the governance arrangements for mainstream health services and Aboriginal owned and controlled services
- need to strengthen and coordinate planning for country and metropolitan health services while ensuring that governance arrangements for country regions continue to respect the specific nature and requirements of rural and remote South Australia
need to encourage greater integration of health services at the regional level to bring together groups of hospitals and a variety of community based health services; including statewide agencies and the non-government sector

need to clarify and strengthen corporate responsibility for providing high quality and safe services across the health system.

GHR has come to the conclusion that the weaknesses of the current governance arrangements in South Australia would become more significant over time.

CHAPTER 2: POPULATION HEALTH AND GOVERNANCE

Population Health Focus
A population health focus will require a fundamental shift in health system perspectives and priorities to place the health of the population at the centre of decision making. Health services have focused on individual priorities rather than collectively focusing on population health. In many ways organisations and their boards have done exactly what they were set up and asked to do — manage their services.

Today’s governance arrangements in the South Australian public health system are enshrined in the SAHC Act which brought together a range of disparate hospitals and health services under a unified system of governance.

Times have changed. Today, one of the primary objectives of health systems around the world is to promote cohesion, ensuring service coordination and integration to best meet population health needs. The challenge for governments is to improve coordination and integration without losing the ability to remain responsive to local and regional communities.

Existing legislative protection of individual health unit boards has stood as a clear barrier to health system reform. The structures designed for the needs of an earlier time have not addressed increasing complexity and the difficulties experienced by both consumers and providers. There is poor communication across the health system, rivalry rather than cooperation and inadequate alignment of services to population priorities.
Problems associated with individual health unit boards have been identified by Labor and Liberal
governments over the past 30 years. Numerous attempts have been made to reform governance,
encourage greater cooperation and coordination, and reduce duplication of services and infrastructure
through regionalisation — with little success.

The GHR has concluded that legislative change is required to substantially reform governance
arrangements in South Australia.

A focus on regional population health needs will ensure resources in the health system are more
effectively directed to identifying and pursuing opportunities for improved population health outcomes.
Through regionalisation of health service governance and funding:

- services will be more effectively networked and able to provide greater continuity of care,
  including better linkages between metropolitan and country services
- investment in services and programs will better match community needs and priorities, and be
  more effective in addressing health inequalities
- a more appropriate balance will be achieved between services to prevent and detect ill-health
  and those which aim to protect, maintain and restore health.

During consultations, GHR was given a clear message that change is expected and that a regional
governance model will be broadly supported.

GHR proposes the following approach to promote a greater focus on population health in the South
Australian health system:

**Planning for defined geographical populations**
Regardless of the governance and funding of health services, population needs assessment and
health service planning across the system will be greatly assisted by the identification and
definition of geographical regions across the state. These should comply with the principles of
statistical geography and make sense from community and service provision perspectives.

**Population approach to health funding**
A population approach to funding will facilitate equitable access to health care across the state.
Based on population size and indicators of health service need within regions, funding for all
types of health care (hospital, community and home based) can be distributed to regions
equitably and service development can be planned accordingly.

**Population service planning**
In addition to regional planning, statewide planning is required for optimum configuration of
high cost and complex services and to determine the overall quantum of services and funding
to adequately meet the overall population’s service needs into the future.

**Population based health governance**
The power to direct and control resources and health services lies principally at the ministerial
level. However, to balance central control and direction, and responsiveness to local
communities, there is a need for a principal governing body with adequate authority and
responsibility for promoting and managing health services for a defined geographical population.
This will require the dissolution of incorporation of all health units and the integration of their
management into regional health services.
Local community participation in health care agencies and issues needs to be maintained and strengthened. It is important to recognise the continuing interest of local communities in assets that they have funded, and to support and encourage ongoing fund raising and contributions in kind.

These four elements are included in the proposed roles and responsibilities for the Minister for Health, DHS, regional health services and health units as shown in Figure 1.

**Legislative Requirements**
The raft of proposed changes to governance structures and processes seeks to fundamentally reorient the health system from:

- managing individual health units to managing the health of a defined geographic population
- focusing on hospitals to focusing on primary health care and community based services.

Legislation needs to make the system more accountable to the community with health system performance and decision making more transparent and inclusive. GHR understands that legislative amendment is a likely prerequisite to the formation of the recommended new country regions and the dissolution of health units.

It is time for new legislation. Not only would new legislation be more practical, it would provide a powerful symbol for change and signal the beginning of a new and reoriented future health system.
• Responsibilities for promoting, maintaining and restoring health of residents and administration of health units in the region
• Board controls affairs of RHS including power to appoint and dismiss regional CE (subject to CE of DHS consent)
• Board is required to administer RHS in line with approved DHS policies, strategies and guidelines
• RHS can enter into performance agreement with CE of DHS
• RHS is employer of RHS administration and health unit staff
• CE of RHS manages affairs of RHS in accordance with board directions
• CE of RHS is ex-officio member of the board
• CE of RHS can enter into performance agreements with managers of health agencies

• Government responsibility for the public health system
• Government can enter performance agreement with Chief Executive (CE) of DHS
• Powers to control and direct the DHS (health) and RHSs
• Appoints members of RHS boards
• Power to remove members of a Board

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• Manager of health agencies appointed by the RHS
• Responsible for providing services in line with RHS directions

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• CE of RHS can enter into performance agreements with managers of health agencies

• Trusts to comprise people from local communities
• Responsible for administering property and funds raised by community in line with RHS plans and priorities
A primary health care focused system is required to ensure illness prevention, health promotion and early intervention are addressed. International evidence demonstrates the benefits of a strong primary health care approach in delivering population health improvements. Primary health care also provides a cost effective use of scarce resources. The more robust the system of primary health care the more favourable the health outcomes for all ages, particularly children.

Focusing on the reduction or elimination of health risks — for example provision of clean water and sanitation, immunisation programs against infectious diseases, increased safety measures on roads and in workplaces, and screening programs such as breast and cervical screening — has contributed significantly to health improvements.

Primary health care delivery is essentially premised around the above strategies and also underpinned by a body of knowledge, evidence and theory with key principles derived from *The Ottawa Charter* and *The Jakarta Declaration* and recommendations from the Mexico International Health Promotion Conference regarding effective practice. The principles of primary health care not only underpin system reform, they also provide strategies and ways of working in the proposed primary health care focused system.

**Commonwealth and state relations**

Commonwealth and state arrangements have been highlighted throughout GHR’s consultations as one of the major barriers to system reform and a major contributor to fragmentation and duplication.

The state has a vested interest in working with the Commonwealth to ensure planning, funding and policy directions support a primary health care focused system. Of particular importance is the development of flexible funding arrangements and incentives to better integrate general practice into the proposed system. It will take time to shift the current public health system from a predominant focus on institutions to a focus on the health of populations.

**Relieving the pressure**

There are some immediate demand pressures being experienced in hospital emergency departments in South Australia. GHR recommends a strategy for the management of metropolitan hospital workload that builds on an approach implemented successfully in Victoria. The key components of the strategy are care in the community, emergency department access, efficient use of inpatient care, and discharge planning. Clinical leadership, collaboration between health providers and cooperation between DHS, regional health services and health units are critical elements.
**Beyond fragmentation**
A comprehensive primary health care focused system can only exist when all health care providers are included in the planning and delivery of services. Providers often not recognised as part of the public health system, but who are critical to it, are:

- people working in public and environmental health
- general practitioners
- other key primary care providers including non-government, volunteer and carer support organisations
- family carers
- private providers.

