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It presented a rare opportunity to heal the context of local, national and global responses.

... roles and responsibilities for as shown in Figure 1.

---


The Jakarta Declaration 1997 [www.who.int/](http://www.who.int/)

See [www.who.int/](http://www.who.int/)

Victorian Department of Human Services, Hospital demand management.
The Hon Lea Stevens, MP
Minister for Health
GPO Box 2000
ADELAIDE SA 5001

Dear Minister

It is with pleasure that I submit to you the Generational Health Review’s report on South Australia’s public health system.

The report provides the framework to meet the health needs of South Australians today and into the next generation.

Significant systemic reform is recommended.

I am confident that implementation of the Report’s recommendations will continue to improve the health status of all South Australian and ensure a safe, efficient and effective health care system into the future.

I wish you success in the report’s implementation.


JOHN MENADUE AO
CHAIR
GENERATIONAL HEALTH REVIEW

April 2003
The Government appointed this review because it correctly recognised the need for change in Health in South Australia. What I have seen and heard over the last nine months across the state has convinced me that the case for change is even stronger than I expected, or perhaps even more than the government anticipated.

In chairing this review, several impressions or events stood out.

The first was the scepticism we encountered that ours might be just another review that went the same way as others over the past 30 years — nowhere — because vested interests and ‘playing politics’ with health beat back necessary changes. Health is so political. That is why we have actively promoted public understanding and support for changes in this review. We have tried to make it an open and inclusive process. Change can only be achieved if there is a broad constituency of support. That constituency carries with it a moral authority. This report offers not only the potential for a long-term sustainable health service but also, perhaps even more importantly, it can enhance public confidence in open and inclusive public processes.

What has to be done is pretty clear. There are really few surprises in this report. Not just in South Australia, but in other states and overseas, the importance of primary care being the foundation of a strong health service is widely accepted. Health takes 24% of the state budget. Getting efficiency and equity in health is important, not only for the health of South Australians but also for the state’s economic future, as is well set out in its Economic Plan. It is clearly unsustainable for South Australia, with 12% lower per capita incomes than the rest of Australia, to spend 4% more on health with no discernibly better health outcomes.

The great strength of the South Australian health system is the dedication of thousands of very professional people. The other side of that coin, however, is that many of the people have worked in the health system all their lives and are reluctant to change. They know no other system. That is why the workforce is compartmentalised in training and operations, and why restrictive work practices, demarcation and denial of career opportunities, particularly for nurses, abound. Building in new people, new ideas, new attitudes, particularly in implementation and change management, is essential.

The second striking impression I gained was the implicit view in some quarters that SA has unlimited health dollars. So we have continual pressure and demands on the system for better equipment, more drugs, more beds and more surgery. These pressures and services are all defensible and probably beneficial on their own merits, but they can be and often are at the expense of Aboriginal health, mental health and early intervention to help children who are the subject of abuse. These are the areas that the community gives priority to — if and when it is consulted. Even if the government doubled the numbers of hospital beds they would quickly be filled, with further demands for new beds. Hospitals are like the family refrigerator — they will always be full, regardless of whether the refrigerator is large or small. Priorities have to be set and choices made. So often, at present, the powerful in the health service pre-empt the dollars.
We all have different views and values on where priorities should lie. What we need is transparency and real community participation that has all interests and views represented at the table when health dollars are allocated. We can’t have all we want in health or in education or in transport. Governments need to persuade the community to this view. It should not be hard, for we know that the health budget is like the family budget — with limited incomes, choices have to be made. If governments ignore this critical issue, they will always be on the defensive over every new demand. It is also unreasonable for hard-pressed and dedicated staff to be subject to unrelenting demands and pressures, when the real problem is a lack of frankness as to what the health system can reasonably be expected to provide.

Australians are great hospital users, about 50% above Canadian rates and 30% above USA rates. South Australia is even more hospital-centric with hospital utilisation 15% above the national average. South Australia spends 67% of its health budget on hospitals. Many patients could be better treated outside hospitals — those with chronic illness, the mentally ill, and the aged — if the services were available. The autonomy and dignity of patients is best secured when they are treated in the home or as close to their home as possible. That is where our report clearly points — to primary care in the community.

Thirdly, we were consistently reminded of poor ‘governance’, with over 70 statutory hospital and health unit boards in SA looking after their own territory. That is what the legislation says they should do. They are expected to manage and promote their own services, often at the expense of an integrated health service. Governance is a ‘crunch’ issue where, in my view, good public policy and sectional interests collide. It results in duplication and fragmentation of care. Many clinicians also told us that the present governance arrangements result in serious concerns about quality and standards.

With good governance and funding distributed on a population basis, we will be in a strong position to remove wasteful duplication and make better decisions about the whole spectrum of health care — how much of our health dollar should go to hospitals and how much to primary care, mental health, Aboriginal health and family health. Otherwise primary care and public health will remain the poor relation. We will keep buying expensive ambulances for the bottom of the cliff when we should be building stronger handrails at the top.

But good regional governance structures alone will not be sufficient. There will also need to be wise decisions about the people governments appoint to regional boards and the respective responsibilities and accountabilities not only of boards, but ministers and CEs.

Fourthly, it became clear to me that present governance arrangements are a real barrier to effective community participation. Many boards represent the interests of the people within the health unit — but not necessarily the community. Yet community participation is essential so that good choices are made at state, community and personal level. Fewer boards must be associated with greater community participation. Relevant information must be shared and processes established so that the community can really participate in decisions — whether more health dollars should be spent on equipment or early intervention to protect children; or more surgery at the expense of the transport of Aborigines to a health unit; or keeping an obstetrics unit open in an area of declining population at the expense of care for the aged. We are proposing a substantial improvement in community participation in the health system. Every service or business needs to be continually called back to its main purpose — in the case of South Australia’s public health service, it is surely to serve the health needs of the whole population rather than the medicalised and institutional focus it presently has.
Finally, the most searing part of my work in this review was meeting with Aboriginal people. An Aboriginal woman elder said to me that ‘in talking to our young people about health, they say to me, “what is the point of being healthy”’. I will never forget that. Their prospects are so bleak and their self-esteem so low. Spirits need binding as much as bodies.

We have a national emergency in Aboriginal health. If all Australians had the same health status as Aboriginal people we would rank 140 in the world, alongside Bangladesh. It is a disgraceful story. I don’t think it is because most people don’t care. I think it is because we don’t know what to do. We must not lose heart and hope. It is in that spirit that we recommend the State Government review the level of investment in programs addressing the quality of life of Aboriginal people and changes in the way services are delivered, with greater emphasis on community, kinship, family and social connectedness.

But many social and economic factors have a major impact on Aboriginal health. Poverty and lack of hope are the major barriers. Aboriginal health does not depend mainly on medical services, but on jobs, education, transport, clean water and social connectedness. That is why a whole-of-government approach is essential, as we propose.

Aboriginal people have suffered over two centuries of dispossession and discrimination. That discrimination continues in the health services today. I saw it and heard about it. But no-one can avoid personal responsibility for his or her health. It cannot be any other way. Paternalism clearly does not work. So trust must be patiently nurtured and responsibility accepted by everyone in this national emergency.

It has been a pleasure working with members of the Generational Health Review Committee. Particular thanks are due to Professor Carol Gaston and her excellent and dedicated secretariat.

The job is only a quarter done. Reports don’t change anything. Implementation and change management is the real test.

JOHN MENADUE AO
CHAIR
GENERATIONAL HEALTH REVIEW

April 2003
**GENERATIONAL HEALTH REVIEW COMMITTEE**

**Chair**  
Mr John Menadue AO

**Members**  
Professor Carol Gaston

Mr Ernie Black (commenced October 2002), Chair, Mid North Region  
Aboriginal Health Advisory Committee

Ms Sue Crafter, Regional Director, Urban Pacific Ltd

Associate Professor Judith Dwyer, School of Public Health, LaTrobe University

Professor Stephen Leeder, Professor of Public Health and Community Medicine,  
Director, Australian Health Policy Institute, University of Sydney

Ms Sarah Macdonald (resigned September 2002), Executive Officer, Youth Affairs  
Council of South Australia

Professor Paddy Phillips, Head of Medicine, Flinders University of South Australia,  
Flinders Medical Centre and Repatriation General Hospital

Professor Dick Ruffin, Department of Medicine, The Queen Elizabeth Hospital  
Campus, The University of Adelaide

Professor David Wilkinson, Pro Vice-Chancellor and Vice President, University of  
South Australia

Dr Helena Williams, General Practitioner and Medical Director of the Adelaide  
Southern Division of General Practice

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Mr Gino DeGennaro, Deputy Under Treasurer

Mr Gerard MacDonald, Director, Policy Analysis, Department of Treasury  
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Ms Miriam Hunter  
Ms Monica Novick  
Ms Vaia Proios  
Ms Vicki Seaman (May 2002 – August 2002)

Administrative Officer  
Ms Donna Feltus (September 2002 – February 2003)
The aim of the Generational Review is to deliver a plan to the Minister for Health that provides effective strategies for health system reform, which ensures that all South Australians enjoy the best possible health and have access to high standards of health care.

The values and principles underpinning the Review include:

- an understanding of health and wellbeing, which includes a social health perspective;
- equity of access to health services;
- equality of health outcomes;
- a commitment to consultation in developing an understanding of issues and strategies for their resolution; and
- participation by communities and individuals in the consultative process.

The Review Committee is to undertake a Generational Review of the South Australian health system giving consideration to the history of the system. The Review Committee will articulate the Government’s vision for health. The Review is to take into account the Government’s ‘five key pillars’ that underpin its health and social agenda and the Government’s commitment to Social Inclusion.

The Review will provide a plan to take into account projections over the next twenty years (2003–2023). It is understood that shorter range planning horizons must be built into the process. This includes identifying strategic implications for budget preparation for 2003–2004, as well as three, five and ten year planning horizons which build into an indicative twenty-year planning horizon.

The Review Committee is to make specific recommendations on:

1. strategies to meet future demands and to determine the broad investments required to deliver health and well being for all South Australians;
2. strategies for an optimal health system with particular regard to service configuration, infrastructure, governance arrangements, legislative implications, planning processes, administration, management and reporting structures for health services;
3. mechanisms to ensure co-ordination and integration across the health system to:
   - strengthen and re-orient linkages towards prevention and primary health care;
   - integrate community and acute health services, particularly the interface between community services, general practice and acute services; and
   - improve the relationship between public health services, private hospitals and private day surgeries;
4. potential funding models that will enhance a focus towards prevention and primary health care delivery; regional funding mechanisms; improvements in efficiency and effectiveness of health care; including value for money and the better management of costs;
5. strategies to improve community participation in health care, including decision making;
6. strategies to facilitate whole government planning, service integration and social inclusion to promote health and wellbeing for all South Australians;

7. strategies to best develop non-government and private sector initiatives for cooperative planning, effective partnerships and integrated service delivery;

8. workforce requirements, professional qualifications and roles, teaching and training to meet future needs;

9. strategies to rebuild connections and capacity and create the climate and culture to deliver a reform agenda. This includes recommendations for planning, monitoring and advisory mechanisms to assist the Minister in sustaining the reform agenda over the long term.

In making recommendations as outlined above the Review Committee will have regard to and may make comment on:

- Commonwealth–state relationships, roles and agreements;

- the role, function and relationship with local government as it relates to health and wellbeing and the health system;

- the role, function and relationship with the private health sector (with particular reference to general practitioners);

- other government commitments including Health Action Zones and the establishment of a Health and Social Policy Council;

- strategies to improve safety and quality of health services as being developed or overseen by such bodies as the National Safety and Quality Council and the South Australian Safety and Quality Council and other relevant bodies

- the role of health and medical research in:
  — informing evidence based practice;
  — developing new initiatives to respond to population health issues and inequalities in health outcomes;
  — the development of individual treatments for health conditions; and
  — fundamental research and development.
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The people of South Australia have a decision to make on what type of health system they need now and for the future generation. A strong message was received from the community and service providers during the Generational Health Review's (GHR) consultations that there needs to be a significant shift from a system focused on illness to a health system reoriented towards health promotion, illness prevention and early intervention.

GHR’s proposed reforms have been developed to ensure that the future health system has the attributes necessary to do this.

The following indicates the consequences of maintaining the current system versus a commitment to implementing GHR’s proposed reform agenda.

From a service provider perspective, the following changes will be evident:

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Service providers would also see a balance between:

| Statewide conformity and consistency       | Local innovation                           |
| Economies of scale                         | Local responsiveness                       |
| Budget certainty                           | Budget flexibility                          |
| Statewide planning                         | Local planning                             |
| Acute hospital based care                  | Acute community based care                 |
| Competition                                | Cooperation                                |

From a community and consumer perspective, the future health care system will:

- deliver services as conveniently as possible to the person, predominantly in a primary care setting, in the home or an easily accessible local facility
- provide services with extended hours covering evenings and weekends
- offer a ‘seamless’ service focused on continuity of care, including service cooperation and coordination across the system
- deliver services that are accessible to all people, regardless of cultural and socioeconomic background
- promote and provide services designed to treat people in the community rather than in hospital, where appropriate
• provide for the needs of an ageing population, by support in the home, early intervention and improved recuperation, rehabilitation and respite facilities
• balance the need to centralise complex, expensive or rare treatments and procedures, with decentralisation made possible by information technology, telemedicine and community based care
• deliver high quality care through networked clinical services in local, regional and central settings.

GHR recognises the intentions and attempts made by the system to achieve system reform. However, this cannot be achieved without fundamental structural reform and government and health system commitment to it.

The implications are clear. System reform is essential.

The 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.

Despite this escalating pressure and demand, a professional, committed and passionate workforce staffs South Australia’s health services, with many people 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.

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

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 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.

Chapter One presents the case for change for the South Australian public health system. A wide range of factors impact on the health system. These include significant demographic, cultural, economic and social changes, and dramatic changes in health care delivery and technology. There is also increasing community awareness, with consumers expecting and believing they have the right to the best of the latest technology and treatments, despite the uncertain values of some of these interventions.

By world standards, Australia has a good health system. However, there are inequalities. The role of the social determinants of health\(^1\) are addressed in this context. The burden of disease has moved towards more chronic conditions. All of these factors cause pressure on the system and impact on the capacity of the system to maintain high quality, safe services.

A modelling exercise carried out by GHR to the year 2011 indicates that, if the proposed reforms are not implemented, the future scenario is bleak. There will be a continuing demand for additional investment in acute hospital services at the expense of primary care. Treatment of illness will remain the dominant focus rather than prevention and early intervention.
The South Australian health ‘system’ is fragmented and uncoordinated. This is exemplified by multiple planning processes, regional boundaries, project funding and governance arrangements.

The case for change provides a blunt message. System reform is the only way to ensure that the next generation of South Australians has a health system that meets its needs.

**Chapter Two** outlines how today’s governance arrangements in the South Australian public health system are enshrined in the South Australian Health Commission Act 1976 (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.

The current governance and funding arrangements of the system, which has over 70 separately incorporated health units, present a significant challenge to establishing a coordinated and reoriented system for the future.

A population health funding model is recommended, supported by a regional governance structure to promote population health, meet equity objectives and find ways to enhance service coordination and collaboration.

**Chapter Three** outlines the weaknesses in the current care delivery system. Apart from the fragmentation and lack of cohesion previously mentioned, the Commonwealth–state funding arrangements provide an additional impediment to establishing a seamless primary health care focused system.

The lack of information technology, telecommunications and appropriate community based resources has also retarded progress. A framework is provided to assist in overcoming some of these obstacles to achieving a primary health care focused system that has a commitment to disease prevention, health promotion and early intervention. Key attributes are explored, from consumer and system perspectives. System components and mechanisms for integration, partnerships and coordination are described.

Engagement with the Commonwealth and local governments is required to ensure coherence of planning, policy and funding directions to enable an integrated primary health care system to be provided. Enabling infrastructure, specifically for information technology, telecommunications, capital, research and health futures, is addressed.

**Chapter Four** puts the case that accountable and effective management of public resources is a fundamental responsibility and challenge for government. Accountability and transparency for the quality and safety of health services is a key aspect of health system performance. However, information is typically poorly disseminated and engagement of the community, consumers and clinicians in decision-making processes happens more by chance than by design.

A framework is provided that will deliver accountable and transparent governance of the health system, founded on the principles of community, consumer and clinician involvement. Mechanisms and structures are proposed to provide meaningful community involvement in decision making and strong clinical governance.
The need for a small independent health system performance monitoring body is identified to ensure the provision of public access to health system information. GHR recommends that this body should also oversee the implementation of the proposed reforms.

*Chapter Five* shows that 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. The demands on the health workforce 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 way in which work is performed in the health system has changed dramatically. The work is physically harder, workloads are heavier, work is more complex and population needs are more acute. There are insufficient community support services available, fewer informal care networks and less down time available for workers.

This section of the report addresses workplace pressures and demands, including morale, workforce culture changes, retention and recruitment issues, and the critical need for workforce strategic planning. Mechanisms are recommended to ensure consideration of future workforce practice and changing requirements.

*Chapter Six* addresses health inequalities and the concept of health as a human right. South Australia has excellent health outcomes by world standards. However, there are significant health inequalities for some population groups. Social, economic, and environmental elements must be considered and assessed in terms of their impact on health and wellbeing.

The health system alone cannot address health inequalities. While health services play a significant role in promoting and maintaining health, preventing illness and treating those who are unwell, there is much that can be done to improve the quality of life and wellbeing of individuals and families by other portfolios. A number of population groups requiring priority attention are identified. These include early childhood, Aboriginal people, homeless people, prisoners and offenders, people with mental health issues and new arrivals. All need to be considered within a whole-of-government approach.

*Chapter Seven* discusses the need for change management to lead the health reform process and provides direction on priority recommendations which start the process, address current service issues and impact positively on health inequalities. Guidance is provided on the sequencing and timing of recommendations and the main strategies for managing the change process. Consideration is also given to the impact of GHR’s proposed reform agenda on the SAHC Act. Significant legislative change is required.
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.

3.9 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.

3.10 DHS provide a planning framework and tools to assist regional health services develop service planning, including capital plans, that facilitate system transition.

3.11 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.

3.12 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.

3.13 DHS establish networked clinical service groups, as appropriate, including a networked group for pathology services.

3.14 DHS continue with the development of the service delineation guidelines on advice from the clinical senate and the state community council.

3.15 DHS review the existing statewide information technology plan and prioritise the resources required for statewide connectivity within five years.

3.16 DHS develop a plan to enable the establishment of a single electronic health record for each patient.

3.17 DHS implement a statewide capital investment plan to deliver the proposed health system reforms.

3.18 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.

3.19 The State Government, with DHS, facilitate the attraction of venture capital to support the translation of health research into practice and products.

3.20 DHS develop a web-based research clearing house to improve access to available research resources and current research, and to facilitate collaboration.

3.21 DHS provide appropriate incentives to maintain clinical research staff in South Australia.

3.22 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.
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.
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 deliver a plan to the Minister for Health that provided effective strategies for health system reform, ensuring that all South Australians enjoyed the best possible health and had access to high standards of care.

The principles and values underpinning GHR took 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 formed the basis for the structure of this report:

- promoting a population health approach
- promoting a primary health care focused system
- accountability and transparency
- workforce development
- health inequalities and health as a human right
- implementation and change management.

Review process

GHR has worked to a relatively short time frame, with the requirement to report to the government by the end of March 2003. The first meeting of GHR was held on the 29 May 2002 and regular monthly meetings, including several planning sessions, were held throughout the review process.

Given the breadth of the review and nature of the reform agenda, GHR established a transparent and inclusive process, covering both stakeholders and the community. It was vital that the stages and progress of GHR’s thinking, informed through consultations, was in the public arena. This was to ensure the final recommendations were practical and received broad support.

GHR produced two key documents in the lead up to this final report, a discussion paper released October 2002 and a progress report released February 2003.

The review process included the following strategies.
**Media and communications**

GHR established a comprehensive media and communications strategy that included the following elements:

- newsletters to provide regular progress reports
- a website which was regularly updated and developed during the course of the review
- a 1800 number and email contact point
- media liaison, including regular media releases, and conferences to maintain a strong public profile and promote public debate
- public speeches and regular briefing notes on key themes in the final report.

An extensive mailing list of community members and stakeholders was developed, and information was regularly disseminated through newsletters, briefing papers and reports.

**Task groups**

GHR involved over 100 people through the establishment of specific task groups (see Appendix 1) to address the key areas for reform of:

- governance and funding
- health care models (one group for development of GHR’s discussion paper and another to undertake a modelling exercise)
- community participation
- workforce and research
- information, telecommunications and capital.

Research on international and national directions on these topic areas was a key aspect of the work of the task groups. Reports from the task groups informed the development of GHR’s discussion paper and progress report.

A number of other working groups were established throughout the duration of the review to use the skills and knowledge of a variety of stakeholders.

**Submissions**

A public call for submissions was made in July 2002 through to the end of August 2002. More than 320 written submissions were received and placed on the website. In addition to the public call, interested people were able to provide input via the GHR website, the phone hotline or by writing directly to GHR.

A further 104 written comments were received following release of the discussion paper. GHR used these written comments to further develop its directions and thinking in the lead up to the progress report.

**Consultations**

A range of consultation processes were used throughout the review. These included meetings with different stakeholder groups, public consultations and discussions with particular groups and individuals, including people who contacted GHR directly.

One of the first consultative groups established by GHR involved regular meetings with a range of clinicians. Held on a monthly basis, these meetings provided an important opportunity for ongoing
dialogue, debate and discussion with the medical profession. Several meetings were also held with various groups of hospital registrars.

During November 2002, more than 60 consultation meetings were held across the State. These included public consultation forums, stakeholder forums, population focus groups, Department of Human Services (DHS) forums and Aboriginal community and advisory group consultations. Questionnaires were distributed at these meetings.

Eleven focus groups were held to undertake a more in-depth analysis of the questions and directions proposed in GHR’s discussion paper. Focus groups included six population specific groups (young people, multicultural, disability, older people, people with a chronic health condition and parents) and five groups comprising members with relevant expertise focused on key areas identified for reform.

Two round-tables were conducted in February 2003. The first focused on ageing and included participants from a range of services, organisations and professional groups associated with services for older people. This group explored the issues of healthy ageing and future service requirements. The second examined the issue of research, focusing on the kinds of information needs, enquiry and research approaches needed to underpin GHR’s service model recommendations.

Considerable time was invested in linking with key South Australian leaders and organisations for critical input and support.

During March 2003, four speeches were presented based on the key themes in the final report. Audiences included government officials and politicians, community members, business leaders, and government and non-government human service providers.

**Reports and working papers**

A number of papers, in addition to the GHR discussion paper and progress report, were released during the review. All reports and working papers were available on the GHR website.

The reports and working papers included:

- Garry Eckstein & Kathy Eagar, *Towards population based funding and governance of the South Australian Health System*, Centre for Health Service Development, University of Wollongong, November 2002
- Paul Laris & Associates, *Community health centres in South Australia: a brief history and literature review*, November 2002
- GHR, *A profile of South Australian Public Hospitals*, South Australia 2002
- GHR, *Our State of Health: demographics, health and human services profile*, South Australia 2002
- GHR, *Consultation Summary*, December 2002
FOOTNOTES

1 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.

SUCCESS STORY

A collaborative approach to primary care psychiatry

A joint mental health project between the Adelaide Northern Division of General Practice and the Lyell McEwin Health Service’s Mental Health Division has focused on exploring alternative ways to facilitate the identification and management of patients with mental illness. A priority of the project has been up-skilling general practitioners in psychiatric assessment and management skills. The project has also explored alternative types of psychiatrist/general practitioner interactions.

An evaluation of the project in 2002 demonstrated:

- a significant improvement in the reduction of anxiety and depression symptoms
- consistent management by the general practitioners of patients with very severe depressive and anxious symptoms
- a reduction in the number of patients requiring intensive support by the hospital.

This project highlights that a relatively simple, time limited, joint consultation of a patient by their general practitioner and a psychiatrist can have a positive outcome on the mental health status of patients.
CHAPTER 1: CASE FOR CHANGE

This is the first review of the entire South Australian public health system in 30 years. It presented a rare opportunity to review the health system within the context of local, national and global demographic, societal and technological change. The purpose of the Generational health Review (GHR) was to recommend a framework that would meet the needs of future generations and provide a template to guide policy and practice over the next 20–30 years.

The current system is under stress. Growing demand for services, staffing issues, workforce shortages, pressures on emergency departments, pressures on general practitioners and the community service sector, and lengthening waiting lists are just part of the picture. The media paints the pressure picture with headlines such as ‘another ward closing’, ‘more beds closing’, ‘hospitals under threat’, ‘staff under threat’. The picture is all too familiar.

Many argue there is no health system at all. Hospitals and health services are operating independently, competing with each other and often struggling to remain viable. Health services today were designed to treat the illness needs of people 30 years ago, and they diligently try to respond to today’s health needs and demands.

Despite this escalating pressure and demand, a professional, committed and passionate workforce staffs South Australia’s health services. The workforce cannot sustain the pressures for much longer, despite the support of dedicated volunteers and family carers.

There have been significant demographic, cultural, economic and social changes, as well as 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 pressures and demands faced by South Australia are reflective of these trends. Issues include:

- changes and projected changes to the population profile
- increasing evidence on the impact of social determinants of health
- changes in disease burden and increasing chronic disease
- increasing community expectations of health care
- imbalance in the mix and distribution of services
- fragmentation and duplication of planning, funding and governance arrangements.
A changing population profile
The demographic profile of South Australia has changed over the past few decades. One of the most significant changes is the rapidly increasing ratio of older people, with Australia a leader in population growth of older people. Australia has the highest population increase in the ‘65 years and over’ age category, after Japan and China, and the highest percentage increase in the ‘80 years and over’ age group in the world. People are living longer than ever before.

South Australia’s population is ageing at a faster rate than other states and territories. Rural South Australia is projected to experience even higher growth of those aged 65 years and over, compared to South Australia as a whole. Also significant is ageing of the aged. The cohort of people aged 75 years and older is expected to grow faster than that of people between 65 and 74 years. Life expectancy is also expected to continue to increase to 82 years for males and 86 years for females by 2051.

By 2051, the median age in South Australia is projected to rise to 49.2 years, compared to 37.1 years in 2000.

This is clearly demonstrated in the age sex pyramids in Figure 1.

Increases in life expectancy have resulted in a compression of morbidity within the later years of life, and the later years of life today occur at a later age. While improved standards of living and health care mean that people are living longer, this may be accompanied by increasing levels of frailty and disability.

For example, war veterans as a group are ageing faster than the average population. The numbers of veterans in need of aged care will increase by 80% in the next ten years. There is substantial evidence that the health of veterans is worse than other men of similar age and chronic conditions in this population group requires significant attention.

A significant factor contributing to South Australia’s older population profile includes a decreasing fertility rate. As illustrated in Figure 2, fertility rates have declined dramatically over the past 30 years and there is a decreasing proportion of young people. South Australia has consistently demonstrated
lower rates that the rest of the country. In 1999, the total fertility rate in South Australia was 1.7, slightly below the national rate.

If current fertility rates continue to decline then, by 2020, 24% of Australian women will remain childless. These demographic changes, together with the significant drop in marriage rates and increased divorce rates, are changing South Australia’s social fabric.

This profile is not representative of all South Australians. In stark contrast, Aboriginal people have a very different demographic structure and much poorer health outcomes than other Australians. The median age at death is currently 51 years. The gap in median age between Aboriginal people and the rest of the population has progressively increased by 26 years over the past 25 years.

The age/sex profile of Aboriginal Australians is vastly different from the rest of the population, as illustrated in the pyramid graph in Figure 3.
The World Health Organization (WHO) uses ‘disability adjusted life expectancy’ to measure health status, but this hides issues of inequality.

Health equality is measured using child survival equality. About 190 countries were ranked according to these measures and Australia ranked second in status behind Japan, but 17th in equality. 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.14 Aboriginal people’s death rates are more than three times those of non-Aboriginal Australians.15

A clear differentiation can also be made when comparing Aboriginal fertility rates with the rest of the population. More than one-fifth of Aboriginal births (21.3%) were to women less than 20 years old, compared to 4.2% for non-Aboriginal women. By age group, birth rates were highest for the 20–24 year age group for Aboriginal women and for the 30–34 year age group for non-Aboriginal women.16

**Social determinants of health**

Evidence on the social determinants of health is growing and supports the view that 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.

There are two predominant studies of poverty in South Australia. They have been undertaken by the National Centre for Social and Economic Modelling (NATSEM)17 and the South Australian Council of Social Service (SACOSS).18 The SACOSS study revealed that 23.3% of South Australian households were in poverty in 1997–98, the highest rate in Australia. The rate of poverty in South Australia more than doubled between 1981–82 and 1997–98.

The report stated that single people aged 21–24 years were at the greatest risk of poverty with 33.3% of people in this cohort being in poverty in 1997–98. The report went on to show that households that relied on social security payments as their main source of income were most likely to be living in poverty. However, poverty among those in full-time employment had risen significantly, particularly for people in single person households.

The SACOSS study claimed that, if it were not for the low cost of housing in South Australia, rates of poverty would be far higher.

The NATSEM study showed an increase in the level of poverty in both Australia and South Australia after housing poverty was measured. The study showed that 237,000 South Australians were living in poverty with a poverty rate for adults of 15.4% (169,000) and for children 14.4% (68,000).19

This study also provided information on the depth of poverty, stating that South Australia’s poverty gap was 50% greater than the national figure.

Sole parents remained the most vulnerable group in relation to the occurrence of poverty. Single people, particularly younger single people, experienced the largest growth in poverty, while the incidence among couples with children also increased.
South Australia had a higher percentage of people in long-term unemployment compared to other states. As at February 2000, nearly 36% of South Australians were in long-term unemployment, compared to 27.3% nationally.\textsuperscript{20}

South Australia had relatively low average incomes in comparison to other states, and there was a significant decline in average income in real terms. Differences in household income could also be observed with the proportion of low-income families significantly higher in country South Australia than in Adelaide. NATSEM\textsuperscript{21} found that, in 1996, around 25% of households in Adelaide had incomes under $15,600, compared to over 30% of households in country South Australia.

A recent analysis of poverty in Indigenous communities indicated that nationally almost 12,500 Indigenous households were in poverty, before housing costs, and almost 15,600 households were in poverty after housing was taken into account.\textsuperscript{22} The highest percentage of Indigenous poverty rates was found in rural South Australia with 19.3% compared to 17.7% nationally.\textsuperscript{23}

Other studies have identified an increasing income gap between the rich and poor in Australia, with the rich becoming better off and the poor worse off.\textsuperscript{24}

Poverty has been linked to inadequate diet, unhealthy lifestyle choices, stress, anxiety and decline in health status. These all detract from optimal health and wellbeing.

The Figure 4 provides information on levels of health status in some of Adelaide’s neighbourhoods.

\textbf{Figure 4: Health status: death of people aged 15 to 64 years*}

South Australian data indicates that people living in neighbourhoods with poorer health status are:

- less likely to have a motor car
- more likely to be an Indigenous Australian
- less likely to own a home
• more likely to be unemployed
• more likely to come from a low-income family (see Figure 5).

The data also shows that people in these neighbourhoods are:
• more likely to be unskilled or semiskilled workers
• more likely to have left school early (see Figure 6).

* Standardised ratio based on the actual and expected number derived from indirect age/sex standardisation using statewide totals

Source: Social Health Atlas of Australia, 2nd Ed, Volume 5: South Australia
Health related behaviour, such as smoking, dietary habits and physical activity, are also associated with socioeconomic status. Studies of the Australian population have found people with low socioeconomic status are:

- less likely to be physically active
- more likely to smoke
- more likely to consume high levels of alcohol
- less likely to buy, prepare and cook healthy food.

Dr. Gro Harlem Brundtland, Director-General of the WHO said:

*We know that poverty leads to ill health and ill health breeds poverty. Where there is structural poverty and ill health, there will be poor development …*  

### Changing burden of disease

Worldwide, the disease burden, and what people die from, has changed significantly over the past 30 years. The health burden is no longer diarrhoea and infectious diseases but is now heart disease, depression, road traffic accidents, stroke and chronic respiratory disease.

A recent study of disease burden in South Australia mirrored this. The number one disease burden for South Australia was cancer, followed by heart disease and accidents. Mental health was the fourth highest. 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.

A large proportion of the disease burden is preventable.

Diseases and injuries related to the ageing process, such as Alzheimer’s disease and osteoporosis, have emerged. There has also been a growth in the number of people who have multiple, chronic and complex conditions as a result of increased longevity and medical science’s ability to address previously life threatening injuries and diseases.

### 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. The number of alternative or natural therapy clinics and pharmacies available today demonstrates that consumers are not satisfied with existing health care options and are willing and able to pay for the care of their choice.

It should not be overlooked that 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. Without information as to the true cost of the services received, consumers and providers have little financial incentive to restrain consumption.

It is this situational context that economists argue can give rise to inefficiencies in health resource consumption. There is a potential for providers to influence consumers in such a way that consumers use more services than they would have if they had made the decision themselves.
On the other hand providers, in establishing a contract of care with an individual, may experience the tension of balancing individual needs with those of the broader community.

**Mix and distribution of services**

**What does the health dollar pay for?**

The distribution of State Government health expenditure shows that hospitals receive just over two-thirds of the total health budget (Figure 7). However, only a small percentage of the population, approximately 12%, requires access to this type of health care. The question must be asked: *Is the health pie being cut in the best possible way?* The current split of the health care pie is no longer appropriate given the changing nature of health care, the population profile and health care needs.

**South Australia spends more, and has more**

South Australia spent 3.7% more on health than the Australian average per person in 1998–99 (while the average income is 12% lower than the national average) and had 3.4 public hospital beds per 1000 population compared to the national average of 2.8 beds, without discernibly better health outcomes. On a per capita basis, South Australia spends more money, has higher utilisation rates, more health professionals and more beds than other states and territories. However, South Australia does have regional variations in health professional supply.

**Figure 7: DHS Health Unit expenditure, 2000–01**

Economic researchers in health have explored the concept of supplier induced demand for health care. That is, the demand for health care is related to the amount of supply, the number of providers, services or options available. While it is not easy to separate supply driven demand from demand resulting from other causes, such as price and other factors, the concept of supplier induced demand is a common feature in health economics. Supply induced demand has been recognised as one of the causes for growth of health expenditure and the use of advanced technology and drugs. This is intimately related to the fact that health is big business and big business seeks and creates markets through promoting products to health services and health professionals as well as consumers.

Current resource distribution, together with broader social influences such as the media and multinational health companies, perpetuates a culture that there is ‘a cure for everything and everything must be cured’. This is adding pressure to the health care system. This is not the best use of scarce resources and what is needed is a refocusing of the system to enable the best investment for the best outcomes.
Are we risking quality and safety?
Where the rest of Australia over the past three to four years has been trending down in cost per case, South Australia has been trending up, despite wage levels being lower than in other states.

The reality is that South Australia has insufficient population to support safe, efficient and effective provision of the current number, range and distribution of clinical services which drive up the cost per case. There is unnecessary duplication of clinical services and the infrastructure that supports them. This is not to say that all services should be centralised. But there are a number of high cost, low volume services, as well as services for declining population groups, which should be consolidated to ensure they are provided safely and efficiently.

There are several issues, in addition to the duplication of services and inappropriate infrastructure, that have a significant impact on the safety and quality of services. The fragmentation of services, under-resourced primary health and community care sector, 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 received by consumers.

These few case studies from the South Australian coroner’s office highlight some of these issues in the state’s health care system.

Case Study One
This report involved a patient who presented to a major metropolitan hospital’s emergency department suffering pain in various parts of her body. She was unable to walk due to the level of pain she was experiencing. She was seen by hospital medical officers and discharged with the diagnosis of a viral infection. The medical officers did not have the patient’s medical records of her previous presentations at that hospital nor the SA Ambulance report. These records would have alerted the doctors of the person’s valvular irregularity and the possibility of the existence of an infective condition associated with that irregularity.

The following day, her condition had worsened and she was admitted to hospital after her local general practitioner was called to her home. She was correctly diagnosed with, and commenced treatment for, a bacterial infection. However infective endocarditis remained undiagnosed. She suffered a stroke on the following day and infective endocarditis was then diagnosed. Further strokes occurred and she died several days later.

The coroner reviewed the conditions within the emergency department at the times of the patient’s presentations and time in hospital. There were a large number of presentations and a backlog of patients waiting to be seen, including a backlog of access to beds within the emergency department itself. Ambulance diversion was occurring every two days. The coroner concluded that, although no conscious decision to discharge the person was made based on overcrowding problems, the doctor’s decision ‘… was made in an environment where the possibility of professional error was significant’.

The coroner concluded that, given the size of material build-up in the patient’s heart valve and the propensity for pieces of the material to break off for several days after commencement of treatment, it was unlikely that had her infective endocarditis been diagnosed on her first presentation to the hospital, her ultimate death could have been avoided. Nonetheless, the coroner recommended the need for educational measures for diagnostic tests under particular circumstances, a system be established to ensure availability of previous medical records and SA Ambulance reports, and improved efficiency in some test results. Continued monitoring and review of strategies to ensure practitioners and patients are ‘comfortably accommodated … in order to reduce the risk of professional error’ was also recommended.
Case Study Two
This report involved patients with a mental health problem and included consideration of a number of cases of a similar nature. The mental health issues were schizophrenia, schizo-affective disorder and/or other mental health problems.

The coroner’s report noted the link between schizophrenia and alcohol and drug abuse. ‘This “co-morbidity” between schizophrenic illness and drug abuse should call for a united effort between mental health services and drug and alcohol treatment services.’ Evidence was provided that prior to 1995 there was a very clear gap in communication between these agencies and that a number of patients were regarded by one agency as the patient of the other and hence fell between the gaps.

The case elaborated the difficulties inherent in treating people with schizophrenia and the clinical dilemma of the risk of side effects against the risk of illness. The need for clinical monitoring, careful periodic mental state assessments and appropriate note taking of positive and negative symptoms are essential in order to obtain a longitudinal view of a patient’s progress.

A number of issues were raised, including the need for early and clear diagnosis, provision of treatment plans, medication that is appropriate, monitored and reviewed, provision of mental health services by, or overseen by, skilled and appropriately qualified medical staff, quality record keeping in case notes and communication.

An instance was identified where the patient was not seen by a qualified psychiatrist on a more regular basis, a situation that was described as unfair on the non-specialist and unfair on the patient who, with a severe illness, warranted the best treatment. Lack of training, lack of experience, understaffing and lack of supervision were raised. Evidence was also provided that stated: ‘… advantages which might flow from the computerisation of psychiatric case notes should receive earnest consideration’.

Communication was raised, along with the need for family support in such cases.

The report also identified the need for a critical mass of expertise and the value of at least one centre of excellence that can facilitate and provide such expertise to the health sector, and that such a facility should continue to exist where patients may seek asylum in such a centre, where and when appropriate. This issue was significant — at the time of death of one of the patients identified, the hospital had lost such a large amount of expertise that they were unable to pursue accreditation as a psychiatric teaching hospital.

Case Study Three
This case involved a country mental health patient with a history of mental illness. On discharge from the hospital (metropolitan) the case notes read ‘follow up has been arranged by medical staff’. However, the country health service community mental health nurse reports that a copy of the handwritten discharge summary was received by fax 20 days later. On failing to contact the patient, the metropolitan hospital was contacted and the community mental health nurse learnt that the patient had been readmitted and discharge was planned. The nurse advised that the proposed discharge date meant that the patient would not be able to be seen until five days after release. This time the community mental health nurse received no discharge summary.

The patient’s general practitioner, who had received a discharge summary by fax for the first admission also reported not receiving a discharge summary for this later discharge, nor was there any recollection of advice by telephone.

Inpatient staff were aware of the patient’s suicidal ideation and propensity, and the issue was taken very seriously. However, this concern did not translate to the preparation for discharge. The coroner’s report stated that the conclusion is inescapable that poor
discharge planning by the hospital prior to discharge increased the risk of suicide. In view of the instability of the patient's condition and the lack of support available, the patient should not have been discharged until better planning had been undertaken. Comment was also made about the general practitioner's conscientious behaviour, having detained the patient twice under the Mental Health Act 1993, yet on both occasions discharge from hospital was undertaken without prior consultation with the general practitioner. The coroner stated: 'If patients are to receive effective treatment in the community after their discharge from hospital, then the mental health system must communicate better with general practitioners'.