Strategies to engage these providers are essential.

**Towards a primary health care focused system**
The key components of the future system include:

- networked primary care services
- integrated community care services
- statewide referral hospitals
- networked clinical services
- population health networks.

This system is set out schematically in Figure 2.

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**Figure 2. A primary health care focused system**

[Diagram of a primary health care focused system with nodes indicating networked primary care services, integrated community care services, statewide referral hospitals, networked clinical services, and population health networks.]
**Networked primary care services**

Networked primary care services aim to improve population health status and should be accessible, integrated, and responsive to and informed by consumers.

Networked primary care services should:

- provide the majority of a community’s health care needs
- provide the access point to the rest of the health care system
- be supported by a range of diagnostic and treatment services available as close to a local community as possible.

A range of different providers in different locations could provide primary care services. Information interchange and commonality of systems will be essential to enable consumers to be linked to the range of services. It may also be possible for a range of primary care services to be collocated within one facility.

Networked primary care services will provide the linkage point for consumers to all other services, for example public and private clinical outreach services, rehabilitation services and hospital services. Networked primary care services will provide an important role in ensuring the provision of seamless health services.

Networked primary care services may consist of services delivered from general practices, small rural health units (especially those currently minimum funded), current Commonwealth funded regional health configurations, community health centres, Aboriginal community centres and aged care services. One of the key roles of networked primary care services is that they develop, support and nurture relationships with community based organisations and individual practitioners who provide consumers with choices that best suit their needs.

Primary care centres do not have beds for planned elective admissions but may have emergency primary care treatment beds. However, this will only form a small role in some primary care centres.

Networked primary care services will need to have strong links with regional integrated community care services and centres, and statewide clinical and population health networks (see below).

Service elements of primary care services can include health promotion, primary care, health maintenance and coordination of health information. Teaching and research is an important element.

Wherever possible, and where facilities permit, networked primary care services should provide hospital outpatient-type services, rehabilitation and hospital ‘avoidance’ services so that care can be provided in the community as much as possible. They should be a single point of access for other state, Commonwealth and private services, and provide resources and support to all consumers in navigating the health system.

It will take a number of years to establish the required networked primary care services across the state. Given the central importance of primary care services to the reform agenda, GHR considers it essential that adequate funding be provided. Based on the learnings from the South Australian mental health reforms where the community sector was not resourced to cater for a shift in demand to the community, it is critical that there is parallel funding in the first instance to shift and enable activity to occur in the regional setting.
**Integrated community care services**

Integrated community care services will provide access to a range of acute, immediate diagnostic and treatment services. These could be networked across a range of locations or collocated in a single centre. Services could include minor and elective procedures, chemotherapy, outpatient medical, surgical, high dependency, uncomplicated obstetrics, and mental health assessment and treatment, in conjunction with general practice. Resident and visiting specialists will provide workforce support to integrated community care services and centres. A teaching and training focus at this service level is an important feature.

Integrated community care services will require a shift to a low technology, high volume and low acuity service. They will be a key support to primary care services in regions and should provide:

- expert 24-hour, 7-day medical, nursing and allied health cover and triage to ensure individuals can have most of their health needs met locally
- an accessible intermediate step between local communities and statewide referral hospitals for patients who require complex diagnostic or treatment procedures (see below)
- an inpatient setting for those returning to their community after admission to hospital, providing placement closer to home.

Integrated community care centres will, in the main, evolve from existing rural regional and metropolitan hospitals and each proposed region would have at least one facility that could be an integrated community care centre. These centres will require inpatient, day patient and diagnostic facilities to be on site.

Successful implementation of integrated community care services will rely on a number of factors:

- a shift of low acuity, low cost, high volume services from statewide referral hospitals to regions
- availability of services and key staff
- support from statewide referral hospitals, primary care services and networked clinical services (see below) to minimise risks in providing low acuity and rehabilitative care closer to the community
- a clear view of the economic benefits, both in dollar terms and consumer cost, of using ‘step down’ facilities to move patients from acute hospitals closer to their community
- moving the focus for new investment in specialist staff, diagnostic equipment and new physical facilities from hospitals to integrated community care centres and from them, as appropriate, into primary care centres or to networked primary care services
- integrating general practitioners through establishing governance and funding mechanisms within primary care services that will encourage their commitment and support to integrated community care services.

**Statewide referral hospitals**

Statewide referral hospitals will deliver specialised, low volume, high cost and complex services. They will be the centre for the introduction of new specialist technologies and treatments with a focus on teaching and research. A key role will be to support the work of primary care services and integrated community care services by providing evidence based, best practice protocols and undertaking high quality research and teaching.
A range of services currently delivered in statewide referral hospitals could be more appropriately and efficiently provided in a community setting. These include:

- hospital emergency departments delivering general practitioner type services including patients returning to emergency departments for follow up
- hospital outpatient departments booking patients for follow-on appointments that could be managed in the community
- outpatient clinics seeing patients for regular appointments for health maintenance such as routine cholesterol management.

Statewide referral hospitals in the future will provide complex secondary, tertiary and quaternary services and include such services as:

- level three intensive care
- a comprehensive range of specialty and super specialty services such as organ transplant and neonatal services
- 24-hour, 7-day emergency departments, covered by specialists in emergency, trauma and retrieval medicine
- acute mental health services
- high technology procedural, diagnostic and treatment services
- training, teaching and research, which includes health professionals rotating through the system to support professional development and service delivery.

Statewide referral hospitals may become centres of excellence for particular specialist and high cost clinical services such as cardiology, cancer, respiratory and trauma services. They will also provide a range of basic services to meet the needs of their local community.

**Clinical planning and networked clinical services**

Clinical service planning is an essential prerequisite for ensuring the provision of continuous safe, quality delivery of clinical services in South Australian health services. These services are intended to meet the challenges and changes of increasing technology, an ageing population, increased demand and the higher costs of providing services.

GHR recommends several strategies to improve planning processes in this area including adoption of broad principles for clinical planning, the concept of statewide networked clinical services (being responsible, among other tasks, for implementing clinical plans) and a framework for the development of clinical plans.

**Service delineation**

An integral part of clinical planning is consideration of the role of health service facilities, at the regional and state level, in the delivery of the specified services. The overall objective of this planning is to ensure that the capacity of the health system aligns with the preferred health care model.

GHR has examined the service delineation of hospitals in metropolitan Adelaide as a priority given the nature of hospital facilities and the resources they consume. The system has notably lacked a planned approach to hospital service delineation. Issues of quality and effectiveness, and changing methods of care must be taken into account in delineating the services and determining the volume of services each hospital should be funded to deliver.
GHR notes that DHS has started work on developing South Australian service delineation guidelines and supports the progress of this work.

**Population health networks**
Population health networks will be population specific. They include whole-of-government responses at the Cabinet level, such as GHR’s Aboriginal and early childhood proposals. At the health portfolio level they may include regional, cross-regional and statewide population health networks as determined by regions or the DHS. Such networks will require the establishment of strategic partnerships with a range of other service providers including other State Government portfolios, Commonwealth services, local government, non-government organisations and others.