The report also raised the issue of bed pressure, and resultant pressure on staff to discharge patients whose condition appears to have improved, to make room for other patients whose condition requires hospitalisation. The coroner stated: 'In these findings, I referred to the phenomenon known as “malignant alienation” namely the feeling of staff in situations where they feel powerless to change a bad system ... clearly, such a syndrome is exacerbated by difficulties such as understaffing, underfunding, lack of training, and lack of cohesion in the organisation in which people work. ... the existence of such a phenomenon should be recognised and addressed. The clouding of clinical judgment by bed pressure is part of the same syndrome, in my opinion. The constant existence of such pressure has an insidious effect on clinical judgment to the extent that the culture of an organisation can change, and quick turnover of patients becomes the norm because there is no realistic alternative. In those circumstances, the very serious issue of whether bed pressure is clouding clinical judgment arises.'

The consequences of no change

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

- not being able to maintain sufficient activity levels to use staff and other resources at the most effective and efficient level, for example neonate intensive care
- continuing to provide services when the community demand for that service has declined, for example obstetrics
- providing care to long-term cases which should be provided through supported care in the community (e.g. increased community nursing and domiciliary care services)
- duplicating infrastructure including capital, equipment, staff, administrative support services and information technology.

Should no reform occur and the system continue to function as it currently does, the following scenario is highly 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 hospital 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 population groups would result in attempts 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 support for people in the community and for people with multiple diseases and chronic conditions will place further pressure on general practitioners.
• 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, and at the same time preventing any opportunity for investment in primary care services. A focus on health promotion, illness prevention and early intervention would not be possible.

This scenario is not acceptable. The status quo cannot be condoned. A systemic long-term reform agenda needs to be implemented.

GHR set out to assess the potential impact on health services of a status quo scenario and a scenario which took into account trends and likely key reform strategies.

These trends and strategies included:
• demographic changes
• changing clinical practice
• changing patient length of stay
• changing population needs as a consequence of the ageing of the population
• increasing numbers of people living with chronic disease
• implementation of demand management strategies (including additional community support services) to relieve the pressure on hospital beds
• the need to be more equitable in the distribution of services
• the need to provide as many services as close as possible to local communities.

What do the pressures mean for the South Australian health system?
The model assisted in determining activity levels and distribution of hospital admissions, bed requirements and costs to the year 2011. The model can be adjusted to take into account various factors such as demographic and clinical practice changes and can make adjustments to reflect desired patient flows (shift of hospital admissions from one hospital to another) and demand management strategies.

The two scenarios examined were:
• status quo that takes account of population projections only
• reform taking into account additional factors covering:
  — current patterns of utilisation
  — projected increases in same-day admission rates
  — reduced average length of stay for overnight acute general patients
  — increased use of ‘hospital at home’ care
  — changes in mental health services; increases in same-day and reduction in average length of stay in line with benchmark parameters set in 2001
  — decrease in average length stay for non-acute services (rehabilitation)
adjustment to patient flows between Adelaide statewide referral hospitals (see Chapter 2) to improve regional self-sufficiency

impact of proposed demand management strategies on separations from metropolitan hospitals.

The results indicated that if there were: no change in clinical practice; no change to patient flows (i.e. 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 GHR, the following consequences would result by 2011:

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

This does not include the capital cost required to maintain the current infrastructure.

Should patient flows not change as planned, on completion of the already current capital works at The Queen Elizabeth Hospital (TQEH) and the Lyell McEwin Health Service (LMHS):

- TQEH would have 100 beds fewer than required
- LMHS would have 100 beds more than required
- the northern suburbs would not have achieved the target of 70% self-sufficiency.

The result would be an increase in the existing structural inefficiencies in the system (already trending away from the national position) and a failure to address the issue of equity of access to services for the people of the northern suburbs.

The tragic result of structural inefficiency is not just increased cost but a decline in the quality and safety of services as the resources become spread thinly across marginally viable clinical 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 model
- implement the *Strategy for managing metropolitan hospital workload*, begun by DHS and supported by 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 (see cardiology case study in Chapter 3).

The effect of these actions by 2011 will be:

- total admissions increased by 7% instead of 10%
- total beds (same-day and overnight) required decreased by 7% (216 beds) instead of the increase of 16% (472 beds) if the status quo prevails
- total cost per annum decreased by 13% ($117.5 million) instead of an increase of 9% ($87.9 million at 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 strategies over the next ten years.

The dollars made available from this strategy can be invested in primary care services, including early intervention programs for:

- infants and young children
- people with a mental health problem
- Aboriginal people
- people with developing chronic diseases such as asthma and diabetes.

The conclusions drawn from this modelling exercise are consistent with previous analyses conducted by DHS over the past ten years. This is irrespective of the methodology and projection variables used. The message is the same — the health system in South Australia is not sustainable in its current form. Change is essential.

GHR provides the South Australian Government with the opportunity to turn its illness focused system into a health focused system. To ignore the outcomes of this modelling exercise is to ignore the needs of our most vulnerable population groups while, at the same time, having to increase significantly the investment in hospitals or risk declining standards of care.

The establishment of a health care focused system is the first step. A shift towards a greater emphasis on the local provision of primary health care and community based services is required, together with a focus on the social determinants of health, in order to invest in the development and maintenance of healthy communities.

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

A recurring theme in the submissions and consultations to GHR was that the South Australian health system is fragmented and uncoordinated. For example, every time a person visits a different service in the public health system, a different record is created. Information technology systems (i.e. computers) are not connected and, even if they were, current software would not allow services to talk to each other. Consumers are repeating their story every time they visit a different health service. Metropolitan systems do not talk with country systems because many rural services do not have the infrastructure. In many instances across the state, particularly in rural settings, there is not the information technology infrastructure to network health services, let alone to link a general practice to a hospital, or one government department to another.

**Multiple planning processes**

In any rural area there is a range of separately funded planning, advisory and governing bodies. They all make decisions on behalf of and with their communities which directly or indirectly affect health status at a regional and local level.

They comprise:

- regional economic development boards (Commonwealth and state funded)
- local government councils and advisory committees
- regional and local health boards.
They might include:

- youth advisory committees and aged advisory committees at state, regional and local levels (sometimes all in place as a requirement of funding authorities)
- school councils
- broad primary health care advisory and social health committees.

There is duplication of planning processes, needs assessments and community consultations, often with very little impact or demonstrated improvement in health outcomes.

**Multiple regional boundaries**

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

It is not uncommon for a community to be represented on more than ten different government or department regions at the state level. On the ground, this can mean that many regional offices are located in a community.

Health, housing, Family and Youth Services, SA Police, Divisions of General Practice, local government, transport and Commonwealth planning regions, such as Home and Community Care (HACC), regional development, tourism and Aboriginal health regions, have different boundaries. An example of the effect this has on planning and service delivery is highlighted below.

One of the highest health care priority needs raised by communities, in numerous needs assessments and consultation processes undertaken in rural areas, is TRANSPORT.

Which government department is responsible for providing a basic service such as transport? Currently, all are. However no one claims to be funded for it.

Who is accountable for a basic performance indicator such as ensuring access to services? Currently, no one is. However all should be.

As a consequence, TRANSPORT needs are not addressed and remain a high priority health need in both rural and metropolitan areas.

**Multiple project funding**

A major reason for the unacceptable number of short-term, unsustainable and duplicated projects is the way programs and health services are funded.

Primary health care and health promotion programs are typical of grant funded programs. Different departments (and many times different levels of government and regions) are competing with each other for the same small bucket of grant funding for a short-term project. Several independent applications may come from departments and/or health units in the one region. Alternatively, project funding is often allocated to individual health services which creates competition rather than coordination across services for the same community need.

The majority of program funding is often based on population numbers, not on need or capacity. Factors such as distance, socioeconomic disadvantage and Aboriginal populations have not been accounted for. This has contributed to a decline in health status in some rural areas.
For example, a decline in population today equates to a decline in funding. The reasons behind a population decline usually equate with a poorer socioeconomic profile (e.g. fewer employment opportunities in rural areas) which usually results in a greater health need. This is met with less funding and so the cycle continues.

Aboriginal health and wellbeing is the highest need of the most disadvantaged population group in rural South Australia. The current state of play in one rural area is as follows:

More than $300,000 in grant and program funding is received for Indigenous health by the regional health service (not including local health unit specific funding). It is all accounted for differently and divided into various small projects.

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Advisory Committee</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Stolen Generation Counsellor</td>
<td>State</td>
</tr>
<tr>
<td>Social Emotional Wellbeing Counsellor</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Aboriginal Female Health worker</td>
<td>Region</td>
</tr>
<tr>
<td>SA Aboriginal Cervix Screening</td>
<td>State</td>
</tr>
<tr>
<td>Aboriginal Male Health Worker</td>
<td>State</td>
</tr>
<tr>
<td>Aboriginal Youth Worker</td>
<td>State</td>
</tr>
<tr>
<td>Aboriginal Liaison Officer</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Aboriginal Partnership Program</td>
<td>Local/Region</td>
</tr>
<tr>
<td>Aboriginal Primary Care Centre</td>
<td>Region</td>
</tr>
</tbody>
</table>

Most programs are grant funded and of short duration, each having its own evaluation criteria and reporting processes. All positions are part-time, casual or contracted regional positions.

Transport and other goods and services are not usually covered within grant funding and programs are often dependent on in-kind support, such as vehicles, from health units. Therefore decisions about Aboriginal health funding are often tied up in health unit management structures.

This has not taken into account Aboriginal program funding for Family and Youth Services, housing, local government, education and Aboriginal workers working at the region’s community centre who also receive bits and pieces for pilot programs and projects.

**Multiple governance arrangements**

The current governance arrangements in the state’s publicly funded health system effectively comprise:

- Minister for Health who, among other powers, has the power to direct health services
- DHS with various powers delegated by the Minister for Health
- South Australian Health Commission with limited functions
- country hospitals and regional health services with boards of governance
- metropolitan hospitals and other health services with boards of governance.

In metropolitan Adelaide there are individual hospital and community based health service boards of governance, while DHS plays a major role in service policy, planning and funding.
In country areas a variety of arrangements exist. Some health units have individual boards of governance, whereas other health unit boards have voluntarily amalgamated. In addition, seven regional boards exist with a role in service planning for the region and resource allocation to individual services. DHS still plays a role in service planning and funding but has now partially devolved this role to the regions.

Health unit boards employ their own staff and, under the South Australian Health Commission Act 1976 (SAHC Act), are required to take account of the policies of the commission and the direction of the Minister for Health. It is worth noting that country health services display a greater level of integration than exists in metropolitan Adelaide with hospital and community based health services often coming under the one board of governance. This situation has arisen due to the relative remoteness and small size of rural communities.

As at 1 July 2002, there were 73 health units incorporated under the 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 GHR has sought to address them at a preliminary level. They include 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 is of the view that the weaknesses of the current governance arrangements in South Australia will become more significant over time. Further, change is needed to enable the system to continue to meet the needs of South Australians as comprehensively as possible, given that continuing tight restraint on resources is almost certain.

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

**Conclusion**

The implications are clear. The present health system 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.

What GHR proposes is not new or world-shattering. The directions proposed 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.
FOOTNOTES

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

3 Australian Institute of Health and Welfare (AIHW), Older Australia at a Glance, 2nd Edition 1999


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

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

7 ABS Estimated Population Time Series, Cat No 3201.0 and ABS (2000) Population Projections Australia, 3222.0, Table 2A, Series II (a) 1999

8 Department of Veterans’ Affairs, SA and NT Office, Submission to GHR, December 2002

9 www.abs.gov.au/Ausstats/abs@.nsf/NT00001DC6

10 ABS Media release 3301 Australia’s fertility rate below replacement level for the 20th year, 12 November 1998

11 Aboriginal groups consulted by GHR preferred the use of the term ‘Aboriginal’ rather than ‘Indigenous’


13 ABS, Experimental estimates of the Aboriginal and Torres Strait Islander Population, Estimated Resident Population Time Series, Cat. No. 3230.0 1998


15 Aboriginal groups consulted by GHR preferred the use of the term ‘Aboriginal’ rather than ‘Indigenous’.

16 AIHW Health and welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2001 www.aihw.gov.au/publications/ihw/hwaatsip01/

17 NATSEM Regional income inequality increasing while the middle disappears Issue Paper no 12 May 2000

18 Both of these studies use relative measures but vary in methodology. NATSEM uses a straightforward measure using 50% of national average income, while SACOSS uses the Henderson Poverty Line, which uses a measure determined in 1973 and indexes this to household disposable income. Due to the difference in methodology, the results vary. Both SACOSS and NATSEM use before and after housing measures of poverty. By incorporating housing costs a better idea of disposable income is obtained, because housing is typically a household’s largest ongoing cost.


20 ABS 6291.0.40.001, Labour Force, selected summary tables, Australia.

21 op cit NATSEM May 2000


23 Jones, op cit 1999


27 DHS SA burden of disease study. Work in progress


29 Note: Community based services include DASC, ShineSA, RDNS, Child and Youth Health, Domiciliary Care, COPE, SADS, Health Development Foundation and country Domiciliary Care. Aboriginal services are specific funded health units that do not include Aboriginal services provided by mainstream health units such as community health services. Includes HACC funds allocated to Domiciliary Care, RDNS and other DHS units


31 Infective endocarditis is a condition caused by bacterial infection. Undiagnosed, it has a 100% mortality rate

32 ibid. Lewin October 1997
33 ibid Pettitt January 2002
34 Submission No 18 to GHR and see Chapter 3
35 Submission No 18 to GHR
37 DHS Mental Health Branch, Mental health service and bed modelling study, 2001
38 It should be noted that DHS has embarked on a capital development plan for TQEH and LMHS (with Cabinet approval in 2001), based on the alteration to patient flows between TQEH; LMHS; Royal Adelaide Hospital (RAH) and the Women’s and Children’s Hospital (WCH) included in this model.
39 DHS set this target for the purposes of previous modelling exercises.
40 South Australian Health Commission, Metropolitan hospitals planning study, 1994
SUCCESS STORY

Cardiac Nurse Practitioner

Patients with Congestive Cardiac Failure (CCF) have special needs due to the complexity of their condition and often are not suitable for a mainstream cardiac rehabilitation program. In recognition of this and based on emerging evidence of the benefit of a nurse led heart failure service, The Queen Elizabeth Hospital's cardiac Nurse Practitioner (recently authorised as a Nurse Practitioner by the Nurses Board of South Australia) expanded the existing service to include a home management program specifically tailored to meet the needs of this patient group.

The cardiac Nurse Practitioner provides assessment, care planning, education and ongoing symptom surveillance to patients with CCF to assist them to optimise their cardiac function within the limitations placed upon them by the pathology of the disease process. Authorisation to practice as a Nurse Practitioner also enables the cardiac nurse to optimise the pharmacological management by developing individualised fluid management plans, and the up-titration of medications such as B-Blockers and ACE Inhibitors, and order relevant pathology tests. This reduces the strain on hospital Outpatient and Emergency Departments.
Objective

The objective of this chapter is to outline governance and funding arrangements that will concentrate efforts in the health system towards improving the health of the population, enhance capacity to promote population health and meet the equity objectives of the South Australian Government.

This chapter considers the effectiveness of current governance arrangements in the South Australian public health system and seeks to find ways of greater coordination and collaboration, and less duplication and fragmentation in health service delivery.

Case for change

A population health focus will require a fundamental shift in health system processes and priorities. This shift will place the health of the population at the centre of decision making and put the needs and interests of consumers, both individually and collectively, first. GHR has received a consistent message that the endeavour of health services in South Australia tends to be focused on individual organisational priorities rather than collective responsibility for maintaining and improving population health.42

Today’s governance arrangements in the South Australian public health system are enshrined in the SAHC Act. The objective of the legislation was to bring together a range of disparate hospitals and health services under a unified system of governance.

At that time a number of hospitals were not formally part of the public health system. In order to bring these hospitals into a unified governance arrangement there was a need to provide some assurance that health services would be able to retain control of their assets and remain as separate corporate entities. The intention of the SAHC Act was to preserve the identity and local decision making capacity of these health units through separate incorporation of hospitals and health services.

Since then hospitals and health services (these are the terms for the various health agencies used in the SAHC Act) have been governed independently by their own boards. Today there are more than 70 incorporated agencies with boards. In addition there are over 100 other health agencies funded by the state but not incorporated under the SAHC Act. These include non-government, charitable and religious organisations.

Health unit boards have a primary responsibility to manage the services of their units and have been very effective in maintaining, promoting and protecting their organisational interests. To this extent, the SAHC Act has been successful.
Times have changed. Today one of the primary objectives of health systems around the world is to promote cohesion. Governments are looking for effective ways to bring resources together, ensure coordination and integration, and decide what mix of services might best meet population health needs. Constant demand pressures on health systems have led to an emphasis on the need to reduce unnecessary service duplication and fragmentation of health services. Consumers can get lost in an increasingly complex and confusing health system, and continuity of care across services and over time is often an unrealised ideal. The challenge for governments is to improve coordination and integration without losing the ability to remain responsive to local and regional communities.43

Existing legislative protection of individual health unit boards has stood as a clear barrier to health system reform. Structures designed for the needs of an earlier time have not been able to address increasing complexity and the difficulties experienced by both consumers and providers. These difficulties include poor communication across the health system, rivalry rather than cooperation between organisations, and inadequate alignment of services to population priorities.

This is not to say that services provided by health organisations are not valuable. In most instances services are of great benefit to those who receive them and are provided by highly competent and dedicated staff.

GHR has received strong representations that local hospital boards provide a powerful voice for the community. It is important not to confuse corporate governance and community participation. Current corporate governance roles of incorporated hospital boards involve ensuring safe clinical outcomes within the hospital, responsibilities in employment and industrial matters, legal requirements, probity, budget management and risk management.

While this does not abrogate the responsibility of hospital boards to address community views in the process of planning and managing hospitals, GHR is of the view that hospital boards can overemphasise their role as a voice for the public and their level of community representativeness. GHR believes community participation is better achieved in a different way (see Chapter 4).

Problems associated with individual health unit boards have been identified at various times by Labor and Liberal State 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 — but with little success.

In 1973 the Bright Report sought to place health system governance within a regional framework.

> The organisation should provide for the decentralisation of health services by regionalization with as much local responsibility as is consistent with good organisational control. The citizen should not be the client of one doctor or one hospital or one power but the client of a regional health system. 44

Bright proposed a ten region model along with individual health unit boards and a central governing body. The SAHC Act provided the legislative basis for these arrangements, including provision for regionalisation but, while incorporated health units were subsequently established, regional arrangements were not implemented.

The 1986 Uhrig Review45 concluded that metropolitan hospital services in Adelaide were:

> fragmented into a series of individual hospital units, each with its own culture, and each with an inability or unwillingness to subordinate individual institutional interests to the objectives of the system as a whole.
This review noted that the absence of an overall system culture had contributed to duplication of services and problems in coordination. It recommended that metropolitan health services come under a regional governance arrangement and that individual health unit boards be dissolved. The recommendations were not implemented.

A review of the numerous reports and inquiries into the SA health system undertaken over the past 30 years reveals they consistently:

- pointed to the lack of a system culture, and fragmentation and duplication of services
- recommended extensive reform to the governance of health services
- failed to achieve substantial and effective change.

GHR agrees with this assessment and has concluded that legislative change is required to substantially reform governance arrangements in South Australia.

Unlike several other states in Australia, and many countries throughout the OECD, South Australia has not been able to bring health services governance under an integrated regional arrangement. Under such governance structures, responsibility to respond to the needs of the population and the necessary authority to make decisions about the nature and location of health care services accordingly are vested in a single governing body.

Experience elsewhere indicates that agencies with these responsibilities, and matching authority and leadership, are better able to tailor services and manage finite resources to meet local needs and priorities. In doing so, they are supported by clinical leaders who have the necessary knowledge to inform their decisions, as well as by direct engagement and feedback from communities and consumers.

GHR has concluded that the continuance and strengthening of regional governing bodies in rural and remote South Australia, and their establishment in greater Adelaide, are crucial to refocusing the health system.46

By reorienting health system governance to focus on regional population health needs, resources in the health system will be more effectively directed to identifying and pursuing opportunities for improved population health outcomes.

GHR concludes that 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 maintain and restore health.

During consultations GHR was given a clear message that change is expected and that a regional governance model would be broadly supported. Stakeholders were seeking arrangements that provide an appropriate balance between central decision making and local responsiveness, without unnecessary duplication of structures.
The health system is approaching a crisis point where the cost of the current arrangements will become unsustainable. There is a clear need to rebalance investment in health services and reduce unnecessary duplication of services and infrastructure. Reform is overdue.