**Health system reform enablers**

**Information technology and telecommunications**
There are around 14,000 information technology users in the human services portfolio, who are using a variety of applications. They are located in over 700 service delivery points throughout the state and include 2000 general practitioners. Very few connect with each other. Patients are often required to provide their personal details many times during any process of care.

Greater connectivity of information is needed across all levels of the system and between agencies including public, private and community. The need for common systems and equity of infrastructure must be addressed. Statewide connectivity is crucial for the development of common records, sharing of information, clinical planning and for linking all services.

There was general agreement throughout GHR consultations that development of a single electronic health record for each patient was a priority. This will require review of existing legislation and rigorous application of policies and procedures to protect the privacy of individuals. The implementation of OACIS (Open Architecture Clinical Information System) in metropolitan hospitals is a positive step in working towards a single electronic health record.

**Capital and asset planning**
The built asset age profile for DHS shows that the major assets were developed in the 1960s and 1970s, with a smaller but significant proportion built before this. The age and condition of South Australian health assets is of critical concern with a significant proportion of assets being at or below 35% residual life and considered to be increasingly difficult to risk manage. The expectations and demands for capital expenditure in the South Australian health sector are at a critical stage. Major metropolitan hospitals are currently queued for significant upgrades or replacements and are predicted to consume a substantial share of the capital funds available to the health sector over the next five to ten years.

It is not possible within current funding limitations to upgrade and maintain existing major hospital infrastructure, as well as develop infrastructure to facilitate the proposed reforms. It is critical that planned re-direction of capital investment occurs to support establishment of appropriate community based primary health care services.

A more strategic system-wide approach is needed for capital and asset resource decisions. GHR recommends DHS investigate savings opportunities by adopting a facilities management approach to its minor works, maintenance, property services (including security) and ancillary services.
**Research**

Research is an integral part of the health system. It is an enabler for many aspects of health care delivery, including informing the promotion of health and wellbeing, strengthening the evidence base for decision making and providing an avenue for stimulating debate for policy makers.

GHR believes a culture of enquiry is needed in the health sector. Health related research should be integrated into all aspects of health care. The culture of enquiry should seek to promote greater linkages between research, policy and practice.

Fostering the ability to come up with better and smarter products and services is the key to driving the future health system. It also impacts on future economic growth in South Australia. Innovation is the single most important element in a successful modern economy.

There needs to be greater investment in research and development activities as well as scientific infrastructure and programs that retain and attract highly skilled workers. The State Government has made some inroads towards these goals through the establishment of the Economic Development Board and the Science and Research Council.

The World Health Organization has highlighted the growing potential contribution of biotechnology for health improvement. Technologies such as these will be adopted more quickly in a health system that has practitioners capable in both biomedical and social enquiry.

The national and international research context is changing and there is a strategic need to ensure the future growth and development of the biomedical research sector. The benefits of research in hospitals and the linking of patient care facilities to research have been proven.

**Public and environmental health research**

South Australia has a highly skilled and dedicated public health workforce providing a solid foundation to build on, strengthening its public health research capacity. Currently the public health service, including practitioners, researchers and academics, is fragmented and uncoordinated with little or no capacity for a statewide approach. GHR supports the recent development of the South Australian Institute of Population Health as one strategy which attempts to address this fragmentation.

**Health futures**

It is not possible to accurately predict the future. However, the future will bring new challenges, discoveries and knowledge. The impacts of globalisation, global warming and international politics, for example, can be anticipated to have some level of impact on the state of the economy, culture and health of South Australia.

There have been several predictions made about health and future health issues. These have included the development of super-bugs emanating from the warmer tropics, illnesses arising from the use of chemical warfare, chronic and complex conditions, and illnesses related to environmental exposures.

Much anticipated is the result of the human genome project and possible impacts on medical science and health care. Ethical debates are likely to play an increasing role in the development of and application of new knowledge.
The changes will impact on the type of health care system required and possible impacts should not be underestimated. It is important for the health care system to maintain a future focus, to continually re-evaluate what it is providing, how it is being provided and, indeed, if new alternatives have rendered some services, practices or facilities obsolete. Consideration of possible future impacts requires health to look beyond its own areas and seek information and advice from key leaders and thinkers in other fields.

**CHAPTER 4: ACCOUNTABILITY AND TRANSPARENCY**

For the delivery of health services and the management of the health system to be accountable and transparent, it is essential for consumers and community members to be included. This objective is based on two key principles:

- that the public health system is accountable to the public
- that the public has a right to have a say on public health system issues and directions.

**Information and education**

For the system to be accountable to the public, the public must have access to information about the system. GHR received a significant number of comments on the lack of consumer friendly information about the system provided to the public.

Ultimately, information and education about the health system will stimulate debate about health and health care. In providing useful and accessible information it should be possible to develop a more productive and useful enquiry that moves beyond the narrow debate that seems to portray a belief that good health and health care are intimately related to the numbers of hospital beds and the proximity of an accident and emergency facility to every home in South Australia.

Health care resources are limited and demand for health care is unlimited. This means services to the community must be rationed through difficult choices around priority setting. Recent examples include investment choices in neonatal intensive care and the provision of an additional MRI machine within the metropolitan region. These decisions are typically taken without any public acknowledgement of the opportunity cost of such investments and the impact of such choices on the capacity of the system to invest in other areas, for example mental health and primary health care.
Community involvement in priority setting

GHR has repeatedly expressed the need for community involvement in setting health system priorities. This requires capacity to be built through informed public debate and the provision of information, as raised above. The establishment of opportunities for statewide community involvement in whole of system priority setting has been considered by GHR and raised in consultations with stakeholders.

Some sections of the health system have been and continue to be active in exploring and involving community and consumers in priority setting activities at the local and service unit level. In other sections of the health system the right of community members and consumers to be engaged continues to be questioned.

There is a need for the public to be involved in debate and informed decision making prior to knee-jerk responses to ‘health dramas’ and ‘scares’ that regularly appear in the media. Failure to do so will see poor investment choices in health continue, driven by ‘insider’ interests without any serious consideration of the investment choices that are at stake. The consequences will be a continued burden on the health system, and see continued rising costs and unacceptable levels of service safety and quality.

Accountability and transparency for the quality and safety of services is a key aspect of health system performance but such information is typically poorly disseminated, if at all. The common reasons given are either fear that it will ‘frighten’ the public who do not understand the bigger picture and/or that individuals or individual health units will be labelled as bad performers resulting in unwanted repercussions. Neither of these claims can be substantiated.

Safety and quality

South Australia’s health system delivers safe and effective care to hundreds of thousands of South Australians every year and there are many skilled and dedicated physicians, nurses and allied health professionals, excellent hospitals and health care systems. Nonetheless, health care is not risk free. Even with the best intentions, the best staff and facilities, things can go wrong and health status does not always improve as a result of health interventions. While these risks can never be totally eliminated, the health care system must continually strive to achieve the highest levels of safety and quality. Equally importantly, the system must aim to achieve improvements in health status, especially for population groups with the poorest health outcomes.