**Ways forward**
GHR has adopted the following approach to promote a greater focus on population health in the South Australian health system:

- **Planning for defined geographical populations in metropolitan, rural and remote areas**
  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, there is a need to take a statewide perspective to planning services. There is a need too for the population to consider the optimum configuration of high cost and complex services, and the quantum of services and funding that is indicated to adequately meet the overall population’s service needs into the future.

- **Population based health governance arrangements**
  The power to direct and control resources and health services lies principally at ministerial level. However, in creating a balance between central control and direction and responsiveness to local communities, there is a need for a principal governing body at the regional level. This body should have adequate authority and responsibility for promoting the health of a defined geographical population and managing the health services within that region in accordance with regional health care needs.

  At the same time, there is a clear need to maintain and strengthen local community participation in health care agencies and health issues. It is also important to recognise the continuing interest of local communities in assets that they have funded, and to support and encourage ongoing fundraising and contributions in kind.

Each of these four elements is defined below.

**Defining geographical populations**
GHR adopted the following criteria, based on a commissioned report for assessing the various options. Not all criteria were given equal weighting and in some cases trade-offs were necessary. The criteria included the following:

- **Principles of statistical geography establish general rules, not necessarily always applicable in the light of other specific factors. The principles include:**
  - major referral patterns from adjacent local government areas (LGAs) to be maintained in the same region
  - regions to have a regular shape
  - integrity of existing health regions to be maintained
  - the approach to configuration to be ‘onion layer’ rather than ‘spoke’ or ‘sector’
  - regions to be contiguous entities (except Kangaroo Island)
  - metropolitan regions to have similar population size to balance influence
— country regions to have similar population size to balance influence
— regions to be aligned with Australian Bureau of Statistics (ABS) statistical collections to enable alignment of health data about the region with other data sources.

- **Communities of interest** is an important criterion but not always clear cut. A community of interest comprises people who identify themselves as living in a particular area, such as the northern suburbs of Adelaide, and has established social and economic links.

- **Critical mass** is an essential criterion which requires the population to be large enough to allow for economies of scale.

- **Maximising self-sufficiency** is an essential criterion but careful definition is required. Tertiary and quaternary hospital services were explicitly excluded in the analysis given it is neither desirable nor feasible for regions to be self-sufficient. Regions should be at least large enough for primary care self-sufficiency.

- **Similar capacity** is a desirable but not essential criterion. It is not feasible for all country and metropolitan regions to have the same services.

- **Consistency with clinical networks within regions** is a desirable criterion. As much as possible, regional boundaries should be consistent with existing networking and referral arrangements between services and clinicians. For example, community hospitals often have well established referral links with a regional hospital.

- **Consistency with related organisations** is desirable. For example, education regions afford a desirable criterion for defining geographical populations.

The recommended regional structure, after considering many alternative configurations, including the status quo in non-metropolitan regions, was a nine-region configuration with three metropolitan and six rural and remote regions. An assessment of the major options against the criteria outlined above is presented in Table 1.

**Table 1: Audit of major regional options against principles of statistical geography**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>3 Adelaide regions</th>
<th>2 Adelaide regions</th>
<th>7 country regions (status quo)</th>
<th>6 modified country regions</th>
<th>6 new country regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole statistical local (SLA)</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Statistical geography</td>
<td>✶✶✶✶</td>
<td>✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Communities of interest</td>
<td>✶✶✶✶</td>
<td>✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Critical mass</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Self-sufficiency</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Similar capacity</td>
<td>✶✶✶✶</td>
<td>✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶✶</td>
</tr>
<tr>
<td>Consistency with related organisations</td>
<td>✶✶✶</td>
<td>✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶</td>
</tr>
<tr>
<td>Consistency with clinical networks</td>
<td>✶✶✶✶</td>
<td>✶✶✶</td>
<td>✶✶✶✶✶</td>
<td>✶✶✶✶</td>
<td>✶✶✶✶</td>
</tr>
</tbody>
</table>

Note: the more stars the better

* Would require a sub-regional management layer
a Northern has high outflow, reflecting current maldistribution of resources
b Southern is swamped by Northern
The recommended regional configuration is depicted in Figures 8 and 9. Table 2 presents the population and population share of each region.

**Table 2: Population and population share for each region**

<table>
<thead>
<tr>
<th>Region</th>
<th>2001 Population</th>
<th>% of SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Adelaide</td>
<td>331,419</td>
<td>21.9%</td>
</tr>
<tr>
<td>Central Adelaide</td>
<td>433,725</td>
<td>28.6%</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>327,016</td>
<td>21.6%</td>
</tr>
<tr>
<td>Northern &amp; Far Western</td>
<td>85,464</td>
<td>5.6%</td>
</tr>
<tr>
<td>Mid North</td>
<td>53,991</td>
<td>3.6%</td>
</tr>
<tr>
<td>Wakefield</td>
<td>75,098</td>
<td>5.0%</td>
</tr>
<tr>
<td>Hills Southern</td>
<td>76,820</td>
<td>5.1%</td>
</tr>
<tr>
<td>Riverland</td>
<td>68,614</td>
<td>4.5%</td>
</tr>
<tr>
<td>South East</td>
<td>62,694</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>South Australia</strong></td>
<td><strong>1,514,841</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Appendix 4 lists recommended regions by ABS Statistical Local Area (SLA).

The key changes from the current health planning regions include:

- Western and Eastern Metropolitan Regions are amalgamated to form the Central Region
- Gawler is moved from Northern Metropolitan Region to Wakefield Region (formalises existing arrangements)
- Yorke Peninsula is moved from Wakefield to the Mid North Region
- The Coorong, Karoonda East Murray, Mid Murray, Murray Bridge and Southern Mallee are moved to the Riverland Region
- Eyre, Northern and Western regions are amalgamated
- various regions are aligned to revised SLA boundaries.

GHR acknowledges there will be a need for periodic review of the rationale and practical functioning of the regions, including consideration of minor adjustments to boundaries in consultation with key stakeholders. For example, the proposition that Gawler move to the Wakefield Region requires further consideration by DHS.

Major advantages of the recommended regional configuration include:

- more evenly balanced populations in rural and remote and metropolitan regions
- better alignment of key referral patterns to regions of residence
- better alignment with the principles of statistical geography
- limited disruption to the existing country regional structure.
Alternative metropolitan regions

The alternatives considered for Adelaide were:

- north, south, central (including TQEH)
- north and south (with Royal Adelaide Hospital (RAH) and Women’s and Children’s Hospital (WCH) in north)
- north-east and south-west (with TQEH in south-west, and RAH and WCH in north-east)
- north-west and south-east (with TQEH in north-west, and RAH and WCH in south-east).

A north and south configuration did not meet key statistical geography and general criteria (e.g. similar population size and its power to influence, similar capacity, critical mass and community of interest). GHR considers that, similar to a one-region model, the northern region of a two-region model for Adelaide would hold disproportionate resources and its influence within the system would not facilitate effective statewide decision making and equitable outcomes.

Similar conclusions are valid for a north-west and south-east configuration. However, in this instance the southern region, with both RAH and Flinders Medical Centre (FMC), would hold disproportionate services and power.

A north-east and south-west configuration would alleviate some, but not all, of the concerns regarding similar capacity associated with a north and south configuration. It did not meet the full criteria to the same extent as the three-region model, including communities of interest covering public transport networks and major roads to economic centres and services, statistical geography and consumer flows. For example, it created a somewhat dysfunctional nexus between transport systems in the west and south of Adelaide.

Conversely, there is a natural nexus between RAH and TQEH provided by the public and private transport routes to the city. This provides better consumer access and links between services. Referral and service networks between RAH and TQEH are being strengthened. For example, the hospitals are currently planning to network and share emergency services to cover the region.

The most important consideration in distinguishing between a two-region and three-region model is the implication for service equity and access.

Over the past 30 years there has been considerable growth in the southern suburbs of Adelaide. The establishment and development of FMC and later Noarlunga Health Services has resulted in a high level of self-sufficiency in the southern region. Conversely, in the northern suburbs, strong population growth over this period has not been matched with similar service developments. Although service development and expansion at the LMHS has been occurring in recent years, the scope and extent of services currently provided in the northern suburbs continues to lag significantly behind other areas in Adelaide.

A three-region model will provide for a visible focus on regional development and the health needs in the north, a focus that would not necessarily occur under a two-region model. It is clear to GHR that, without strong advocacy, leadership and political will, the health inequities that exist in the northern suburbs of Adelaide will persist.
It follows that without a separate governance function, without adequate funding and without separate identification of the communities involved, the lack of health services in the northern suburbs could easily be overlooked and disguised. The implications of this issue are taken up further in the following section on population health funding.

GHR acknowledges that changes in governance arrangements will be difficult and require strong will and fortitude. It will be resisted by some entrenched institutional based groups who wish to maintain the focus of the health system on institutions rather than the population. However, GHR believes that the only way forward to ensure equitable access for health care in the metropolitan area is to start this process with a three-region model that openly and transparently has the health of each region’s population as its focus, rather than the narrow institutional focus of the past.

In summary, the proposed three-region model for Adelaide provides:

- the best fit with the criteria
- better alignments with transport routes (bus, train, car), corridors of movement, and developing service networks and referral patterns
- a specific focus on growth areas in the northern and southern suburbs
- a sound basis for pursuing the policy objectives of equity and access.

**Alternative rural and remote regions**

The main alternatives considered for rural and remote South Australia were:

- Existing five regions with amalgamation of existing Northern and Far Western and Eyre regions
- Realignment of existing five regions and amalgamation of existing Northern and Far Western and Eyre regions
- configuration of five regions
- configuration of four regions.

Extensive consideration was not given to regional configurations of fewer than four, given the likely disruption to the current regions.
Figure 8: Recommended regional configuration for South Australia

Note: See Appendix 4 for the list of LGAs by region
Figure 9: Recommended metropolitan regional configuration

Note: See Appendix 4 for the list of LGAs by Region
The Chair of the Regional Chairs Group of Country Health Regions compiled a summary of key achievements since the regions were established in 1995–96. It is apparent that much effort has been invested in these regions in developing cultures of trust and building capacity. There are indications that it is only now that these regions are starting to reap the benefits of this investment through improved management structures, administrative efficiencies, improved quality and the movement of resources into primary care.

In light of this, GHR has taken the view that improvements to the existing configuration would be preferable to wholesale changes of the overall country regional structure.

**Required minimal changes**

There are good reasons for seeking to establish regions of roughly equivalent population size in the country. Such an arrangement enhances equity in regional self-sufficiency, in the ability to attract talented professional and managerial staff, and in the influence of the regions with decision makers in Adelaide. For example, currently senior positions in the regions in South Australia are placed at different points on the career scale, creating an incentive for staff to leave smaller regions. Similarly, it is more difficult for the smaller regions to attract skilled clinical staff.

In the light of these goals, and the need to minimise the disruption of change, GHR has focused on several key adjustments on the margins to enhance arrangements in rural South Australia.

The relatively disadvantaged position of the Northern and Far Western Region needs to be addressed, given that this region faces the problems of sparse population, remoteness from the services of Adelaide and relatively smaller resources. The needs of the Aboriginal population of this region require specific responses and service profiles.

The placement of Whyalla in the Northern and Far Western Region was fundamentally problematic. Whyalla lies near the head of the Eyre Peninsula and its hospital is a major referral centre for four geographical areas to the west and south in the Eyre Region. This means that consumers living in the Eyre Region naturally flow into the Northern and Far Western Region to receive services. The principles of statistical geography clearly indicate that Whyalla should form part of the Eyre Region.

However, the reallocation of Whyalla to the Eyre Region would reduce the population of the Northern and Far Western Region to about 29,000, by far the smallest of the regional populations, a situation which is not sustainable.

GHR concluded that the health interests of the people of these two regions will be best served by amalgamation to create one region. The proposed new region will be of sufficient size to enhance regional self-sufficiency in services and the ability to attract and retain skilled staff. This will also enable the region to advocate more effectively for its needs in negotiations with government and the many other agencies which provide services to the people of the region but are not headquartered within it.

However, the large size of this region will require different arrangements from those in other rural regions. The sub-regional management arrangements currently in place, particularly in the far north and west of the region, will need to continue and be strengthened.
Recommendations

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.

Consistency with related organisations

In the absence of any current process to achieve consistency with related organisations (see criteria above), GHR took a pragmatic approach in line with the priorities of the review. GHR has sought, in the first instance, to identify and establish geographic boundaries that make sense for the health service system.

An opportunity for consistency may be possible in the future with the boundaries of the Divisions of General Practice. The Commonwealth Government announced a review of these divisions in October 2002 with terms of reference including consideration of the size and number of divisions, other health boundaries, governance, funding and national performance indicators.

The South Australian Divisions of General Practice submission to the Commonwealth review stated:

*The opportunities presented by reviews such as SA’s Generational Health Review should be utilised and this may include matters such as realignment of boundaries between state health regions and Divisions. What needs to be emphasised though is the importance of the local Division’s presence and locally based service and support.*

For regional governing bodies to more fully accept responsibility for the quality of life and health of a population, whole-of-government approaches to service provision will have to be pursued. GHR considers the alignment of administrative boundaries across government would greatly enhance service planning, coordination and provision across portfolios in the state and would be pursued most effectively in a staged and planned fashion at a central government level.

The initial priority should be on the establishment of common geographic boundaries for DHS across health, housing and community services.

Recommendation

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

Population health funding

Population health funding is an approach to allocating funding based on measurable indicators of regional population need for health services and programs. In order to move from a sole focus on managing health services to a focus on responsibility for improving population health, the principal governance bodies need first to have responsibility for a defined population. They also need the authority to make decisions about the best use of resources and the best service arrangements to meet population health needs.
To this end, GHR has a firm commitment to the concept of population health funding.

Health systems around the world question whether they can afford to provide the full range of health services to the population in the future. GHR believes difficult decisions will need to be made and the community must become more involved in the setting of priorities for service provision. A discussion of related issues is set out in Chapter 4. However, within this global context, there are two key funding challenges confronting the South Australian health system today:

- quantum of hospital funding
- distribution of health funding.

**Hospital funding**

A key finding of the Productivity Commission Report 2003, in relation to hospital services is that South Australia’s public hospitals provided 15.1% more inpatient services per head of population than the national average in 2000–01, after adjusting for the age and sex of the population.

South Australia has reported consistently higher levels of hospital utilisation over a number of years as shown in Figure 10.

![Figure 10: Separation rates in (non-psychiatric) public hospitals](image)

> Figures are directly age-standardised to the Australian population at 30 June 1991.
> Source: AIHW (2002a); table 9A.7.

It is suggested that this discrepancy is the result of differences in the manner in which activity is recorded in South Australia as compared to other states and that this difference artificially inflates the level of inpatient activity in the South Australian hospital sector. This is an important matter given that the level of funding provided to South Australia through the Australian Health Care Agreement is largely predicated on the reported level of inpatient activity of the public hospitals.

A preliminary comparison of NSW and South Australian age and sex inpatient utilisation data by external consultants demonstrated that SA hospitals provided 15% more inpatient services than the NSW hospital system in 2000–01. GHR, in conjunction with DHS, sought to further investigate this
outcome by undertaking a direct comparison of inpatient data sets from NSW and SA hospitals. In consultation with leading experts in the analysis of hospital data, adjustments were made to allow for any identified differences in data reporting and service configurations that may distort comparison of the two systems and improve the validity of the results.

While a data difference was detected for the 0–4 age cohort, which could not be reconciled prior to this report, the overall results of this further analysis are considered robust. The data provides evidence that the South Australian hospital utilisation rate was at least 15% greater than NSW in 2000–01. Figures 11 and 12 present the outcomes of this analysis by sex and age cohort.

**Figure 11: NSW and SA male hospital utilisation per capita**

Source: NSW and SA Morbidity Data Collections 2000-01.

**Figure 12: NSW and SA female hospital utilisation per capita**

Source: NSW and SA Morbidity Data Collections 2000-01.
National data on inputs (i.e. resources used in inpatient services) tends to confirm the conclusion that SA has higher inpatient utilisation of hospital services. For example, South Australia has 26% more available public hospital beds per capita than the national average, including 16% more in metropolitan areas, and 8% more full-time equivalent (FTE) staff working in public hospitals per capita than the national average, including 22% more salaried medical officers and 14% more nurses (see Figures 13 and 14).

**Figure 13: Number of available beds by region, public hospitals, 2000–01**

![Figure 13: Number of available beds by region, public hospitals, 2000–01](image)

Note: the horizontal line denotes the SA rate

**Figure 14: Average FTE staff, public hospitals, 2000–01**

![Figure 14: Average FTE staff, public hospitals, 2000–01](image)

Note: the horizontal lines denote the SA rate
Together this evidence indicates that the South Australian health system provides above average levels of hospital services per head of population, after taking into account the age and sex of the population. The evidence points towards this situation being attributed to relatively favourable supply conditions in South Australia. It may be that a relative undersupply of alternatives to acute hospital care, such as step down, sub-acute or home based rehabilitation services, contributes to the apparent overuse of acute beds.

Supplier induced demand
The notion of supplier induced demand is a concern for policy makers in both market and public finance focused health systems.

In health care a number of conditions for a well functioning market are either distorted or fail due to the complexity of health needs and services, the historically passive nature of consumer relationships with providers and the existence of health insurance. Consumers of health care tend to rely on the advice of providers to determine what services they need and seek to access. Patients do not admit themselves to hospitals. Doctors admit them. The agency role that providers play is underpinned by the existence of insurance (public or private) which effectively removes the price (and disguises the true cost) of the service at the point of decision making. Without price signals both the consumer and provider have little financial incentive to restrain consumption.

It is this situational context that economists argue can give rise to inefficiencies in health resource consumption. There is a potential for providers to influence consumers in such a way that they use more services than they would if they had made the decision themselves within optimal market conditions (i.e. good knowledge).

It follows that if a level of discretion exists in generating demand for services by providers, and sufficient capacity in the service system is available (e.g. beds, staff), there is a potential for inefficient or over supply of services. This would come at significant social cost.

Distribution of health funding
The maldistribution of funding and resources would not present such a significant challenge to South Australia if the public health system were operating in an expansionary environment. Greater investment in health services would allow SA to move to a more equitable allocation of resources and services across geographical regions and across the health system without need for divestment and reinvestment.

Given the current supply situation and economic context for South Australia the challenge for GHR is to improve resource distribution without exacerbating or increasing supply in the longer term, that is, how to secure opportunities for reinvestment.

Population health funding will not address the supply issue. It will address distribution by providing a powerful tool to drive the equity objectives of government, enabling flexible use of resources at the local level. Population based funding assumes that health care resources should be distributed on the basis of relative need of regional populations rather than solely on the basis of where services are currently provided.

At the regional level it would involve allocating funding to regional health services on the basis of the size and nature of the population to be served and take into account the known risk factors which influence health care need, including the age and sex profile of the community and socioeconomic status.
It follows that the definition and establishment of geographic populations is a prerequisite for a move to population health funding, with recognition that there will be variation of socioeconomic status and risk factor prevalence within a region.

GHR commissioned work\textsuperscript{53} to develop an indicative approach to population health funding for the South Australian public health system. The consultants developed an indicative resource allocation formula that can be used to inform the funding of regions on a population needs basis. The formula is based on the methodology developed and employed by NSW to guide resource distribution in its public health system.

The NSW methodology was used for a number of pragmatic reasons:

- The NSW approach has been used and refined over the past 20 years.
- It avoided unnecessarily ‘reinventing the wheel’ in South Australia.
- It allows useful comparisons between SA and NSW.
- Time and other GHR resources were constrained.

Given time constraints, modelling was limited to acute inpatient care and based on the preferred regional structure of three metropolitan regions and six rural and remote regions. The outcomes are indicative rather than definitive.

The population health funding model in NSW is comprehensive and aligns with the program structure of the NSW Health Department which provides the basis for strategic investment decisions by the portfolio and reporting to Treasury. A separate funding formula drives each component and acute inpatient services is only one of the nine components of this model. The model has been progressively developed and refined over 20 years, including revision of the central administration’s program structure to more effectively reflect the key dimensions of service delivery for population health.

Table 3 details the components of the NSW funding model and the associated program in the NSW health program reporting structure for illustration.