In recent years, interest in standards setting and monitoring for safety and achievement of improved health status in health care has been growing. This is partly in response to the poor health status of some sections of the South Australian population, in particular the extremely poor health status of Aboriginal people, the well publicised adverse incidents (e.g. missed diagnosis of breast cancer) and the recognition that as health care is becoming more complex, and as the population ages, the risks associated with health care are increasing.

There is evidence of variation in quality of care and medical errors in most health care systems, and this has prompted governments to seek improvements in quality of care. The direct hospital costs of preventable adverse events in Australia in 1992 were estimated to be nearly $900 million per annum. Moreover, people are now more consumer oriented; they are less deferential to and expect greater accountability from professionals. High quality appropriate care should be a right for every person who comes in contact with the health system. Today, the public is more likely to question the ability of the health system to meet these modern challenges.
GHR believes that the health system can meet these challenges and overcome them, but it must be prepared to change and focus on the things that really matter to patients.

Variations in quality have complex causes but arise from three main factors in South Australia:

- With separately incorporated health units typically in competition with one another, there are minimal incentives to share best practice.
- There have been no clear health outcome and health system performance indicators that all health services are expected to achieve or contribute to achieving.
- The South Australian public health system has not been sufficiently open and accountable about the quality of the services it offers to the public.

Variation in care is wasteful and unfair. The cost to individual patients, let alone the taxpayer, is unacceptable. Patients suffer if resources are not used to best effect, just as they suffer if quality standards vary.

**Consumer and community participation**

In addition providing information to the community and being accountability for health expenditure there is also a need to actively engage consumers and community through participation processes. GHR recognises the importance of community participation in health and health care in improving health outcomes, and maintaining high quality and effective health services.

Providing opportunities for consumers to be involved in a positive way with the health system, not just as receivers of services but also as partners, can have a positive impact on health outcomes. Logically, it follows that at the broader level, community participation can be useful as a health promotion, prevention and early intervention technique. It is also one of the foundations on which a primary health care focused system is built.

Issues of miscommunication in the provision of health services to Aboriginal people are significant and can result in poorer health outcomes. It is critical that the health services provided adequately meet the needs of the person. If their needs are not met people may not care for and manage their health care needs because they don’t understand the directions they have been given or they don’t access a service at all.

The provision of culturally appropriate and aware services is important and can only be done if services enter into partnerships with those for whom it provides services. There is a range of other population groups for whom issues of access, culturally appropriate services and communication also apply. These include people from culturally and linguistically diverse backgrounds, children and young people, older persons, people with a physical disability, and people with a mental health issue.

Participation is important for quality of life, health and wellbeing, and is an important mechanism for service improvement and quality and safety. In all businesses, talking to one’s customers is one of the basic principles of operation. It is no different for health.

**Mechanisms for community engagement in priority setting**

There are numerous examples of community engagement in priority setting both nationally and internationally. Examples come from NSW regional work on community priority setting; and from Oregon (USA), Canada and England.
A range of mechanisms can be used including:

- deliberative polling
- community values identification, for example the Canadian model of the citizen’s dialogue
- citizen juries
- hypotheticals
- community involvement in the development of appropriate performance indicators for the health system
- development of quality of life indicators at a community level — to help develop accountability for whole-of-government action on health inequalities (see Chapter 6).

GHR supports the establishment of strategies that provide opportunities for community and consumer participation in the development and implementation of such reforms.

Community engagement in priority setting at the statewide level will need to be an ongoing process of development and there may be a variety of pathways explored over time. Commitment to the process of engagement is key. GHR believes deliberative polling can provide an ideal tool to begin such an approach. The finite resources of health care require choices to be made. Engaging the public in a process that focuses on this issue will assist with developing an understanding of the need for hard choices to be made. It may be possible to use some case studies such as the duplication of clinical services as a vehicle for teasing out debates on health investment choices.

GHR proposes a way forward which involves a partnership between levels of government, DHS, regional health boards, the clinical professions and the community. The responsibilities of each partner must be clear.

**Health system performance monitoring**

A transparent system of performance management will ensure the public of South Australia is able to access useful information to assess the performance of the health care system, particularly the safety of health care provided by health services.

DHS does not have a comprehensive performance management system for its health services. The development of the National Health Performance Framework provides an excellent opportunity to establish a system that can meet the needs of consumers, community and health services. It would facilitate the mapping of progress for the population of a region or service. It could also be used to examine progress in tackling a particular health problem, and to take a wider look at the interface between health and other government departments, the private sector and non-government organisations.

Monitoring performance against set standards and indicators does not provide sufficient transparency nor does it automatically foster trust within the system. Therefore GHR recommends an appropriate degree of independence between the bodies responsible for governing South Australian health care services and responsibility for strategic performance monitoring. It is envisaged that a small independent body could be established to oversee implementation of the recommendations of GHR. This body would have a role as independent monitor of performance across the sector. It would also have a role for ensuring a synchronicity between performance measures and community expectations.
This body would be responsible for ensuring the community has access to public information on the safety and quality of the health system. It is important that this body is independent from the delivery of services. GHR believes that it is a classic governance failure to have those responsible for service delivery also being responsible for monitoring performance. There is an inherent conflict of interest between these two roles.

There are several options that could be considered to establish such a body including the development of new legislation or using the existing SAHC Act.

**Clinical governance**
Clinical governance represents an organisation-wide strategy for improving quality within the South Australian health system.

The clinical governance of health care delivery is the responsibility of the service delivery agencies, enacted through individual, unit, local and agency-wide measures to ensure the quality and effectiveness of clinical services. Effective clinical governance requires the bringing together of clinical and managerial approaches and effort.

Long-term success will depend on effective leadership and support services, on protected time to get involved and on effective teamwork among the different professions and organisations. Each health care agency should have in place a high-level collaborative group with the responsibility for advising the regional chief executive on clinical standards and clinical governance.

A statewide framework is required to support clinical governance throughout the health system. This framework should provide overarching benchmarks, standards and quality targets for the system, as well as providing a mechanism through which statewide clinical planning for clinical services can be addressed.

To facilitate involvement in planning, provision and monitoring of clinical services across the state, GHR recommends that a clinical senate be established at the statewide level. Clinical governance bodies should also be established in each region.

The current activities of the DHS South Australian Hospitals Quality and Safety Council will need to be subsumed into the new monitoring body, clinical senate, and regional and local clinical governance.

**Community councils**
GHR heard claims that health unit boards represent the community. Health unit boards are made up of community members but that does not mean they represent the community nor is the focus of their activity around the broader social health needs of communities. The role of health unit boards is to provide governance for the particular facility they oversee. Boards are required to focus on issues of governance and management to ensure the facility is duly and appropriately governed, funds are appropriately expended and accounted for, activities are lawful, and efficient and effective health services are provided. Furthermore, current legislation governing the establishment of hospital boards does not provide any specificity about community representation on boards.

With the proposed establishment of regional governance structures, which removes the need for health unit boards, GHR considers that a formal mechanism for community input at the regional level is critical. This is in addition to the regional governance structure. South Australia’s previous experience with health and social welfare councils and other structures involving community members has led GHR to believe the establishment of these councils requires legislative protection.
In addition to community councils in all regions it is also proposed that a statewide community council be established to provide for community input at this level.

GHR is proposing that an explicit commitment to the principles of community and consumer participation be made within legislation. This will require health services and regions to report on the implementation of processes and practices that actively involve the community and consumers in health. The activity would be additional to the formal council structures proposed.

This structure will provide community members and consumers with three levels of input into the health system, at the local level through their health units and services, community and consumer participation processes, through the regional community council and through the state community council.

**Accountability and transparency framework**
The above elements linked together provide the accountability and transparency framework. This is illustrated in Figure 3.

This figure also includes proposed accountability arrangements for Aboriginal health taking into account the reform agenda and governance developments specific to Aboriginal services and the need to ensure they work in partnership with proposed mainstream arrangements. This reform agenda focuses on, inter alia, strengthening the shift to personal and community empowerment and the right of Aboriginal communities to take responsibility for their own affairs at a time and pace suitable for them.

GHR has made a number of specific recommendations on Aboriginal governance given the totally unacceptable health status of Aboriginal health compared to the general population.

**Framework for community participation**
Taking participation into the future requires a change strategy that will embed participation into all aspects of the health system, including planning, service delivery and evaluation. The establishment of public reporting on health system performance and community councils are actions that signal system reform. However, in order to deliver a system that is based on community and consumer involvement further action to address culture change across the health system is required.

The proposed framework for community participation is made up of the following key action areas: legislation, leadership, public information and education, workforce development, incentives, accountability, and services and programs.
Figure 3. Governance, accountability and performance management framework
CHAPTER 5: WORKFORCE DEVELOPMENT

The future of work

There is a wide spectrum of views on the way people may work in the future, including issues such as job security, attachment to the workplace, locus of work and increased leisure time. In addition there are potential changes in technology that could significantly alter the world of work.

The major quantitative trends or changes in the workplace that seem likely to affect the future world of work include:

- feminisation of work in the western world
- ageing, more educated workforce in the western world
- decline of manufacturing production jobs in the western world
- increased employment in health and personal care.

The future for health care workers

The future for health care workers is largely dependent upon the way in which health care is delivered over the next decade. This will affect numbers, roles, where people are employed and training requirements.

Shaping the future of work roles does not have to be limited to health professionals. A future ‘trained care assistant’, for example, could undertake a wide range of work including direct client care that in today’s terms would be described as nursing work. This would relieve some system pressure currently experienced by nurses who have high workloads and rapid turn over.

The South Australian health workforce

The health service is one of the largest employers in the public sector. Employees are spread across a large number of organisations, in differing settings and locations. The demands on these people are significant, with ever-increasing services, changing demographics, new treatments and a need to stay continually up-to-date with skills. Many services are delivered 24 hours a day, 365 days a year.

The key issues facing the health workforce are:

- changing service demands, including technological innovations
- ad hoc workforce planning
- workforce culture and stressors
• pervasive distrust
• lack of critical mass
• restrictive work practices and limited career opportunities
• difficulty in retaining skilled staff.

**Workplace culture**
GHR believes there needs to be a major shift in health workplace culture to meet changing demands now and into the future. Such a shift is critical in embracing change and moving forward. In particular there needs to be a focus on the following strategies:

• a healthy workforce
• positive identity and culture of innovation
• stewardship
• trust
• shared leadership
• shared responsibility.

**Workforce planning**
Workforce planning would be assisted by the introduction of a population policy for South Australia. This would ensure that in the future South Australia had an appropriate population demography to assist in developing the health workforce. GHR supports the South Australian Economic Development Board’s recommendations on this issue.26

**Predicting the future**
Health workforce planning must be integrated into overall health system design issues.27 Planning should be done from a population base and on the basis of health care team requirements for regions.

In order to avoid, as much as is possible, inaccuracies in predicting future workforce requirements, the methodology of backcasting should be adopted. Backcasting scenarios reason from a desired future situation and offer a number of different strategies to reach this situation. It assists in outlining migration paths to the future. The ‘future health workforce’ must incorporate multiple futures because the future is not easily predicted and there are many possible pathways. The migration or developmental path can assist in effectively planning for the future.28 It may avoid the mistakes made by previous predictions or models for the future.

**Coordination of information**
GHR was informed that there is no overarching health workforce planning in South Australia, therefore workforce discussions become circular and are never really satisfactorily resolved. A change in thinking is required otherwise ad hoc disparate reports will continue to sit on shelves. In addition competition for staff undermines attempts to coordinate planning. For example, each region, town or suburb within a region has a set of unique needs. These needs will not be addressed if individual stakeholders continue to compete for limited resources and conduct recruitment and planning in isolation.

Links are required across the different sectors, communities, regions and DHS, in order to create a comprehensive approach to workforce planning where accountability for planning is defined. This change in thinking requires a change agent or leader/champion. The health sector, like other businesses, requires change agents to effect significant improvements. The DHS has undertaken significant work around nursing workforce planning and recently made significant inroads into medical
workforce planning. This is due mainly to individual effort and a systematic approach is still required to effect any real change.

The creation of a statewide health workforce planning group to provide focus and expertise for health workforce planning is recommended. There are intellectual, financial and political resources required to change the current focus from ad hoc planning to coordinated planning. This will require a new structure, preferably a planning body within DHS.

**New ways of working**

**Roles**

Clarity about service, skills and staff needs and requirements is necessary to ensure the delivery of effective and efficient services. The South Australian workforce needs to be transformed in order to meet future care needs. Current workforce planning and development arrangements inhibit multi-professional planning and do not support creative use of staff skills.

New ways of working in health care in the future will have an emphasis on:

- **team working** across professional and organisational boundaries
- **flexible working** to make the best use of the range of skills and knowledge which staff have
- **streamlined workforce planning and development** stemming from the needs of patients not of professionals
- **maximising the contribution of all staff to patient care**, doing away with barriers which say only doctors or nurses can provide particular types of care
- **modernising education and training** to ensure that staff are equipped with the skills they need to work in a complex, changing health system
- **developing new, more flexible, careers** for staff of all professions
- **expanding the workforce** to meet future demands
- **deploying staff more flexibly** to maximise the use of their skills and abilities.

**Education and training**

The higher education sector and vocational education and training (VET) sector are separate and different educational areas. Education provides a broad theoretical and conceptual framework that encourages and requires critical analysis. The focus of education is general preparation for a future role. Training has a focus on the skills and knowledge necessary to perform a job that exists now.

The distinctions are reinforced by the Commonwealth–state split of funding and program responsibilities, the variation in funding systems, and definitions of output and industrial relations. VET is better equipped to provide shorter vocationally specific courses and retraining programs. Universities in contrast specialise in more extended vocational programs and carry out research. A strengthened VET sector could have the potential to free up universities from the pressure to be more vocational which appears to be undermining its quality and depth.

In terms of determining curriculum, the South Australian Government must have more influence. The mechanism could be provided by the proposed statewide health workforce planning group. Working collaboratively with universities this group can ensure training and education institutions in the state meet future health workforce needs.
Increased cooperation and collaboration between South Australia’s three clinical schools is desirable. The schools must work towards fostering and supporting a mechanism for a coordinated and strategic approach. This would ensure collaboration rather than competition for scarce resources. DHS offers financial support for some university positions. More cross-faculty responsibility or joint appointments are required. An increase in this type of collaboration would enhance the leadership of clinical networks.