*Table 3: NSW population funding model*

<table>
<thead>
<tr>
<th>Component of Funding Model</th>
<th>NSW Health Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health</td>
<td>Population Health Services</td>
</tr>
<tr>
<td>Oral Health Services</td>
<td>Primary &amp; Community Based Services</td>
</tr>
<tr>
<td>Primary &amp; Community Based Services</td>
<td>Primary &amp; Community Based Services</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Aboriginal Health</td>
</tr>
<tr>
<td>Emergency Department Services</td>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Acute Inpatient Services</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Overnight Acute Inpatient Services</td>
</tr>
<tr>
<td>Rehabilitation and Extended Care</td>
<td>Same Day Acute Inpatient Services</td>
</tr>
<tr>
<td>Teaching and Research</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation and Extended Care</td>
</tr>
<tr>
<td></td>
<td>Teaching and Research</td>
</tr>
</tbody>
</table>
SA will need to develop a comprehensive model. The progressive development and implementation of components of the model will be required to enable the public health system to effectively move to a regional population based funding approach, including alignment with the designated key outputs and programs of DHS. It is likely that a review of the DHS program structure will be required in the development of the comprehensive model.

The results from GHR’s preliminary work are informative and the indicative model provides a good starting point for SA. Acute care is a major component of the health care system and resource utilisation. Hospital services account for approximately 67% of government expenditure on health services in South Australia.

At one level, the indicative model developed for GHR is relatively straightforward and involves two key steps:

- weighting the population for measures of need weighted:
  — on the age and sex of the residents in the region using service utilisation as the proxy for need
  — for other need measures, including premature death, socioeconomic disadvantage, remoteness and Aboriginal and Torres Strait Islander population
- adjusting for consumer flows between regions.

### Population weighting

Table 4 illustrates the impact on the regions from applying a weighting for age and sex, service utilisation and other needs, through the health needs index.

<table>
<thead>
<tr>
<th>Region</th>
<th>Raw</th>
<th>Utilisation</th>
<th>Needs index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Adelaide</td>
<td>21.9%</td>
<td>19.3%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Central Adelaide</td>
<td>28.6%</td>
<td>31.2%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>21.6%</td>
<td>21.9%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Northern and Far Western</td>
<td>5.6%</td>
<td>5.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Mid North</td>
<td>3.6%</td>
<td>4.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Wakefield</td>
<td>5.0%</td>
<td>4.9%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Hills Southern</td>
<td>5.1%</td>
<td>5.2%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Riverland</td>
<td>4.5%</td>
<td>4.5%</td>
<td>6.3%</td>
</tr>
<tr>
<td>South East</td>
<td>4.1%</td>
<td>3.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The impact of this weighting process is significant for some regions. For example, the population funding share of Northern and Far Western nearly doubles when population need factors are taken into account, indicating the responsiveness of the model to the health needs of remote and Aboriginal populations.

It is worth noting that there will be health inequalities within every region and the health needs index described below will accommodate for this.
Table 5 provides an indication of the composition of the health needs index and the relative indices for each of:

- standardised mortality ratio (SMR)
- index of relative social disadvantage (IRSD)
- accessibility and remoteness index (ARIA)
- Aboriginal and Torres Strait Islander percentage (ATSI%).

<table>
<thead>
<tr>
<th>Region</th>
<th>SMR</th>
<th>IRSD</th>
<th>ARIA</th>
<th>ATSI%</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Adelaide</td>
<td>97.81</td>
<td>964</td>
<td>0</td>
<td>1.54</td>
<td>97.27</td>
</tr>
<tr>
<td>Central Adelaide</td>
<td>105.25</td>
<td>1026</td>
<td>0</td>
<td>0.80</td>
<td>96.96</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>82.60</td>
<td>1035</td>
<td>0</td>
<td>0.71</td>
<td>89.73</td>
</tr>
<tr>
<td>Northern and Far Western</td>
<td>138.29</td>
<td>956</td>
<td>5.65</td>
<td>9.75</td>
<td>140.46</td>
</tr>
<tr>
<td>Mid North</td>
<td>116.45</td>
<td>950</td>
<td>3.49</td>
<td>2.65</td>
<td>118.34</td>
</tr>
<tr>
<td>Wakefield</td>
<td>100.55</td>
<td>1006</td>
<td>1.44</td>
<td>0.77</td>
<td>101.82</td>
</tr>
<tr>
<td>Hills Southern</td>
<td>87.76</td>
<td>1021</td>
<td>1.37</td>
<td>0.59</td>
<td>97.06</td>
</tr>
<tr>
<td>Riverland</td>
<td>112.09</td>
<td>957</td>
<td>3.28</td>
<td>2.80</td>
<td>116.15</td>
</tr>
<tr>
<td>South East</td>
<td>100.67</td>
<td>995</td>
<td>3.05</td>
<td>1.08</td>
<td>108.94</td>
</tr>
</tbody>
</table>

The somewhat counter-intuitive high SMR for Central Adelaide is noted but there is wide variation of IRSD within Central Adelaide. Also NSW found that the ABS counted all homeless (and people with no fixed address) to postcode 2000. It is likely a similar situation exists for Adelaide. At the NSW department’s request, ABS has now dealt with this situation and SA will need to address these sorts of issues in the next rounds of refinement.

Adjusting for consumer flows

The model takes account of consumer flows across regional boundaries and differentiates between general flows, and high cost and complex case (HCCC) flows. HCCC flows seek to represent services concentrated in statewide referral hospitals (see Chapter 3) that are considered neither possible nor desirable to reverse. Conversely, general flows are services that are currently provided out of the region but could feasibly be reversed with adequate changes to local service capacity and referral patterns.

There are four key options for adjusting for consumer flows across regional boundaries for services:

- Adjust for all flows.
- Distinguish between HCCCs and other flows. Build HCCCs into the model but have regions contract for other flows.
- Use the NSW approach in which all flows are built into the formula but there is a planned flow reversal strategy using a budget holding approach.
- Do not adjust for flows. Have regions receive full share of funding and contract for services with each other.
At one end of the spectrum, the population share of funding could be given to the region of residence and any consumer flows would require regional funding transfers. This would include transactions for consumer flows that are not feasible or desirable to reverse and could be unnecessarily complicated and inefficient.

At the other end of the spectrum, the funding of consumers flows could be given to the region providing the services. In this case, no inter-regional transfers would be needed. However, the region responsible for the health of its population would have little leverage over the resources required to reverse consumer flows through service developments.

It is not feasible nor desirable for some services to be provided within each and every region of the state. Making a conscious decision about what level of self-sufficiency is appropriate for metropolitan and country regions would guide decisions on how to deal with consumer flows in the funding allocation model.

NSW has separated out HCCCs and general flows and has recently set up a budget holding approach whereby, on the basis of a business case, a region is allocated the funding required to establish and provide specifically targeted services locally for 12–24 months. If after this period the services are deemed effective and sustainable, a decision is required to permanently shift funding from the historical to new region of provision. The advantage of the budget holding approach is that this can be achieved in a planned fashion, incrementally in line with regional funding targets and local service priorities.

An alternative is for the region of service to hold all the funding for HCCC flows and regions of residence to hold the general flow funding and contract with provider regions.

GHR supports an approach whereby DHS:

- builds all flows into the initial regional allocations, that is funding is allocated to the region providing the services
- develops a basis to distinguish between tertiary and quaternary flows and natural and general flows for SA
- avoids moving to a model that will involve significant transaction costs
- plans and targets flow reversals.

Experience shows that to make such service changes requires significant planning, resourcing and commitment over the longer term.

Using the NSW basis for distinguishing flows, the net flow (i.e. inflows less outflows) of services for Adelaide metropolitan regions were calculated and are presented in Table 6 for the recommended Adelaide regions.
Table 6: Net flows in the Adelaide metropolitan regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Net general flow only (weighted separations)</th>
<th>Net HCCC flow only (weighted separations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Adelaide</td>
<td>21,500 outflow</td>
<td>11,500 outflow</td>
</tr>
<tr>
<td>Central Adelaide</td>
<td>45,500 inflow</td>
<td>29,500 inflow</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>0 flow</td>
<td>2,500 inflow</td>
</tr>
</tbody>
</table>

Note: Includes rural and remote flows

The key observation from this analysis is that residents living in the northern suburbs of Adelaide, in direct contrast to residents in central and southern suburbs, are receiving significant levels of general and HCCC services out of their region.

The financial implications of this are indicated in Figure 15. The average cost per weighted separation has been estimated at $2300.4 for this purpose.

Figure 15: Net flow of funds for three Adelaide metropolitan regions

Note: Includes rural, remote and interstates flows.

This analysis indicates a significant investment in service capacity and provision is required in the northern suburbs to ensure consumers do not have to travel out of their region to access general hospital services. Within a constrained budgetary context for health, this level of investment will require counterbalancing contractions in service capacity elsewhere in the service system.

As indicated in the assessment of regional configurations in the previous section, a two-region model for metropolitan Adelaide would not identify the maldistribution of services in the northern suburbs (Figure 16).
By combining northern and central Adelaide the resource and service issue in the northern suburbs is not identified. There is a net inflow of consumers from other regions to the northern region, suggesting there is scope for flow reversal out of the region rather than the strengthening of services in the northern suburbs. The two-region model masks, rather than highlights, the clear need for investment in service capacity in the northern suburbs of Adelaide.

As stated earlier, GHR believes that without strong advocacy, management leadership and political will the health inequalities that exist in the northern suburbs of Adelaide will persist. Without a separate governance function, without adequate funding and without separate identification of the communities involved, the lack of health services in the northern suburbs could easily be overlooked and disguised.

GHR believes there are compelling reasons to support a three-region model in metropolitan Adelaide as it will more clearly demonstrate and achieve equity objectives.

**Model development and ongoing refinement**
The development, refinement and introduction of a population health funding model for South Australia will require significant investment in change management, technical expertise and analytical capacity within the central administration.

There are several key components of the indicative SA model that will require further initial consideration, including:

- definition of the basket of diagnostic related groups to be considered HCCC
- policy that specifies what level of self-sufficiency is considered desirable and achievable at the regional level for each service category
- development of a discount factor for private hospital utilisation recognising that it is not all substitutable for public hospital utilisation
- policy for dealing with consumer flows, including how to plan and target specific flow reversals.
Inevitably there will need to be progressive development and application of the full population health funding model, including periodic refinement and updating as new data comes to hand and research indicates material changes to the validity of the model. For example:

- reviewing need indices
- updating population projections
- refining age and sex weights
- refining program budgets
- reviewing the treatment of revenue
- investigating output measures for teaching and research, and community based services.

The experience of NSW demonstrates that the model will evolve over time and, to help guide the development of the model and increase its understanding and ownership in the health system, an advisory group made up of clinicians, administrators and academics is invaluable. In NSW this group is called the Resource Distribution Formula Advisory Committee and is chaired by the departmental officer responsible for the population health funding model.

**Recommendations**

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.

**Population service planning**

Population health funding works to allocate to regions a fair share of the fixed pool of health funds. This enables regional responsibility for the planning and delivery of services to improve population health. However, there is a need to consider overall statewide service requirements, both now and in the future, to determine the global quantum of funding that will need to be made available for allocation to regions through the population funding model.

The development, upgrade or redevelopment of inpatient facilities needs to be planned, not on a hospital by hospital basis as it has to date, but on a population needs and system-wide basis. With regional structural arrangements it is necessary to address service requirements at both a statewide and regional level.

As outlined in Chapter 1, a population service planning model has been developed to assist in determining the activity levels and distribution of hospital admissions, bed requirements and costs to the year 2011. The model can be adjusted to take into account various factors, such as demographic and clinical practice changes, and can make adjustments to reflect desired patient flows (shift of hospital admissions from one hospital to another and from one region to another) and demand management strategies.
For the purposes of GHR the model produced two scenarios. The first scenario is the status quo, which takes into account population projections only. The second scenario incorporates changes to reflect the refinements recommended by GHR.

At this stage the model focuses on acute inpatient care and it is suggested that further work be carried out to assess the broader community service requirements. This is a priority to ensure that a system focus is developed and maintained.

The recurrent implications of the capital and service developments indicated by the work are significant. GHR considers that capital and service development plans for South Australia should be guided by the projected regional funding targets set through the population health funding model in the future. Therefore, it is important that specific facility activity targets within the population service planning model accord with the direction and magnitude of recurrent regional funding indicated under the population funding model.

**Recommendation**

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.

**Population health funding and health service funding**

The approach to population health funding recommended by GHR will be an integral component of a two tier funding model for the South Australian public health system.

**Tier One** will operate between DHS and regions and seek to distribute resources equitably across the geographic regions. The underlying principle is that people with equal need should have equal access to health care. The population health funding model will be the principal mechanism guiding funding at this level.

**Tier Two** will operate between the regions and the health services and seek to distribute resources equitably to health services. The underlying principle is that services doing equal work should receive equal funding.

Regions will receive and apply the funding allocation from DHS to fund health services under their management.

GHR is of the view that funding models based on the outputs or casemix of services, involving statewide funding guidelines and benchmark pricing, should be developed and employed by the regions to fund acute hospitals and integrated community care centres. The intention is to expand output based funding to other services and programs currently funded on an historic basis as suitable classification schemes are developed. This includes primary care community based services, and will require significant investment in research, development and supporting infrastructure by DHS and the regions.

Current research and development capacity for funding models and classification instruments in DHS is limited. There is a strong case for investing resources in this area so as to inform strategic funding and service performance policy in the future, including issues relating to service quality and safety.
Further, there is scope to develop additional capacity in population health research that will also inform funding allocation issues.

GHR recognises that South Australia needs to continue refining its approach to service funding as alternative methods for funding specific health services are developed, along with clear demonstration of their practical application and usefulness for facilitating desired objectives. For example, in some areas, it may be possible to move to higher level outcome based funding in the future.

**Recommendations**

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.

**Greater certainty in population health funding**

The planning, development and eventual provision of health services require significant lead time and will involve longer term decision making at the regional and statewide level.

Health authorities and services in South Australia work within a financial context that is based on annual appropriations of funding. While forward estimation by the SA Department of Treasury and Finance provides some basis for future financial planning in the health system, there can be no firm commitment by government to these estimates, given the appropriation of funds by parliament on an annual basis.

GHR considers there is scope within the current funding context for health to improve longer term certainty in funding for regional health services (see below) in South Australia and thereby assist with longer term service investment decisions. A commitment to a three year budgetary cycle would provide:

- greater certainty in funding for regional governing bodies for future years
- indexation that appropriately takes account of changes in price, utilisation and clinical practice
- a basis for a higher level of financial discipline to be encouraged in the health system.

GHR believes there would be significant benefit to health services in South Australia if DHS developed a similar commitment to multi-year recurrent funding for health programs. Discussions should continue between the Department of Treasury and Finance and DHS regarding avenues to achieving greater certainty over capital funding over the longer term, for example five to ten years.

GHR believes this is a particular issue for Aboriginal agencies, where a lack of funding certainty means it is difficult for agencies to plan beyond the annual funding cycle and many staff are dependent on short-term grants for their employment. This makes it hard to attract and retain Aboriginal workers and perpetuates the perception of a highly transient Aboriginal workforce.
Recommendations

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.

Population health governance

While the establishment of planning regions and population health funding are important elements in driving a population health approach, GHR believes they will not be fully effective without corresponding changes in the organisation and governance of health services.

As indicated earlier in this report, GHR considers that current arrangements for governing public health services in South Australia create major barriers to improving service coordination and promoting population health.

There is a need and a message of broad support from GHR consultations for a governance structure that promotes stronger partnerships and linkages between and among the many providers, organisations and sectors. This can be achieved by locating the authority and responsibility for population health within a regional framework.

GHR considered two alternative approaches to regionalisation.

- **A regional governance approach** — would provide two levels of governance and involve the creation of regional boards of governance in metropolitan Adelaide, maintenance of a regional board structure in rural and remote South Australia, the dissolution of existing incorporated health units and provision for the establishment of local community advisory bodies to preserve and strengthen community participation.

- **A whole-of-system approach** — would provide one level of governance and involve the dissolution of existing incorporated health units and provision for the establishment of local community advisory bodies to preserve and strengthen community participation. Unlike the regional governance approach, this would involve the dissolution of existing country regional boards and the establishment of regional offices of the central administration.

Two key goals for the new governance arrangements are:

- **population health focus** — to establish strong regional governing bodies that are adequately equipped to accept some level of real responsibility for maintaining and improving the health of a population

- **efficiency and effectiveness** — to minimise duplication of governance structures and processes while enhancing community input into decision making at the regional level.

After careful consideration, GHR strongly supports the regional governance approach and is proposing the creation of incorporated regional health services and regional health boards.

This decision was made with a clear understanding of the need to locate unambiguous authority and responsibility for population health care to ensure effective and timely decision making at the right levels in the health system. GHR has responded to the need for an arrangement that provides an appropriate
balance between central decision making and local responsiveness. To this end, and in the pursuit of efficiency, GHR sought to ensure that there are no more than two levels of governance.

GHR strongly favours the establishment of a second tier of governance in the form of regional boards. By establishing legislated boards of governance at the regional level, the government will be able to effectively pursue a population health focus in the health system and strike an appropriate balance between central coordination and planning of statewide services on the one hand, and local decision making about the appropriate level and mix of services on the other.

This will require the dissolution of all currently incorporated health units and the integration of their management into regional health services.

During consultations GHR was given a clear impression that the public, providers and administration considered that regional governance provided a good compromise between local parochialism and centralised control.57

About 80% of people responding during the consultations indicated that they would prefer boards of governance to be responsible for all health services in their region rather than just their hospital. Further, over twice as many people thought regional governance with the dissolution of individual health unit boards would be more efficient and effective in contributing to seamless services than regional governance with the maintenance of individual health unit boards.58

**Existing agreements with incorporated units**

Over recent years a number of smaller country health units have combined to form new amalgamated governance arrangements in order to establish and manage multi-purpose services (e.g. the Kangaroo Island Health Service). Sub-regional service arrangements, in a partnership between the South Australian Government and the Commonwealth Government, have been pursued. The current parties to the agreements supporting these arrangements are DHS, on behalf of the state, regional health services, the amalgamated health unit board and the Commonwealth Government.

GHR considers as a general principle that all agreements between health units incorporated under the SAHC Act and other parties will need to be renegotiated to reflect the new regional governance arrangements with regional health services and/or DHS as the principal state party to the agreements.

This will require all sub-regional agreements to be renegotiated with the Commonwealth to establish regional health services and DHS as the state parties to the agreements. This form of approach to multi-purpose services is consistent with other states, in particular NSW where a regional governance model is currently in place.

**Community participation**

Previous attempts to undertake similar reforms have been criticised for the apparent lack of checks and balances on ministerial powers and the delegated powers of the central administration. During GHR consultations it was clear from the community and providers they want a strong voice to be maintained out in the community. GHR believes regional boards, along with a legislated mandate for local community participation and input into decision making, will provide this voice (see Chapter 3).

**Other incorporated and unincorporated services**

The regional governance approach will bring hospitals and community based health services under a common regional framework.
There are several incorporated health agencies that require specific consideration, given the nature of the services and the population they serve. This includes Child and Youth Health, Drug and Alcohol Services Council, and SA Dental Service (SADS).

There are a number of unincorporated agencies currently operating under the auspices of incorporated health agencies that will need to be considered under any new regional governance arrangements. These services include Yarrow Place, Women's Health Statewide, Pregnancy Advisory Centre, and Child and Adolescent Mental Health Services (CAMHS).

Finally, there are several statewide and metropolitan community based agencies that are not incorporated under the SAHC Act or under the auspices of incorporated agencies even though they provide core public health services and are largely funded through government sources. Examples include Sexual Health Information Networking and Education, South Australia (SHine SA) and Royal District Nursing Service (RDNS).

The following services are given specific consideration in this section:

**Statewide services**

- Child and Youth Health
- Drug and Alcohol Services Council
- South Australian Dental Service
- SHineSA (not incorporated under SAHC Act)
- BreastScreen SA (not incorporated under SAHC Act)
- Yarrow Place (not incorporated under SAHC Act)
- Women’s Health Statewide (not incorporated under SAHC Act)
- Pregnancy Advisory Centre (not incorporated under SAHC Act)
- Child and Adolescent Mental Health Services (not incorporated under SAHC Act)

**Aboriginal services**

- Pika Wiya Health Service
- Ceduna Koonibba Aboriginal Health Service Inc

**Metropolitan home based care**

- Metropolitan Domiciliary Care
- RDNS (not incorporated under SAHC Act).

**Regional governance**

GHR considers, as a general principle, that all health agencies incorporated under the SAHC Act should be dissolved (including their boards) and form part of a regional health service.