**Rural and remote workforce**

Rural and remote communities must have an appropriate mix of skilled health care providers to enable health care needs to be met. Rural and remote areas have an ageing workforce, particularly within the nursing and medical professions. Workers experience professional isolation and lack of access to peer support, poor access to ongoing education and postgraduate studies, limited career opportunities and lack of career paths, lack of relief or locum staff and high levels of part-time employment. All this adds pressure to families and impacts on the health and wellbeing of practitioners.

There has been an emphasis on attracting rural people to gain qualifications in the health field on the premise that upon completion they are more likely to return to work in rural localities. However, the changing age structure of rural communities means that over time there will be fewer young people entering the workforce. As a consequence, more mature age groups need to be attracted to these areas.

The introduction of generic rural health practitioners may assist in addressing some of the problems experienced by rural and remote health workers. The employment of these generic rural health practitioners will decrease the load on general practitioners in rural and remote communities by providing them with professional assistance and taking a caseload where necessary. It is hoped that, among a number of other positive outcomes, generic rural health practitioners will be able to enhance the efficient delivery of health care to Australians living in rural and remote areas.

**Aboriginal health workers**

Aboriginal health worker positions are often marginalised and there is no flexibility to allow for career progression and transfer between streams of learning. An example is enabling Aboriginal health workers to apply for nursing or administrative health positions. The skills of Aboriginal health workers are often unrecognised and poorly remunerated and there are wage disparities between Aboriginal health workers and other health professionals such as nurses.

The role of the Aboriginal health worker has been poorly developed and there is a significant need for more male Aboriginal health workers.

Aboriginal health workforce training in South Australia is funded on an annual basis in April each year. In other states the Aboriginal health workers training is funded over three to five years. Annual funding is contributing to low retention rates for students and teachers.

**Aboriginal nurses**

A report of the Indigenous Nursing Education Working Group advocates a national approach to the development, implementation and evaluation of recruitment, retention and curriculum strategies to increase the number of Indigenous graduates from mainstream nursing programs, and to raise the capacity of all nurses to provide culturally safe care to Indigenous people.

Studies that have researched why there are so few Aboriginal registered nurses and midwives have identified a number of barriers to the success of Aboriginal students of nursing. Some of these barriers
include negative and sometimes derogatory attitudes of university staff and health workers, and pressure to perform due to fear of disappointing those who had been supportive and fear of reinforcing other people’s expectations that they would fail. These barriers require addressing in order to ensure that more Aboriginal people undertake nursing education and graduate.

**Industrial environment**

The structure of the workforce is hierarchical and rigid. Compliance and rules are paramount. Sound industrial relations policies are essential to assist the workforce to become more relevant to patient needs and improve job opportunities and work satisfaction. New ways must be found to open up new career opportunities for many health workers. Unless this is done, particularly for nurses, the long-term shortage of skilled workers will continue to worsen.

The traditional ethos and values of the workforce have been severely challenged by an approach to public administration that emphasises those aspects of work and performance that can be reduced to contractual terms. At the same time, significant improvements in productivity have been achieved and many traditional work practices that had become irrelevant or unproductive have also been changed. The challenge is to balance the best of the old ethos and commitment to service on the one hand, with the best of the new practices and accountabilities on the other. GHR believes that there is now an opportunity to implement innovative solutions that will serve staff and the community.

Innovative ways of using rewards and incentives should be developed to ensure that the numbers and quality of staff required for the public health system are met. For example in Israel, medical students and residents in understaffed specialities in the future may receive financial incentives and public sector doctors’ wages may be significantly increased. This is in order to ensure that in the future the public system in Israel is one that can meet the needs of its population. Government and employers clearly need to provide the right incentives to reform the system, and they need to be able to create the right environment to promote workforce flexibility.

There is a clear need to increase joint decision making between management and employees. Employers could develop schemes for consulting employees about issues such as technological change, contracting out and the introduction of new work methods.

**Process re-engineering**

The encouragement of a process re-engineering approach to health may assist greatly in changing the structural inefficiencies that GHR has observed. Process mapping and re-engineering has been used very little in health and would be useful in the development of locally based strategies to assist the workforce to become more relevant to patient needs. The reasons for taking this approach include poor financial performance, competition for resources and emerging market opportunities. Process re-engineering is not about downsizing or restructuring organisations. It could, however, assist in improving health system performance and workforce planning.

The notion of partnership at work is gaining momentum overseas. It seeks to enhance consultation, cooperation and trust between employees and employers. This could include the establishment of elected committees of employees consulted by management on key workplace decisions. These committees are designed to improve workers’ rights in the areas of information, consultation and participation.

Through a proactive plan that is well costed, industrial relations should be addressed principally at the system and local levels. In pursuing these types of strategies, there will need to be appropriately skilled and experienced people to implement the changes.
CHAPTER 6: HEALTH INEQUALITIES AND HEALTH AS A HUMAN RIGHT

**Health inequalities**

It is not possible to talk about reforming the health system without exploring the antecedents to disease, illness and injury. It is necessary to explore the social determinants of health (social, economic and physical environments) that give rise to poor health, disease, illness and injury. In order to do this, it is necessary for other portfolio areas to be involved in cooperative action. Such action will not only improve the health outcomes of South Australians but also improve the overall quality of life for people in this state.

The impact of social determinants on health and wellbeing outcomes for population groups cannot be ignored. The health portfolio alone cannot address health inequalities in South Australia. While health services play a significant role in promoting and maintaining health, preventing illness and treating the unwell, there is much that can be done to improve the quality of life and wellbeing of individuals and families by other portfolios.

Whole-of-government action is required. The policies of other government portfolios such as justice, transport, education, employment, housing, welfare and others impact on population health and wellbeing outcomes.

The work of Sir Douglas Black and the more recent works of Acheson, and Wilkinson and Marmot have been used in the UK to inform a whole-of-government approach to health inequalities that recognises the importance of all arms of government in developing and sustaining healthy communities.

**Health as a human right**

The enjoyment of the highest attainable standard of health is a fundamental right of everyone. This should occur without distinction of race, religion, political belief, economic or social condition.

Overall, Australia demonstrates a positive human rights record at the domestic level and has been an active promoter of human rights internationally. Australians experience human rights protections similar to any other nation, if not better than most.

Nonetheless, Australia, as for all other countries, does not have a perfect human rights record and ongoing work is required to guard against human rights abuses. The right to health is not equitably distributed. GHR has identified several population groups and particular health areas where the right to health requires specific effort.
These include:

- early childhood
- Aboriginal people
- homeless people
- prisoners and offenders
- people with mental health issues
- new arrivals.

All need to be considered within a whole-of-government approach.
RECOMMENDATIONS

Chapter 2: A population health approach

2.1 DHS establish a regional configuration of six rural and remote regions and three metropolitan regions as defined in Appendix 4.

2.2 DHS review the regional configuration after 12 months of operation, along with governance and funding functions, to address issues relating to marginal adjustments to regional boundaries.

2.3 DHS establish unified regional boundaries for the human services portfolio, including housing, health and community support services within 12 months.

2.4 DHS develop and implement a population health funding model to inform funding at the regional level, commencing with acute inpatient services and progressing to a comprehensive approach in line with the key output classes of the health system.

2.5 DHS establish a technical reference group of members with clinical, health administration and academic backgrounds to advise on issues relating to the development and ongoing refinement of the population health funding model.

2.6 DHS continue with the development of the population service planning model (including incorporation of community service requirements) in alignment with the regional funding targets set under the population funding model, and use it to inform capital development plans.

2.7 DHS develop a comprehensive output based funding model that takes into account recommendations on population health funding and planning of services at a regional level.

2.8 DHS invest in its capacity to develop and refine information and classification systems that will enable effective establishment of output based funding for community based services.

2.9 DHS commit to a multi-year health program budget cycle and work with the SA Department of Treasury and Finance to achieve greater certainty in capital funding over the longer term.

2.10 DHS commit to a multi-year health program budget cycle for Aboriginal health services as a priority.

2.11 The State Government ensure that regional health service board members will:
   (i) have the expertise and experience essential to the business of regional health services
   (ii) be paid an appropriate sitting fee
   (iii) be provided with an intensive induction and ongoing education program.
2.12 DHS develop the governance arrangements outlined in Chapter 2, which include:

(i) regional health services in each of the geographic regions
(ii) dissolution of separate incorporation of all hospitals, health services and regional health services currently incorporated under the SAHC Act, including statewide services
(iii) broad roles and responsibilities for the Minister for Health, DHS, regional health services and health units as defined
(iv) appropriate bodies to administer community resources in line with regional health service priorities
(v) regionalisation of all other incorporated and unincorporated services within three years, giving due regard to the specific nature of organisation service provision in each case
(vi) funding for all other incorporated and unincorporated services to be incorporated in the population health funding model and allocation targets set for each region.

2.13 DHS provide drafting instructions for new legislation to replace the SAHC Act and incorporate provision for the establishment of the new governance structures and processes.

Chapter 3: A primary health care focused system

3.1 DHS implement the Strategy for managing metropolitan hospital workload.

3.2 DHS establish an out of hours statewide health call centre, providing telephone triage and referral services, supplemented by advice on self-care and information about service availability.

3.3 The State Government initiate discussions with the Commonwealth Government for a joint Commonwealth–state commission to deliver shared governance and funding arrangements and provide mechanisms for collaborative planning.

3.4 DHS establish a public and environmental health division to enhance capacity to lead and coordinate public and environmental health across the state.

3.5 The State Government, through DHS, work with the Divisions of General Practice and the Commonwealth Government to develop strategies that enable general practitioners to be partners in networked primary care services, including primary care centres.

3.6 DHS work with the non-government sector and private allied health professionals to build sufficient capacity to enable their effective inclusion in a primary health care focused system.

3.7 DHS ensure that the proposed primary health care policy underpins and drives the recommended health system reform agenda.

3.8 DHS provide funding in the first year of reform to initiate the development of networked primary care services.
<table>
<thead>
<tr>
<th>Section</th>
<th>Task</th>
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<tr>
<td>3.9</td>
<td>DHS initiate discussions with the SA Department of Treasury and Finance to secure adequate parallel funding to maintain existing acute care services at current levels and to enable transition to the proposed primary health care focused system.</td>
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<td>3.10</td>
<td>DHS provide a planning framework and tools to assist regional health services develop service planning, including capital plans, that facilitate system transition.</td>
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<td>3.11</td>
<td>Regional health services develop a business case and implementation plan within the first year of reform, to further develop networked primary care services and centres, and establish integrated community care services and centres.</td>
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<tr>
<td>3.12</td>
<td>DHS review existing clinical service plans to ensure their alignment with the proposed reform agenda and implement a process for their ongoing development and review.</td>
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<tr>
<td>3.13</td>
<td>DHS establish networked clinical service groups, as appropriate, including a networked group for pathology services.</td>
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<tr>
<td>3.14</td>
<td>DHS continue with the development of the service delineation guidelines on advice from the clinical senate and the state community council.</td>
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<td>3.15</td>
<td>DHS review the existing statewide information technology plan and prioritise the resources required for statewide connectivity within five years.</td>
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<td>3.16</td>
<td>DHS develop a plan to enable the establishment of a single electronic health record for each patient.</td>
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<td>3.17</td>
<td>DHS implement a statewide capital investment plan to deliver the proposed health system reforms.</td>
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<td>3.18</td>
<td>The South Australian health and medical research advisory council develop a plan that identifies potential priority areas of excellence for research in South Australia and recommends an appropriate balance of investment across all areas of health research.</td>
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<td>3.19</td>
<td>The State Government, with DHS, facilitate the attraction of venture capital to support the translation of health research into practice and products.</td>
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<td>3.20</td>
<td>DHS develop a web-based research clearing house to improve access to available research resources and current research, and to facilitate collaboration.</td>
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<td>3.21</td>
<td>DHS provide appropriate incentives to maintain clinical research staff in South Australia.</td>
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<tr>
<td>3.22</td>
<td>DHS develop strategies to promote a culture of enquiry and innovation in the workplace and strategies that seek to give South Australia a competitive advantage within Australia and globally.</td>
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</table>
3.23 DHS fund and develop a process, in partnership with state, national and international thinkers and leaders, that promotes a focus on the future of health and health care, to inform policy and planning.

Chapter 4: Accountability and transparency

4.1 DHS implement and evaluate strategies that effectively involve the community in ongoing priority setting decisions of the health system, including the use of deliberative polling.

4.2 DHS establish appropriate community involvement strategies in the implementation of any major review, substantial system change or decision-making process around new priorities of significance at the statewide level.

4.3 DHS develop a comprehensive performance management approach to ensure achievement of key performance targets by regional health services.

4.4 The State Government establish a small independent body to oversee implementation of the proposed health system reform agenda and to provide ongoing monitoring and regular reporting to the public on health system performance.

4.5 Regional health services establish clinical governance processes to ensure effective advice on clinical services, and quality and safety issues.

4.6 DHS establish a statewide clinical senate to provide advice on clinical planning and the development of a statewide framework for quality and safety benchmarks and standards.

4.7 Each regional health service establish, on the commencement of the proposed reform process, a regional community council to provide a mechanism for community participation. The council's role and function will be incorporated in the proposed legislation.

4.8 DHS establish a statewide community council to provide a mechanism for community participation. The council's role and function will be incorporated in the proposed legislation.

4.9 The proposed health system legislation include a provision that commits the health system to the principle of community and consumer participation, with appropriate accountability.

4.10 DHS build leadership capacity within the health system and in the community to support community and consumer participation.

4.11 DHS encourage and support management at all levels in the health system, including central administration, to ensure workforce capacity in consumer and community participation, including skills in working with specific population groups.
4.12 DHS develop a strategy for coordinating ongoing public information and education across the health system.

4.13 DHS support the development of community capacity to provide independent consumer voices within the health system.

Chapter 5: Workforce development

5.1 DHS and health services provide management training and development to ensure effective leadership capacity and creative responses to change.