GHR considers it is not sufficient for a health service to be able to demonstrate that it provides a super-regional or statewide service to be exempt from the regional arrangements. For instance, it is intended that all currently incorporated public hospitals become part of a regional health service, regardless of any statewide role of major metropolitan hospitals.
However, unlike acute hospital services where consumers generally need to attend a facility, it may not make sense in all instances to locate the control of each particular community based service in the region where its central facilities currently lie or indeed within only one region.

While it may be expedient for some statewide services to initially become part of one region, the overriding longer term aim will be to ensure, where feasible, that each region has the capacity to manage and provide specialised community services regionally. This will require the full regionalisation of the services.

In considering the feasibility for full regionalisation, the social benefits of local provision and access of services needs to be considered in the light of an assessment of the potential for achieving efficient and effective local service provision — sufficient critical mass, economies of scale and/or scope, and local workforce capacity.

GHR considers that, as a matter of principle, all service funding should flow through the population health funding model and allocations be established for each region.

Three approaches were identified.

- **Integrated governance** — where funding is allocated to the regions and the regions develop and provide the services locally. Under this approach governance, funding and planning are integrated.

- **Integrated funding** — where funding is allocated to the regions and the regions develop agreements with the service organisations outside their region regarding the nature and level of services to be provided locally. This may ultimately drive evolution of service provision to regions of residence over time.

- **Integrated planning** — where funding is allocated to the region but tagged to specific services and organisations. However, there will be a requirement that health services, or their home regional health service, participate in service planning with the respective regions. If this option is used, budget holding approaches could be introduced to encourage local provision of appropriate services over time.

GHR has not sought to make recommendations on the specific governance and funding arrangements for each of the services listed above. However, it does support:

- the dissolution of separate incorporation of all health services under the SAHC Act considered above and their integration into regional health services along with incorporated hospitals and other health services
- funding for all health services considered above to be incorporated into the population health funding model and allocation targets set for each region
- the full regionalisation of all health services considered above (where planning, funding and provision are integrated into the regions) within three years, giving due regard to the specific nature and organisation of service provision in each case.

One possible approach to regionalisation for each service identified above is outlined below for consideration.

**Statewide services**

- **Child and Youth Health**

  GHR considers the nature and scope of services provided by this organisation lend themselves to being fully regionalised (with the possible exception of Torrens House).
• **Drug and Alcohol Services Council**
  GHR considers that the nature and scope of services provided by this organisation lend themselves to being fully regionalised.

• **South Australian Dental Service**
  GHR considers the nature and scope of services provided by this organisation lend themselves to being partially regionalised with the community based service funding and provision becoming the responsibility of each individual region. The SA Dental Hospital and research and training functions could be retained centrally and become part of a metropolitan region.
  GHR is aware of the potential impact acute funding difficulties, and resultant long waiting lists for oral health services in South Australia, may have on immediate regionalisation of these services. Although the waiting time for dental services has decreased since June 2002 with the injection of an additional $2 million by the State Government and introduction of demand management strategies, current waiting time for dental services is more than three years with 71,000 people waiting for basic restorative and dentures services.
  As long as the current funding context prevails, it may not be prudent to proceed with the partial regionalisation of SADS. Regionalisation of community based dental services at this time could place unrealistic expectations on regions for service provision. This could run the risk of misdirecting public concern and undermining the overall success of the new regional arrangements.
  In the short-term, SADS could become part of one of the metropolitan regional health services. SADS funding could be managed through the integrated planning approach (defined above) in the first instance, with community based service funding tagged to regions and strengthened SADS participation in regional planning.

• **SHineSA (not incorporated under the SAHC Act)**
  SHineSA provides public statewide sexual health services. GHR considers it may be beneficial, given the nature and scope of services provided by the organisation, for SHineSA to be given the opportunity to be integrated into regional health services. Discussions between DHS and SHineSA to explore the possibility of regional governance of the organisation are indicated.

• **BreastScreen SA, Yarrow Place, Women’s Health Statewide and the Pregnancy Advisory Centre, SA Organ Donation (not incorporated under the SAHC Act)**
  This group of organisations are either auspiced under incorporated health services or operate as a unit of DHS, as is the case of BreastScreen SA and SA Organ Donation.
  Consistent with developments in rural regions, where women’s health services are being increasingly integrated at the regional level under the National Women’s Health Program, there is a case for full regionalisation of women’s health statewide with governance, funding and planning integrated at the regional level. DHS could assume a role in statewide policy and advocacy for women, to the extent this is currently provided by Women’s Health Statewide.
  GHR considers it would be beneficial to the public health system, given the nature and scope of services provided by the other organisations (e.g. Yarrow Place), for these services to become part of a regional health service in the first instance. In the case of services auspiced by incorporated units, it is intended that the service and the auspicing unit come under the same region.

• **Child and Adolescent Mental Health Services (unincorporated)**
  GHR considers it would be beneficial to the public health system, given the nature and scope of services provided by CAMHS and its regional presence, that it be fully regionalised. This could involve reconfiguration of existing services and establishment of regional service structures that align with, and become part of, the new metropolitan regional health services.
Coordination and provision of services in rural and remote regions is provided by CAMHS, in Adelaide, through regional metropolitan service locations. The continuation of this form of arrangement in the first instance may be warranted. However, there may be opportunities for some country regions to establish local services and this could be pursued in line with funding and service targets through a budget holding approach (if feasible within the capacity of the system).

- **Aboriginal Health Services**
  Consideration of the Pika Wiya Health Service and Ceduna Koonibba Aboriginal Health Service Inc is detailed later in this report.

**Metropolitan home based care**

- **Metropolitan Domiciliary Care**
  GHR considers the nature and scope of services provided by this organisation lend themselves to being fully regionalised with service funding and provision becoming the responsibility of each individual metropolitan region.

  However, GHR is aware that the organisation has recently embarked on a process of consolidation whereby it has moved from a regional based metropolitan service to a centrally administered service with one governing board. DHS has supported this move in anticipation of opportunities for systems development, service efficiencies and alignment with other similar metropolitan community based services, such as RDNS.

  In light of this development, GHR sees the merit of Metropolitan Domiciliary Care becoming part of one metropolitan regional health service in the first instance. Along with other services, the longer term objective would be to achieve fully regionalised domiciliary care services within three years, whereby governance, funding and planning is integrated at the metropolitan region level.

- **Royal District Nursing Service** (not incorporated under the SAHC Act):
  RDNS provides advice and services to people to maintain their capacity and functioning in the community and at home. Experience through the Commonwealth coordinated care trials, and recent moves to more coordinated approaches to community based care, indicate that strong synergies exist between RDNS, Metropolitan Domiciliary Care and general practice.

  While their client groups vary in focus from time to time, together the agencies provide a powerful base from which to build services to help return people to the community after an acute care episode, and to maintain capacity and function in the community rather than access residential care or require acute care in the first place.\(^{59}\)

  Both RDNS and Metropolitan Domiciliary Care have developed central corporate entities in recent times and provide services essentially limited to metropolitan Adelaide. Significant work is under way to rationalise assessment processes and ensure greater integration of home support services in Adelaide.

  There is strong case for Metropolitan Domiciliary Care and RDNS to be placed on a similar footing in terms of governance and funding in the future.

  In line with the overall direction taken to population health governance, the full regionalisation of RDNS in three years could be considered, whereby governance, funding and planning is integrated at the metropolitan regional level.
Other organisations

Certain non-profit, religious, charitable and non-government organisations and institutions are considered to be part of the health system as they control hospitals, health institutions, health services and health support services that significantly contribute to the operation of the system. These affiliated organisations will require clear legislative recognition of their role. While the governance of such organisations will lie outside the recommended regional governance model, GHR considers it is appropriate for DHS to:

- review current arrangements with these organisations and seek ways to improve accountability for funding through performance agreements and capacity building
- progressively devolve responsibility for funding these organisations to regions through extension of the population health funding approach.

GHR supports the integrated planning approach (see definition above) to funding for these organisations in the first instance, with a view to moving to regional funding in the medium term.

Roles and responsibilities

This section will define the broad roles and responsibilities of the Minister for Health, DHS and regional health services (including all their constituent services). Each is considered separately below and all are summarised in Figure 17.

Minister for Health

The Minister for Health has principal responsibility for the public health system and its contribution to the health of the population of South Australia. As such, the Minister for Health should have clear powers to control and direct the resources and services of the health system, in particular DHS as the principal body responsible to the Minister for Health for the management of the public health system.

The recommended regional health governance approach will require appropriate and effective delegation of some of the Minister for Health’s powers to the Chief Executive of DHS and the boards of regional health services.

The Minister for Health should have the following specific powers:

- to control and direct DHS
- to appoint members to regional health service boards
- to dismiss a board of a regional health service or any of its members in defined circumstances
- reserve powers to direct service agencies not delegated to the Chief Executive of DHS (e.g. certain emergency response or public health powers).

Chief Executive of the Department of Human Services

The Chief Executive of DHS has the principal role in facilitating and coordinating the effective, efficient and fair operation of the public health system on behalf of the Minister for Health and through DHS and its senior executive. As such, the Chief Executive of DHS must have clear and significant powers to carry out this role.

The Chief Executive of DHS should be given (either directly or by delegation of the Minister for Health) the following key powers, inter alia:

- to enter into performance agreements and service agreements with regional health services and any other health service organisations to which funds are allocated directly by DHS
- to allocate funding for the provision of health services
- to establish policies, strategies and guidelines for the provision of health services
to appropriate authority over central human resource policies and industrial matters
- to monitor the performance of regional health services in line with performance agreements
- to direct regional health services and other agencies to comply with financial, performance and clinical audits
- reserve powers to direct funded agencies in the coordination of response to emergencies, and when safety and quality of patient care are at risk.

The appointment and dismissal of the Chief Executive of DHS will continue to be managed in accordance with normal public sector management process for government departments.

GHR recognises the need for performance agreements to be mandatory and binding on the participating parties. GHR supports the establishment of arrangements whereby:
- a process of arbitration is set out to facilitate the finalisation of agreements in dispute
- funding can be held back if an agreement has not been reached by a certain time or under certain circumstances
- appropriate unavoidable penalties and rewards (for both parties) are attached to performance under the agreements.

It is proposed that the senior executive of DHS be made up of:
- Chief Executive of DHS
- executive directors of DHS
- chief executive of each regional health service (recommended 9).

GHR considers the inclusion of the chief executive of each regional health service in the senior executive of DHS will promote shared leadership and accountability in the public health system and establish regional health services as central to the decision making of DHS.

The Chief Executive of DHS and the Minister for Health will have the general capacity to meet directly with the chief executive and chair of the board of all the regional health services from time to time in relation to the operation and performance of the health system.

**Role of DHS**

Regionalisation and decentralisation of the South Australian health system will have significant implications for the role and function of DHS. Along with devolution of operational matters, DHS will need to withdraw from direct control of local service planning, funding and management. DHS principal roles will be to provide statewide policy direction, set standards and guidelines for cross-regional infrastructure, regulate and coordinate public and environmental health services across the state, build sustainable capacity within the government and non-government services sectors, provide equitable levels of funding to the regions, and carry out appropriate regulatory functions.

The clear lesson from other health systems, where regionalisation has taken place, is that DHS should play a strong role in developing common service planning approaches, service funding protocols and setting high level common standards and practices across the system. For example, while the particular information needs of regions will vary, there is a case for DHS to develop a statewide information policy. This would ensure information technology and information systems and classifications for the health system, including data definitions, are consistent across all regions and services.
In particular, DHS will have a continuing and strengthened role in:

- setting of statewide policy directions and priorities
- coordinating statewide planning and policy making, including clinical service planning for tertiary and quaternary services where self-sufficiency at the regional level is not feasible or desirable
- promoting clinical service networking within and across geographical regions, including stronger coordination of metropolitan and country service provision
- ensuring shared clinical and non-clinical support services across regions and statewide (e.g. information technology, pathology, payroll)
- setting and implementing funding policy (including budget negotiations)
- advising the Minister for Health on the allocation of budgets to regions
- providing and coordinating support services to regions
- regulating and coordinating public and environmental health
- improving capacity and providing a repository for statewide funding, service and population data
- coordinating statewide health research.

Authority and responsibility for population health improvement and health services will rest with regional health services. Regionalisation will require a significant relocation of central resources and staff to regions. The new regional structure will need to be developed from within existing resources.

**Regional health services**

Regional health services will be established with a board of governance. The board will control the affairs of the regional health service and will be responsible to the Minister for Health and Chief Executive of DHS for promoting, maintaining and restoring the health of the resident population of the region and for the conduct and management of the health service agencies in the region.

The board will be required to provide governance for all aspects of the operation of the regional health service, in line with approved policies, strategies and guidelines.

The regional health service will be the employer of all regional staff. The board will have responsibility for the appointment and dismissal of the chief executive of the regional health service, subject to the consent of the Chief Executive of DHS.

The regional health services will have the power to enter into agreements and contracts with other public and private health care providers for the provision of health services for the people of the region.

**Board membership**

GHR considers that the success or failure of population health governance will largely depend on getting human resources right. Getting the right governance structures is one thing, but experience from other regional health systems clearly indicates that unless the right people are appointed to boards and into management the system will fail. Boards need people with strong leadership skills who bring expertise and experience essential to the business of the regional health services. The role of a board member brings with it a special set of responsibilities.
GHR considers the following will be essential to attract and prepare board members for their role:

- All board members will be paid a sitting fee at a rate determined by the Minister for Health.
- All board members will be provided with an intensive induction and ongoing education program.

**Recommendation**

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.

Establishment of regional health services can be by various mechanisms. One approach is for the SAHC Act to deal with all matters to do with their establishment and operation. Another and more flexible approach is to deal with substantive matters in the SAHC Act, with other matters covered in a constitution. Under the latter approach, the Minister for Health could approve for each regional health service a constitution under which services will be administered. The appointment of board members, including the chair, would be by the Minister for Health, with the constitution delineating the number of members over which the Minister for Health has discretion and those the Minister for Health appoints following nomination or election.

As part of a nomination process, GHR supports:

- the provision for regional health services to undertake a public call for expressions of interest for a specified number of positions and requiring specific expertise and experience
- a membership based on skill requirements and merit not on representation.

**Regional chief executive**

The chief executive is responsible for the affairs of the regional health service in accordance with board directions and is an ex-officio member of the board. The chief executive will be appointed by the board of the regional health service, subject to the approval of the Chief Executive of DHS, and will be required to enter into a performance agreement with the board.

The chief executive of the regional health service will have delegated authority to lead and manage the operation of the service on behalf of the board.

**Health agencies**

Health agencies previously incorporated under the SAHC Act will be incorporated within regional health services, which will become the employer of all staff.

Alignment of health unit services with the health needs of the population and service priorities identified by the regional health services will be critical to the success of the regional health services as they seek to improve the health of residents and address health inequalities. Accordingly, the chief executives of regional health services should enter into performance agreements with the health unit managers.

As discussed earlier, GHR proposes that the funding of non-government organisations, charitable and religious organisations be devolved to regional health services over time. Regional health services will have the power to enter into service agreements with these organisations in the provision of public...
health services. In practice, a statewide agreement may be preferable in some specific cases. However, by devolving all funding, the regions can have effective input into these agreements and greater potential leverage over the level and nature of services that could be provided locally over time.

**Community control of property and fundraising**
Community members have expressed concern that community participation and fundraising efforts could be threatened through perceived loss of control over local health units and, in some instances, the property and other resources vested in the health service but acquired by the community.

GHR proposes that, upon the transfer of an incorporated health unit's functions to a regional health service, the relevant property of the unit will be vested in the regional health service. However, if the property cannot be dealt with in this way, provision will be made for a trust to be established with trustees drawn from the community served by the incorporated health unit, to provide ongoing custodianship and voice for the interests of the local community. For the purposes of illustration in this report, these bodies have been termed community resource trusts.

In recognition of the important fundraising role played by the community in support of local health services it is intended that community resource trusts also have the capacity to receive, administer and disburse funds on an ongoing basis.

Alignment of community contributions with service plans and priorities of the regional health services will need to be a fundamental objective in establishing these new bodies.

**Recommendation**

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.
• 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

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

• 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

• Trusts to comprise people from local communities
• Responsible for administering property and funds raised by community in line with RHS plans and priorities
Legislative requirements
The SAHC Act provides the legislative basis for defining the current structures, functions, powers and accountabilities within the public health system. There are currently more than 70 organisations incorporated under the SAHC Act, with over 100 unincorporated organisations receiving state funding and contributing to the operation of the public health system.

The changes to the governance structures and processes recommended in this report seek to fundamentally reorient the health system from:

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

GHR is seeking through legislation to establish bodies and processes to make the system more accountable to the community with health system performance and decision making more transparent and inclusive. Chapter 3 details these recommended changes.

The existing legislation is poorly placed to accommodate the recommended changes. Advice to GHR indicates that extensive amendment to the SAHC Act will be required to enable the implementation of the full set of recommendations. Even then, the fundamental objects and language of the SAHC Act would still reflect the health system of 30 years ago.

GHR understands that legislative amendment is a likely prerequisite to the formation of the recommended new country regions and the dissolution of health units. This is because under the current legislation each existing incorporated health unit (including the existing seven country regions) cannot be dissolved or amalgamated without the consent of its health unit board.

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.

Recommendation

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.
42 Submission numbers 266, 272, 280, 286 and 289 to GHR.
43 Submission numbers 154, 188 and 192 to GHR.
44 Bright CH, Report of the Committee of Inquiry into Health Services in South Australia, Government Printer, South Australia p311, 1973
46 Submission No 192 to GHR.
47 Eckstein G and Eagar K, Towards population based funding and governance of the South Australian health system, Centre for Health Service Development, University of Wollongong, 2002
48 Duffy P, Country health regions: a summary of key achievements since regionalisation, DHS Adelaide 2001
49 SA Divisions of General Practice Inc, submission to the Commonwealth Department of Health and Ageing Review of Boundaries for Divisions of General Practice, p 5, 2003
51 op cit Eckstein G and Eagar K, 2002
52 op cit Steering Committee for the Review of Commonwealth/State Service Provision, 2003
53 op cit Eckstein G and Eagar K, 2002
54 op cit Eckstein G and Eagar K, 2002
55 Corporate governance is the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as the board, managers, shareholders and other stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set, and the means of attaining those objectives and monitoring performance. Definition by OECD, Principles of corporate governance, 1999 www.oecd.org/daf/governance/principles.htm
56 Submission numbers 154, 266, 289 to GHR and Australian Nursing Federation response to GHR Discussion Paper October 2002.
58 ibid page 20
59 Advanced Community Care Association, Advanced care in residential living project, Adelaide, 2003
60 GHR, Drafting guidelines for new health legislation, March 2003
SUCCESS STORY

Early Intervention Therapy Centre

A Riverland Paediatric Team consisting of an Occupational Therapist, Paediatric Physiotherapist, Speech Pathologist and the Early Intervention Services Coordinator was formed in 2001. The team has strengthened its relationship with Education Department staff and broadened its membership to incorporate the visiting Paediatrician. This cooperative approach has resulted in an overall improvement in the assessment, screening and provision of services to this client group. In particular, it has resulted in an increased awareness of the child’s overall needs from the time of initial referral, rather than the child being referred to one discipline and then further needs being determined months later.

The team provides support, education, activities and therapy for children 0-6 years with developmental delays or disabilities or at risk of delay and has been held at preschool facilities for approximately ten years.

In 2001, the Riverland Regional Health Service purchased a transportable building and established the new Early Intervention Therapy Centre on health service grounds. The Centre now provides central based therapy, groups and resources and promotes a sense of belonging for families. This has enabled therapists to provide therapy, assessments and groups using shared resources and equipment.
CHAPTER 3: PROMOTING A PRIMARY HEALTH CARE FOCUSED SYSTEM

This chapter delivers a framework for a reoriented health system focused on primary health care. The key attributes of a primary health care focused system are explored from consumer and system perspectives. The text describes the component parts of the system and mechanisms for integration, partnerships and coordination, and also addresses enabling infrastructure including information technology, telecommunications, capital, research and health futures.

**Objective**

The objective of this chapter is to propose a framework that will ensure that the South Australian health care system, in partnerships with governments and stakeholders, can provide safe, accessible, efficient and effective health care.

**Vision for the future**

GHR proposes a primary health care focused system for the future that:

- is centred on the needs of consumers, providing services appropriate to people’s needs and delivered as close to the home as possible, with compassion and sensitivity
- provides a seamless system of care for people, with information shared among health professionals to promote continuity of care
- improves integration and coordination across the health care system, with common protocols, single points of entry and closer links and partnerships between private and public services.