5.2 DHS establish a statewide health workforce planning group with responsibility for:
   (i) developing integrated information systems, including human resource systems, that will provide accurate workforce data and information
   (ii) developing a strategic planning process that employs appropriate evidence based methodologies and enables identification of future health workforce requirements
   (iii) ensuring integration of workforce, service and financial planning
   (iv) developing partnerships with universities, technical and further education, and other key stakeholders, to facilitate implementation of health workforce plans
   (v) developing a future clinical workforce that reduces demarcations, encourages teamwork, and enhances career opportunities and skills
   (vi) developing a marketing and recruitment capacity for the health system with resources contributed by major public and private employers
   (vii) developing an approach to regular staff satisfaction/climate surveys to be used by DHS and regional health services with the capacity for statewide benchmarking.

5.3 DHS develop a comprehensive strategy to attract mature age students from rural areas into health professional education.

5.4 The State Government, through DHS and all South Australian universities, approach the Commonwealth Government to seek approval and funding for the introduction of a postgraduate distance education program for generic rural health practitioners.

5.5 DHS provide a focus on the development of the Aboriginal health workforce by initially:
   (i) regulating and formally recognising the role of the Aboriginal health worker
   (ii) extending funding for Aboriginal health worker training from an annual cycle to a three-year cycle
   (iii) increasing the number of clinical placements for Aboriginal nurses
   (iv) funding statewide cultural awareness training on an ongoing basis to address racism faced by Aboriginal health staff.
5.6 The State Government negotiate enterprise bargaining agreements that are more sensitive to age, gender and the culture of the workforce, and provide greater capacity for use of innovative incentives in the workplace.

5.7 DHS reduce reliance on the casual workforce, particularly through greater certainty of ongoing funding.

5.8 DHS develop a capacity for process re-engineering within health care agencies to ensure patient care outcomes and system performance are improved.

Chapter 6: Health inequalities and health as a human right.

6.1 The State Government give consideration to the establishment of a Cabinet committee to develop whole-of-government portfolio performance benchmarks to improve quality of life for South Australians and focus on populations with poor health status.

6.2 The State Government provide regular and public reporting on progress against whole-of-government benchmarks.

6.3 The State Government, through the proposed Cabinet committee, develop a whole-of-government strategic plan to provide a coordinated approach to early childhood health and wellbeing.

6.4 The State Government, through the proposed Cabinet committee, develop targets, in the context of a whole-of-government strategic plan for Aboriginal people, to address quality of life, commencing with the health and wellbeing of Aboriginal infants and children. This recommendation should be a first priority for a whole-of-government approach.

6.5 The State Government review its level of investment in programs addressing improvements in the quality of life for Aboriginal people and establish mechanisms to ensure efficient and effective use of resources in line with the whole-of-government strategic plan for Aboriginal people.

6.6 DHS in partnership with Aboriginal health advisory committees:
   (i) ensure there are no changes to rural and remote Aboriginal health advisory committees unless requested by relevant communities
   (ii) establish Aboriginal health advisory committees aligned with metropolitan regions
   (iii) ensure the recommended legislation incorporates the protection and validation of Aboriginal health advisory committees.

6.7 Regional health services provide adequate funding support for Aboriginal health advisory committees, including appropriate sitting fees for Aboriginal health advisory committee meetings.
6.8 Regional health services work in partnership with Aboriginal communities to ensure effective representation of the communities and their interests on regional health boards.

6.9 DHS revise its program structure to establish a program category for Aboriginal health that combines specific Aboriginal health service and Aboriginal mainstream service funding.

6.10 Aboriginal health advisory committees, in partnership with regional health services, develop performance agreements that address detailed service improvement plans, including a focus on mainstream service access for Aboriginal people and ensuring adequate funding for the unique issues and needs of Aboriginal people.

6.11 DHS explore governance options in partnership with Pika Wiya Aboriginal Health Service and Ceduna Koonibba Aboriginal Health Service.

6.12 DHS consider extending the same support services provided to Aboriginal health services incorporated under the SAHC Act to Aboriginal health services incorporated under other legislation.

6.13 DHS convert the existing SA Prison Health Service into a community based primary care service with an expanded role to support prisoners and offenders released from custody. A detailed business plan should be developed, including additional resource requirements for the expanded role.

6.14 DHS develop a community model of health service provision to deliver health care to the homeless in partnership with other government and non-government organisations.

6.15 The State Government, as a priority, fund DHS to implement the ongoing mental health reform agenda, including provision of parallel capacity, a capital and service development plan, legislation, workforce, improved service system coordination, community mental health reform, and community consultation and communication.

6.16 DHS develop a new arrivals policy, in the context of a primary health care framework, to address coordination of health and human services and access and equity in the provision of mainstream services, particularly for refugees.

**Chapter 7: Change management and implementation**

7.1 DHS consider the preferred priority recommendations and related performance targets when developing its implementation plan.
FOOTNOTES

1. Bright CH, Report of the Committee of Inquiry into Health Services in South Australia, Government Printer, South Australia, 1973


3. ABS Population Projections Australia, 1999 to 2051, 3222.0, Table 2A, Series II(a) 2000

4. Aboriginal groups consulted by the GHR preferred the use of the term ‘Aboriginal’ over ‘Indigenous’.


6. Social determinants of health refer to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action. Examples are income, education, occupation, family structure, service availability, sanitation, exposure to hazards, social support, racial discrimination, and access to resources linked to health.

7. DHS has embarked on a capital development plan for The Queen Elizabeth Hospital (TQEH) and the Lyell McEwin Health Service (LMHS) (with Cabinet approval in 2001) based on the alteration to patient flows between TQEH, LMHS, Royal Adelaide Hospital and the Women’s and Children’s Hospital included in this model.


10. The Ottawa Charter 1986 www.who.int/

11. The Jakarta Declaration 1997 www.who.int/

12. See www.who.int/


15. WHO, Genomics and World Health; April 2002 www3.who.int/whosis/genomics/pdf/genomics05.pdf


18. Cromwell D, Halsall J, Viney R and Hindle D, Ilawarregon: Development of a model to assist priority setting by an area health service, Centre for Health Service Development, University of Wollongong NSW, 1995


21. See Patients’ Voice www.nhs.uk


23. The Citizens Dialogue on the Future of Health Care in Canada project is just one element of the Canadian Commission’s larger consultation and engagement strategy. The full report of the Citizens Dialogue is posted on the commission website at www.healthcarecommission.ca


25. As at June 2002 there were 28,270 persons employed in health and community services, second only in SA to the education sector (South Australian Office for the Commissioner of Public Employment).

26. SA Economic Development Board, The state of the state: Key issues facing South Australia, population export capability, 2002

27. Response 77 to the GHR Discussion Paper October 2002


29. www.doh.gov.uk/hrinthenhs/workdev.htm


31. op cit Marginson S, p.15

33 GHR consultation meetings November 2002

34 Indigenous Nursing Education Working Group Getting em n keeping em Report to the Commonwealth Department of Health and Ageing Office for Aboriginal and Torres Strait Island Health, September 2002

35 ibid Goold 1995


37 See www.plutoaustralia.com/news/


39 Acheson D (chair), Independent Inquiry into Inequalities in Health Report Department of Health, United Kingdom 1998

40 Wilkinson R and Marmot M (Eds), The solid facts: social determinants of health WHO 1998

41 WHO www.who.int/archives/who50/en/human.htm