South Australia’s proposed future health care system will have a strong primary health care focus with more integrated, coordinated and responsive services, addressing individual and population needs. It will pursue opportunities for health promotion, illness prevention and early intervention with the inclusion of public health functions as key facets of the proposed system. Networks will be built across the health care system to develop and implement strategies in partnership across governments, non-government organisations, community and private providers.

The future primary health care focused system will be delivered within a population health framework that encourages and enables action on the social determinants of health. It will have the following consumer attributes:

- 24-hour access to a primary care provider
- easy to understand information about quality of care and clinical outcomes to facilitate informed choices about provider and treatment options
- ability to make a range of appointments with clinicians, for diagnostic tests or treatment, with one phone call
- a wide choice of primary care providers able to give adequate time to consumers
- routine contact with people with chronic disease to ensure problems are identified early; provision of education and in-home assistance, and training in self-care to maximise independence
- good coordination between primary and specialty care
- basic personal facts and history provided to each health professional through a secure shared system including common assessment processes
- no need for consumers to undergo the same test many times for different providers
- health professionals informed of the consumer’s hospitalisation, diagnostic or treatment procedures, drugs prescriptions, referrals to other health unit or other service responses through the secure shared system
- no wait for care due to incapacity of the system to meet demand.

From a community and consumer perspective, the future health care system will:

- deliver services as conveniently as possible to the person, predominantly in a primary care setting, in the home or in an easily accessible local facility
- provide services with extended hours covering evenings and weekends
- offer a seamless service focused on continuity of care including service cooperation and coordination across the system
- deliver services that are accessible to all people, regardless of cultural and socioeconomic background
- promote and provide services designed to treat people in the community rather than in hospital, where appropriate
- provide for the needs of an ageing population, by support in the home, early intervention and improved recuperation, rehabilitation and respite facilities
- balance the need to centralise complex, expensive or rare treatments and procedures, with decentralisation made possible by information technology, telemedicine and community based care
- deliver high quality care through networked clinical services in local, regional and central settings.

South Australians overwhelmingly endorsed this vision of a primary health care focused system during the consultation process.

**Case for change**

The system needs to respond to demographic, cultural, economic and social changes, as well as emerging trends in health care and technology. These trends are not unique to South Australia. Health systems all over the world are grappling with these issues.

**The system is under pressure**

The role of hospitals has changed since the last review of the South Australian health system, but not enough to meet the needs of the people of South Australia today or tomorrow. Many medical conditions no longer require hospital admission and previously institutionalised people are now cared for in the community. Advances in medical technology and treatment are leading to better detection of illnesses, better targeting of treatment and less invasive procedures. Better pharmacology is leading to improved drug and treatment management enabling day surgery, shorter hospital stays and quicker rehabilitation. Changes in policy have resulted in the transfer of previously institutionalised people to
community settings (e.g. aged care and mental health). There is an expectation that people with chronic illness and disability, or the frail, should be supported in the community.

Coupled with increasing public expectations for these services, there is a lack of community support service capacity. This is contributing to pressure on the system and affecting the capacity of hospitals to provide timely access to services.

There is international evidence that 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. One study found that the stronger a country's network of primary health care providers, the lower the health care costs and generally the better the health of the population. The more robust the system of primary health care, the more favourable the health outcomes for all ages, particularly children.

The Commonwealth Government's recently commissioned report *Returns on investment in public health: an epidemiological and economic analysis* provided evidence that public health campaigns to address tobacco consumption, childhood immunisation, HIV/AIDS, road trauma and heart disease have resulted in reductions in cases of disease and produced significant and positive returns on investments.

The report states that between 1970 and 2000 there has been a saving of $1.55 for every $1 spent on preventing measles. It also found that the net benefits of reduced tobacco consumption, as a result of the investment in a range of public health measures, amounted to $8.4 billion.

The report suggests that the estimated total benefit of health improvement in 1998 alone, due to lower tobacco consumption from 1970 onwards, was $12.3 billion. Smoking prevention programs have saved the Commonwealth Government $2 for every $1 spent over the past three decades.

GHR acknowledges the challenges of adapting services and clinical practice to meet new demands within the current infrastructure. It is difficult under the current system to shift resources to meet changing demands. The action that is required to address primary health care requires a coordinated and balanced response from a system that consists of much more than hospitals. Strong and effective public hospitals are needed, however the focus of the health system needs to be where people live and work.

**The system is fragmented and duplicated**

GHR received a consistent message that the health system is fragmented and complicated. The current fragmentation and duplication of health care in South Australia is a major weakness that limits system effectiveness. GHR was advised of a number of examples of service duplication that are inefficient and potentially unsafe. Four principal factors contribute to fragmentation on a statewide level which impacts on system capacity to respond effectively to improving health outcomes:

- current governance arrangements
- Commonwealth and state relationships
- primary health care/public and environmental health funding
- lack of infrastructure and common systems.
Current governance arrangements
As discussed in Chapter 2, there are over 70 incorporated health units with separate boards in South Australia. Their primary responsibility is to manage and provide services. To this end they have been effective in maintaining, promoting and protecting their own organisations.

These governance arrangements, together with casemix funding, do not support a population health framework. Casemix drives a funding culture based on hospital beds, length of stay and throughput of patients. This creates disincentives for the system to take a proactive, population based health approach and contributes to competition, duplication and inequity. This is especially evident in rural and remote areas.\(^69\)

Commonwealth and state relations
Commonwealth and state arrangements have been highlighted throughout GHR’s consultations as a major barrier to system reform and a major contributor to fragmentation and duplication. Issues include:

- governance and how Commonwealth funded programs will relate to regional governance structures
- general practitioners and how they can be integrated into a state primary health care system
- duplication of systems and funding streams, particularly evident in smaller communities.

The Commonwealth has a range of responsibilities for health including:

- provision of Medicare funding, including the Medical Benefits Scheme (MBS) which funds general practitioners
- provision of the Pharmaceutical Benefits Scheme (PBS)
- aged care services, including high and low care accommodation, community care packages and HACC services
- primary care services such as Commonwealth regional health services in rural and remote areas
- health program funding such as Aboriginal health, children and families, older people and information technology.

It is essential that the State Government works with the Commonwealth to ensure that the planning, funding and policy directions of the primary care sector provide an integrated primary health care system.

Key to delivery of a primary health care focused system is the inclusion of general practitioners and development of flexible funding arrangements such as funds pooling. A primary health care modelling project undertaken by GHR\(^70\) raised issues of service duplication of primary care service provision by the Commonwealth and state, especially in rural areas.

General practice issues raised included the following:

- MBS has been continually degraded since its inception.
- MBS fails to provide incentives for general practitioners to integrate their activities with state funded health systems, despite the enhanced MBS items available to support primary care activities.
- The workforce is not attracted to entering general practice.
• This is a lack of incentives for general practitioners to delegate aspects of patient care to appropriate nursing or allied health staff.

• General practitioners are not provided with incentives to engage in many preventive, promotional and educational activities, despite many reporting to GHR that they would like to have the flexibility and capacity to be involved in the provision of a more comprehensive primary health care approach.

• There is a lack of choice for consumers to enrol for packages of care.

Primary health care funding
GHR acknowledges the innovative and collaborative programs and projects developed through various grants and short-term program funding across the state. There is much frustration, however, when successful innovations are seldom built into mainstream services. In addition, community expectations are often raised when programs are initiated only to be abandoned, despite their value.71

Primary health care, particularly health promotion and prevention activities, is not typically seen as core business and in many areas is reliant on surplus budget. The pressure is on health units to meet activity targets, limiting the capacity of health units to fund innovative responses to population health needs.

Lack of infrastructure and common systems
Every time a person visits a different agency or health practitioner, a new health record is created. Systems do not talk to each other and consumers repeat their story to each provider. This is exacerbated between regional and metropolitan areas. Metropolitan systems do not talk with country systems. There is little information technology infrastructure to network hospital-to-hospital, provider-to-provider or government department to government department.

A regional health service in a rural area has a different UR Number (case file) for hospital admissions, community and allied health admissions, although they are part of the same organisation and co-located. These identifiers differ from pharmacy, statewide services and general practice. Although an individual may access all services for the one issue, there may be up to four medical records for the same health issue resulting in four assessments and four clinical plans.72

The system does not respond to population health needs
As discussed in Chapter 1 and Chapter 6, it is necessary for the health system to focus on the groups with poor health status, such as Aboriginal people. Aboriginal people have the worst health outcomes of all population groups in Australia and the system is failing to respond to their health needs.

GHR was informed of many instances where health services failed to meet the needs of Aboriginal people. The GHR modelling project in the southern metropolitan area73 identified a range of issues for Aboriginal people:

• transport difficulties

• no sense of Aboriginal ownership and being uncomfortable and unsupported in mainstream services

• lack of local access to general practice services to meet specific Aboriginal health and related needs in a community setting (e.g. people travel by train from Noarlunga to Port Adelaide Community Health Centre to see a general practitioner whom they respect and whom they feel understands them)

• lack of cultural awareness by professionals and services, and the failure of services to provide culturally relevant help

• difficulty navigating the fragmented service system, resulting in poor use of available services and unnecessary reliance on hospital emergency departments.
Ways forward

Relieving the pressure
GHR recognises that 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. However, there are pressures, resulting from the current system design, that require immediate attention. GHR has considered the increasing demand pressures being experienced by hospital emergency service departments in South Australia.

Emergency departments and hospitals are part of a large complex interdependent system. To make an impact on the problems within emergency departments, consideration needs to be given not only to emergency department services but also to the impact of upstream and downstream components of the health system — acute, post-acute, residential care, community health, ambulance services, general practice and specialist services in the community.74

Historically, health systems have tended to provide a greater focus on supply factors to influence utilisation in the hospital sector. However, in recent years the role of the consumer in self-care and health service decision making has attracted greater recognition and, consequently, strategies to strengthen demand side responses are beginning to gain momentum.

Within this context, demand management has been defined as the use of decision and self-management support systems to enable and encourage consumers to make more appropriate use of medical care.75

In this sense, demand management does not imply the withholding of treatment or a decrease in access. Rather, it indicates that the informed consumer is best served by selective, thoughtful requests for medical services and emphasises the autonomy of the individual and the need for appropriate accessible information. By these means, it seeks to reduce both variability in the response to similar medical problems and the mean level of response.76

GHR recommends a strategy for the management of hospital workload that builds on an approach implemented successfully in Victoria.77 This approach emphasises changes in clinical practice (supply) and the way in which consumers access the health system (demand).

The key components of the Strategy for managing metropolitan hospital workload reflect a multi-level system approach to managing the pressures on emergency departments. The components are:

- care in the community
- emergency department access
- efficient use of inpatient care
- discharge planning.

New and existing projects and initiatives have been identified for each component of the strategy, addressing both supply and demand factors (see summary in Figure 18). The links between services and initiatives signal the move away from a single focus to a system focus.

A project management approach, with appropriate project sponsorship, will be necessary for the success of this proposed strategy. GHR recommends that incremental approaches to implementation, including monitoring and evaluation components, be embedded within the process.
Collaboration between health providers in order to create shared opportunities is central to the strategy, and the active pursuit of cooperation between DHS, regional health services and health units in the design of projects and initiatives is critical. A number of partnership opportunities exist including:

- identifying, testing and validating new approaches to health service delivery in order to develop innovative models of care
- reorienting from episodes of care to systems of care required for an illness episode
- increasing levels of information provided to health care consumers, allowing them to pro-actively manage their own health
- promoting self-management, especially for people with chronic diseases
- promoting health outcomes research and evaluation
- continuing to increase efficiency through clinical process redesign
- developing care pathways, building on evidence based practice.
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<tr>
<th>Strategies</th>
<th>Initiatives</th>
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<tr>
<td><strong>Care in the community</strong></td>
<td>Avoidance of hospital admissions: Hospital avoidance packages are categorised into three groups, according to whether the package of care originates from emergency department hospital avoidance packages, general practitioner, hospital avoidance packages or nursing home hospital avoidance packages.</td>
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<tr>
<td></td>
<td>Admission prevention program aims to:</td>
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<td>- identify target conditions and/or cohorts of patients with high volume emergency department presentations and admissions that have potential to be proactively managed in the community</td>
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<td>- undertake focused literature reviews for high volume conditions to document best practice principles and establish an evidence basis for specific prevention plans</td>
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<td>- develop specific prevention plans for hospitals engage clinicians in driving major clinical practice change for target conditions</td>
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<td>- contribute to establishing a collaborative and cooperative preventative approach between all sectors of the public health care system oversee implementation of hospital specific plans</td>
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<td>- establish condition specific network(s) to share information with all participating sites</td>
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<td>- coordinate evaluation of funded projects.</td>
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<td>Call centres have the benefit of improving access to services and information in relation to health and wellbeing.</td>
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<td>Establishment of an interim care or sub-acute system: timely access to high quality sub-acute care plays a critical role in the optimal flow of patients through the health system. This project will review the sub-acute system in South Australia and make recommendations for future service system development.</td>
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<td><strong>Emergency access</strong></td>
<td>Monitoring of ambulance bypass</td>
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<td>Examine improvements to</td>
<td>Consistency of triage project: aims to improve consistency in application of the national triage scale across South Australian emergency departments</td>
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<tr>
<td>emergency processes</td>
<td>Emergency department critical pathways project: aims to standardise treatment according to best practice.</td>
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<td>Development of comprehensive emergency department performance indicators</td>
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<td>Breakthrough collaboration: aims to analyse a range of quality improvement projects, including addressing strategies that examine waiting times and patient satisfaction in emergency departments</td>
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<td>Chest pain evaluation areas: designed to improve the efficacy of patient assessment, thus improving health outcomes as well as maximising efficient use of hospital resources</td>
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<td>Short stay units: examination of the use of such units within South Australian hospitals and the potential for improved efficiencies in the management of suitable patients</td>
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### Strategies

<table>
<thead>
<tr>
<th>Efficient use of inpatient care</th>
<th>Discharge planning</th>
</tr>
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<tbody>
<tr>
<td>Inpatient beds must be used in the most efficient and effective manner possible.</td>
<td>By achieving effective discharge the hospital is freeing up capacity to receive more patients</td>
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</table>

| Designing care: aims to achieve quality improvement, system thinking and organisational learning, business process re-engineering and change management education and training | Sub-acute/acute interface project: aims to improve the transition between the two systems |
| Medical inpatient study: aims to develop a comprehensive account of medical inpatient care | Aged/acute interface project: aims to develop alternative models of care, including maximising access to home based, residential and community services for older people in acute care settings |
| Planning for predictable seasonal variation: will include emergency departments | Care coordinator teams (Phase 1 and 2) would be responsible for the total management of a patient’s discharge into the community. Hospitals would be expected to report on their discharge performance against developed performance indicators. |
| Workload management clearing house | Flexible resources strategy: If future activity can be forecast, bed capacity and resources should align themselves to the assumed activity. Flexible bed capacity and resourcing would occur between and within hospital wards and emergency departments |
| Flexible resources strategy: If future activity can be forecast, bed capacity and resources should align themselves to the assumed activity. Flexible bed capacity and resourcing would occur between and within hospital wards and emergency departments | Hospital in the home and rehab in the home project: involves identification of common condition and potential performance indicators for both programs |

Clinical leadership will be essential and could include:

- expertise and advice in strategy design
- a major role in the implementation process
- input into the coordination of emergency department bypass, including consideration of public and private services
- participation in the development of a coordinated approach to intensive care unit utilisation
- input into the development of a coordinated approach to trauma and retrieval management.

Key elements of the first phase of the strategy include:

- avoiding hospital admissions by improving the management of people with chronic conditions and the elderly in the community, including the provision of care in the home when appropriate
- development of leadership in the area of workload management within DHS.
Over time and based on evidence, funding will be required to channel into supporting improved clinical practices that avoid hospital admissions and redirect care to community based options, sub-acute services, transitional care, short stay and palliative care.

The longer term aim is to provide hospitals with the capacity to improve access and quality of care for emergency patients through individually tailored packages of substitution, emergency department and discharge planning initiatives.

**Recommendation**

3.1 DHS implement the *Strategy for managing metropolitan hospital workload.*

**Call centres**

Internationally there has been increasing interest in call centres, initially for the purpose of medical triage in response to the need to reduce escalating health care costs. More recently, call centres have been being established with the objective of improving consumer health knowledge (e.g. help lines) and as a strategy to reduce unnecessary use of health resources (e.g. emergency departments).\(^78\)

In countries such as the United States, United Kingdom and Canada, call centres act as gatekeepers for access to emergency health care services. The centres provide telephone triage and recommend appropriate levels of care, supplemented by advice on self-care and information about availability. This gatekeeper function has realised indirect benefits, such as improvement in service access across primary care, in addition to emergency services, especially after hours.\(^79\)

As a consequence, health call centres have evolved with a much broader purpose than just medical triage and can be more aptly defined as a navigational service to assist people in accessing appropriate health care and information by employing skilled staff and adopting clinical protocols and specialised information technology. A contemporary health care centre provides a telephone accessible health information and advisory service and can include a supporting internet site.\(^80\)

In Australia, statewide call centres are developing at different rates in each state. Western Australia’s *Health Direct*, launched in 1999, is a free call service that achieved full statewide coverage by June 2000. The ACT’s *Healthfirst*, which began in 2001, includes a health information internet site. Other states are in various stages of implementation or planning.

South Australia currently has more than 160 State Government supported health related help lines. GHR notes the DHS telephone helpline network project, begun in 2001, provides processes for coordinating linkages across the existing telephone help lines and has set up the basis for a more consumer oriented and integrated referral front line health triage centre.

In addition, the National Jurisdictional Group on Call Centres, auspiced by the Commonwealth Department of Health and Ageing, will shortly release a consultancy report. This will provide a meta-evaluation of health call centres nationally and internationally and may assist DHS in the development of plans for the provision of these centres.

In the meantime there is an immediate need for out of hours health information and referral advice. The South Australian Ambulance Service,\(^81\) which has as its primary role to provide pre-hospital medical emergency care and patient transport, is reporting escalating numbers of people using its emergency response line wanting general information about health issues and health services.
GHR believes that a health call centre providing out of hours access to health information and referral advice, facilitated by a telephone helpline network, is one strategy which may assist in managing more effectively the demand on emergency services in the short to medium term.

**Recommendation**

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.

**State and Commonwealth relations**

GHR supports the memorandum of understanding between the Commonwealth and the State Government to establish greater collaboration for primary health and community care. This is an important first step in providing a clear foundation for shared government objectives. State and Commonwealth must build on this understanding and encourage processes for collaborative efforts in the longer term to maximise return on investments in primary health and community care.

The focus on primary care recommended by GHR requires general practitioners to engage in the development of primary care networks and services. This is critical and is one of many examples requiring cooperative action between the Commonwealth and the State Government. Other areas include aged care services, rural and remote primary care services, and program and grant funding.

To address shared governance, cooperative planning and service duplication, GHR believes a joint Commonwealth–state body is essential to reduce duplication and administrative waste. This mechanism is an essential prerequisite to build on the partnership approach developed through the memorandum of understanding.

**Recommendation**

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.

**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 include:

- people working in public and environmental health
- general practitioners
- other key primary care providers
- family carers
- private providers.
Public and environmental health

The definition of public health is:

... the organised response by society to protect and promote health, and to prevent illness, injury and disability. It aims to control the determinants of disease and reduce public exposure to risks encountered as part of lifestyle or in the environment.

Public health takes a population health approach, the goal being to maintain and improve the health status of the entire population and to reduce health inequalities.

Many public and environmental health interventions occur in the primary health care setting. However, many more occur at the population and community level before consumers visit a health professional. These activities include health protection and health promotion strategies, such as health impact assessments, vector surveillance and control, food safety, water and air quality, immunisation, communicable disease surveillance and control, and activities that address lifestyle factors.

Governments have a responsibility for public health legislation, policy development, funding, and monitoring in relation to a wide range of prevention and early detection services. These are integral to the delivery of the social model of health and the proposed primary health care system.

Primary responsibility for public and environmental health services rests with DHS. Local government also plays a vital role in the delivery of public and environmental health services and is ideally placed to respond to local issues. Partnerships between local government and the health system must be maintained and fostered if there is to be an effective public and environmental health response.

Reform of public and environmental health services, like the rest of the health system, is required to address emerging health challenges. Emerging challenges include environmental pressures related to climate change, threats associated with extreme weather events, expanding vector-borne diseases, emerging communicable diseases, land use and degradation, social pressures related to industrialisation, poor diets and physical activity, and demographic changes.

By acting to protect and promote health, a population health approach reduces pressure on clinical services. However, a successful public and environmental health service often goes unnoticed, simply because it is successful. It is easier to identify shortcomings, for example the failure to manage a food-borne disease outbreak, than it is to identify successes, such as statewide protection against the occurrence of such outbreaks. As a result, public and environmental health attracts less emphasis and lower levels of funding than curative medicine.

Funding pressures for public and environmental health have been recognised in the recent review of health services in Western Australia. The report recommended that public and environmental health be seen as a high priority with a ‘... consolidated, quarantined, transparent and centrally allocated budget for preventive public health efforts’. GHR believes that a similar approach in South Australia would provide funding certainty and enable the development and implementation of more effective and responsive public and environmental health policies and interventions.

Public health capacity will provide an important assisting and technical advisory role to the proposed whole-of-government approach detailed in Chapter 6 and to the health performance monitoring body proposed in Chapter 4.
The State Public and Environmental Health Service has an obvious and crucial role to play in reorienting the health care system to a future focus foreshadowed by the [GHR] discussion paper.

The [service] would have multiple functions including:

- Monitoring the incidence and prevalence of a range of diseases and conditions of public health importance
- Coordinating a statewide approach to workforce development in public health and health promotion
- Risk assessment and risk management in relation to population health issues
- Monitoring and control of infectious diseases
- Monitoring and control of non-communicable disease
- Health promotion
- Initiating and supporting public health research
- Evaluation of health promotion and disease prevention measures
- Policy development and advice and advocacy across the whole government
- Injury prevention and control.

DHS requires a strong capacity in public and environmental health, including a critical mass of expertise to meet the above challenges and support the primary health care focused system. GHR believes that DHS should retain its statewide role in population health services planning, delivery and evaluation, working with regional health services, local government, communities and other stakeholders. This includes the provision of epidemiological, research and surveillance capacity.

**Recommendation**

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

**Engaging general practice**

The need for reform in primary care has been recognised and implemented internationally. Examples include Canada, Eire and the United Kingdom. All have made substantial changes to health governance and funding and incorporated general practitioners into the primary health care system.

General practice has a central role to play in a primary health care focused system. It provides primary care, which includes health promotion and illness intervention, continuing care, teaching and research, and referral to specialists, allied health, pathology and imaging services. General practitioners are often called health service gatekeepers and play a role in coordinating and integrating health care services as required.

The majority of general practitioners operate independently through private practices. They receive fee-for-service payments, the majority funded by the Commonwealth Government through MBS.
However there are several other arrangements through which general practitioners operate including:

**Salaried**
This enables general practitioners to be part of a public sector primary care team. Adelaide Central Community Health Service teams located at The Parks and Port Adelaide advise that success is dependent on recruiting general practitioners who share the community health ethic. In these settings the general practitioners see patients about 60% of the time and this time is charged against MBS with resultant income being returned to DHS to offset general practitioners’ salaries. This model has tended to be very popular with Aboriginal clients who tend not to access Medicare and who may not be able to make the gap payments required by many independent general practitioners.

**Sessional**
This is working at Noarlunga Health Services where registered general practitioners provide public services in the emergency department. Noarlunga Health Services recovers fee-for-service income against this arrangement.

**Corporatised practices**
A number of trials of corporatisation of general practitioner services are in place in Australia, notably in the Hunter Valley and in Western Australia. This generally involves a corporate entity claiming fee-for-service on behalf of a group of salaried general practitioners. These arrangements showed early promise but may have relied too heavily on associated diagnostic and pharmacy income to be sustainable in the longer term.

There is a general view that MBS payments to general practitioners limit practice flexibility, particularly in relation to health promotion and illness prevention. The Commonwealth initiated the enhanced primary care program in an attempt to address this issue. However, if South Australia is to have a strong primary health care focused system it will require general practitioners to have the flexibility to work in different ways including increased and ongoing collaboration with other service providers. This may mean a range of activities in addition to patient consultations.

GHR notes Commonwealth and State Government initiatives to provide greater integration of systems between hospitals and general practitioners and between general practitioners and primary health care providers. For example, the general practice memorandum of understanding between DHS, the South Australian Divisions of General Practice and the 14 Divisions of General Practice commits to:

- working collaboratively to develop a more integrated health care system to improve patient care
- involving general practitioners in the planning and development of health services at the local and state level
- involving general practitioners in the development and evaluation of health policy
- improving health system efficiencies (considering opportunities to measure and share savings and benefits)
- identifying and building on examples of good practice.

Getting the right model for general practitioners is essential to the success of primary care services in South Australia. This requires increased capacity in the community based primary care services including 24-hour, 7-day access.
To develop this capacity DHS needs to continue to work with Divisions of General Practice and general practitioners to investigate models that will enable the health system to engage more fully with general practitioners. Options may include funding through a mix of Commonwealth MBS fee-for-service and state resource supports and/or the provision of shared infrastructure to enable linking of primary care providers, including allied health. The establishment of primary care centres and networks could be privately operated and contracted by regional boards.

**Recommendation**

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.

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**Engaging other key primary care providers**

GHR was advised of the lack of inclusion and recognition of non-government organisations, volunteer and carer support organisations in the health care system. These providers are also facing increasing demands at the community level. The SA Ambulance Service also reported to GHR significant increases in the demand for its services, particularly out of hours services. In addition, the need to include other private practitioners in the health system, especially allied health, is important. In some areas these may be the only accessible health service providers. It is essential that these providers are integrated into the system.

The need to include complementary therapies was also raised at several GHR consultations. In particular, several submissions from alternative and complementary therapy providers reiterated the need for acknowledgment of their role. GHR recognises the importance of providing consumer choice in health care.

Non-government and other primary care service providers also need to be involved in refocusing the health system. It is important that regions include non-government organisations and other private health practitioners as critical and essential partners in the planning and development of primary care services and networks.

**Recommendation**

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.

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**Engaging family carers**

Informal, unpaid family care is the foundation of community care in South Australia. Family carers are conservatively estimated to provide at least 74% of all community care assistance. GHR acknowledges that the formal health and community care system relies heavily on the support of family carers. Public expenditure on health care would increase dramatically if only a small number of family carers ceased support. Family carers are major partners in the delivery of primary care and of significant financial value to the health system, estimated at over $2 billion per annum.
There is a need to support family carers at the interface between hospital and community care. Care in the home needs to be integrated into the system. The serious consequences of not providing this support in the future are well documented and include risks for family and relationship breakdown, physical injury and disability of carers, depression and anxiety, poverty, social isolation and an inability to participate in education, training and employment. This goes further than just recognising the role family carers play. It is about ensuring access to the assistance and support required by family carers.

GHR supports the development of a family carers policy which is currently being developed by the State Government.

**Private and public partnerships**
Private health providers play an important role in the health system and state services need to work with them to ensure system coherence and pursuit of the best possible solutions.

There are many South Australian examples of public–private partnership arrangements. In the early 1990s, the South Australian Health Commission tendered private provision of a lithotripsy service for public patients. Other examples include the private management of Modbury Hospital, provision of joint public and private services at Noarlunga Health Services and co-location and shared infrastructure at Flinders Private Hospital. In recent times, metropolitan public hospitals have contracted staff to private hospitals and some joint services have developed.

Many hospitals use external contractors for the provision of support services, such as cleaning, catering, engineering and maintenance. In rural areas this has generally been the norm. Noarlunga Health Services, for example, uses private information services, pathology, radiology and pharmaceuticals. Flinders Medical Centre has from time to time contracted with private facilities to accept down transfers in obstetrics, medicine and surgery.

Examples of these public–private arrangements appear to fall into the three categories of:

- support service contracts
- physical co-location of services requiring capital development
- ad hoc inter-hospital clinical service arrangements.

The first two categories have tended to be coordinated centrally whereas the third has been based on local decisions and goodwill. It is this last category which provides significant opportunities for relationships between public and private sectors to transcend parochial and professional barriers.

Opportunities for partnerships include but are not limited to:

- joint clinical, service and capital planning
- networking of services for planning and management purposes, such as emergency departments and cardiac surgery
- tendering of additional public work to the private sector, such as elective surgery
- tendering for the provision of public non-diagnostic scopes to the private sector
- negotiating the provision of packages of care for sub-acute cases in emergency departments to be cared for in the private sector.

There are opportunities at both statewide and regional levels to develop partnership agreements with private facilities where there are prescribed benefits to both parties to the agreement. GHR supports ongoing discussions with private sector health services.
Primary health care

The Bright Inquiry\textsuperscript{96} raised the importance of prevention, early intervention and health promotion and noted modern medical problems did not always fall under the banner of disease, but were better described as community health problems.

The top ten risks, globally and regionally, in terms of the burden of disease they cause are underweight, unsafe sex, high blood pressure, tobacco consumption, alcohol consumption, unsafe water, sanitation and hygiene, iron deficiency, indoor smoke from solid fuels, high cholesterol and obesity. Together these account for more than one-third of all deaths worldwide.\textsuperscript{97} Reducing and preventing major risks to health has obvious health benefits.

Focusing on the reduction or elimination of health risks (e.g. 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) have 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\textsuperscript{98} and The Jakarta Declaration\textsuperscript{99} and recommendations from the Mexico International Health Promotion Conference\textsuperscript{100} regarding effective practice. These principles are:

- working in partnership
- focusing on population health
- focusing on the promotion of health, prevention of illness and early intervention
- reducing health inequalities
- involving the community
- working in effective and sustainable ways.

The principles of primary health care not only underpin system reform, but also provide strategies and ways of working in the proposed primary health care focused system.

GHR notes DHS is developing a primary health care policy. This is an essential first step in system transition.

Recommendation

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

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 19.

**Networked primary care services**

Networked primary care services aim to improve population health status and should be:

- accessible
- integrated
- planned
- flexible and adaptable
- responsive to, and informed by, consumers.

As a result, a comprehensive primary health care system will reduce the load on hospital services.

Networked primary care services should:

- accommodate 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 co-located within one facility, providing a primary care centre for consumers to access. Primary care centres could evolve into centres of excellence specialising, for example, in diabetes prevention, men’s health, positive ageing programs or mental health promotion.

Networked primary care services will provide the linkage point for consumers to all other services (e.g. public and private clinical outreach services, rehabilitation services and hospital services) and play 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 with minimum funding), current Commonwealth funded regional health configurations, community health centres, Aboriginal community centres and aged care providers.

One of the key roles of networked primary care services is to develop, support and nurture relationships with community based organisations and individual practitioners who provide consumers with choices best suited to their needs.

The distinguishing feature of primary care centres is that they do not have beds for planned elective admissions, and therefore are not reliant on acute output based funding.

Primary care centres may have emergency primary care treatment beds. However, these will be only a small component of some centres. In rural areas, a feature of primary care centres is likely to be a significant focus on positive ageing and aged care services. Provision of permanent aged care accommodation may be achieved either through networked services with other providers or physical location at a primary care centre. A teaching and training focus at this service level is important.

Consumers must have ready access to a range of services through networked primary care services. This presumes:

- optimal access via affordable public and private transport
- a flexible service delivery philosophy that includes providers travelling to consumers
- a move from the current bricks and mortar philosophy, which is pervasive in government, to flexible uses of multiple venues and a preparedness to move services and support focuses to meet changing patterns of need within a local area.

Networked primary care services need to be outwardly focused and take their mandate from, be informed by and respond to, population need. Local community participation and engagement processes will be critical to the development and design of networked primary care services and centres.

Networked primary care services will need to be resourced to enable strong links with regional integrated community care services and centres, and statewide clinical and population health networks.
Service elements of primary care services can include:

- **health promotion** — establishing systemic community based strategies, through collaboration between local agencies and organisations (e.g. schools, local government, community health and pharmacies), that include processes for community education and a population wide focus on particular health outcomes

- **primary care** — providing general health care services, early detection and early intervention, restorative health (rehabilitation, post-acute care), pharmacies, dental health, complementary health care, allied health, counselling services, child and maternal health and community mental health

- **health maintenance** — promoting independence, health and wellbeing, including home care and property maintenance, in-home personal care and health care, social support, psychiatric disability support, self-help, carers support and respite services

- **provision and coordination** — of health information, service information, single entry point, linked referral mechanisms, case management and brokerage services.

Wherever possible, and where facilities permit, networked primary care services should provide:

- **hospital outpatient type services** from regional integrated community care centres and hospital services

- **rehabilitation and hospital avoidance services** to maximise opportunities for consumers, especially those with multiple and chronic conditions, to be cared for in their homes and communities

- **single point of access for other state, Commonwealth and private services** and resources designed to address consumers’ social, health and welfare requirements (in smaller primary care centres and their outposts this may be limited to information about these services and referral to them)

- **support for all consumers navigating the health system**, and in understanding and accessing services appropriate to their circumstances, by:
  - informing people of services and choices available to them
  - advocating for those who find it difficult to deal with the system (e.g. Aboriginal people, the elderly and those with disabilities)
  - accessing or dealing with other related social and infrastructure services (e.g. education, transport, police and courts).

GHR’s modelling project outlined a rural primary care centre as an example of what could evolve in some smaller rural and remote hospitals. The primary care centre and services delivered are identified in the project and detailed in the box on the previous page.

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. In the initial term, this funding will need to be in addition to current levels of system resourcing. It is also essential that the development and maintenance of networked primary care services is supported by an appropriate level of teaching, training and research.
<table>
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<tr>
<th>A primary care centre (PCC)</th>
<th>A primary care service (PCS)</th>
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| A facility that is a base in the community for health and wellbeing, supported by transport networks to and from the centre. A PCC may be a general practice, or be linked with general practice/s, and have a health promotion focus. It may serve an immediate population of around 1000–3000 or be part of a wider network of PCCs. | PCS, delivered on the ground in an organised network, which is both local and regional, should include as a core:  
  - general practitioners  
  - allied health services such as  
    - audiology (hearing assessments, hearing protection  
    - education, especially farm safety programs)  
  - dietetics (assessment clinics, dietary advice, healthy shopping and cooking education)  
  - occupational therapy (early intervention for developmental delay, home safety assessments,  
    advice and equipment to enable independent living, coordinate falls prevention programs)  
  - physiotherapy (assessment clinics, mobility and home safety assessments)  
  - podiatry (e.g. assessment clinics, particularly diabetes, healthy feet promotion)  
  - social work (in teams with mental health and youth workers, providing programs aimed at addressing social disadvantage and improving wellbeing)  
  - allied health professionals (forming part of a wider regional network of service teams, such as coordinated whole-of-government child development teams, population health networks and networked clinical services) such as  
    - mental health workers  
    - health promotion officers  
    - drug and alcohol workers  
    - youth workers  
A networked primary care nursing approach may include:  
  - community midwifery  
  - outreach nursing  
  - domiciliary care  
  - principal nurse educators in diabetes, asthma, continence and respiration  
  - palliative care  
Nurses have a vital practitioner role within the facility and in the community.  
Services include shared care partnerships between general practice and PCCs, as well as building on close relationships and partnerships with non-government, individual practitioners and community organisations. |
| The PCC should include room for:  
  - community and volunteer groups  
  - allied health clinic rooms  
  - nursing clinic rooms  
  - day care and other respite facilities, including mental health  
  - day treatment rooms  
  - palliative care/hospice accommodation  
  - 24-hour access and up to five emergency holding treatment beds  
  - conference rooms  
  - office space for outreach services  
  - ideally, general practice co-located in same facility.  
In some cases aged care accommodation will be provided within the facility. Services provided from a PCC, either home based or facility based include:  
  - counselling services (such as social work, mental health, palliative care and bereavement)  
  - primary care treatment services (such as chemotherapy, minor day type surgery)  
  - early intervention and prevention education clinics (such as diabetes, asthma, speech and language development)  
  - antenatal and postnatal education, parenting education and support  
  - rehabilitation services  
  - home nursing/RDNS nursing services/post-acute care  
  - carer and respite support services.  
The PCC is a base and will be situated in a town, probably evolving from an existing local hospital, general practice or health service. It will serve as the hub of a network of PCSs with surrounding communities and service providers (e.g. private allied health, complementary therapists, community advocacy groups such as women’s groups, transport providers, other general practitioners, local government and community service providers, local support groups such as GROW and cancer support groups, located in smaller centres). |
All regions should develop business plans for the establishment of primary care services and centres during the first year of regional arrangements. Regions will need to explore appropriate local responses that will facilitate the establishment of networked primary care services and centres. For example, some regions may be able to offer competitive tenders while, in other areas, upfront investment in primary health care will be required in the first instance.

**Recommendation**

3.8 DHS provide funding in the first year of reform to initiate the development of networked primary care services.

**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 co-located 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. A teaching and training focus at this service level is an important feature. Resident and visiting specialists will provide workforce support to integrated community care services and centres.

Integrated community care services will require a shift to a low technology, high volume and low acuity service. They will be a key support for primary care services in the 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
- 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, need to develop from current facilities. These centres will require inpatient, day patient and diagnostic facilities on-site. They could evolve from existing rural regional and metropolitan hospitals, as each proposed region (see Chapter 2) has at least one facility that could become an integrated community care centre.

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
- optimal access via affordable public and private transport
- support from statewide referral hospitals, primary care services and networked clinical services 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 to closer to their community
- a shift in 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, to primary care centres or networked primary care services
• integration of general practitioners through establishing governance and funding mechanisms within primary care services that will encourage their commitment and support for integrated community care services
• mechanisms for rotating students through the system
• teaching and research requirements balanced across the continuum of care.

The majority of these factors will be addressed over time through comprehensive clinical and regional planning that will enable flow reversal to regions and community locations. There is a need for parallel funding in the first instance to shift and enable activity to occur in the regional setting. The South Australian Mental Health Reform was consistently cited as an example of reform where the community sector was not resourced to cater for a shift in demand to the community. This was especially notable in rural and remote areas.

Recommendations

3.9 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.

3.10 DHS provide a planning framework and tools to assist regional health services develop service planning, including capital plans, that facilitate system transition.

3.11 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.

Statewide referral hospitals
Statewide referral hospitals will deliver specialised, high level tertiary and complex services. These services are typically high cost and low volume.

Statewide referral hospitals 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.

GHR was advised of a range of services currently delivered in statewide referral hospitals that 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 3 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.

Optimal access via affordable public and private transport is essential.

**Clinical planning and networked clinical services**

Metropolitan clinical service planning began in 1998. It provides quality, comprehensive, integrated metropolitan clinical service plans intended to meet the challenges and changes of increasing technology, an ageing population, increased demand and the higher costs of providing 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.

The two case studies below illustrate the need for ongoing service reviews in light of population and clinical practice changes.

**Case Study Four**

*Responding to changing demographics and enhanced clinical practice changes*

Within South Australia, obstetric services are currently provided in a range of health units (private, public metropolitan and public rural). Within the public sector there are 43 health units providing birthing services with annual birth numbers ranging from four to the largest health unit with up to 4000 births.

However, from a statewide perspective, inclusive of private hospital births, the total number of births has declined from a peak in 1992 of 20,092 to 17,667 in 2001.\(^\text{104}\) This decline needs to be placed in the context of South Australia’s changing demography, which will have a significant effect on future birth numbers. An analysis of the most recent ABS data\(^\text{105}\) indicates, based on the current forecast, the birth rate will continue to fall by a further 20% to approximately 14,000 in 2019.

Over the past two decades, there have also been significant changes in the provision of obstetric and neonatal services through two major elements, enhanced clinical practice and the community’s expectation of choice from the traditional model of obstetric care to alternative models of care. This supports low intervention and shorter lengths of stay in hospital. Examples of changes include:

- improved antenatal care with early detection of at-risk clinical indicators and referral
- enhanced retrieval services to rural locations
- reduced average length of stay of mothers in hospital
- improvements in discharge planning and implementation of domiciliary care midwifery programs
- implementation of low risk midwifery models.

It is appropriate to consider opportunities for maximising the use of resources to ensure safe and quality services. Just as important is the need to provide the primary care options for the majority of the community at one end of the health care spectrum to the 5% of highly complex cases at the other.

Published literature indicates that one level 3 neonatal intensive care unit is required for a birth catchment population of 10,000–20,000. NSW utilises the ratio of 0.7 ventilated cots per 1000 births and one non-ventilated cot per ventilated cot for planning of level 3 neonatal intensive care units.

Based on the current number of births of 17,667 in South Australia, 13 ventilated and 13 non-ventilated cots are required. South Australia's two units provide 28 cots with an average utilisation of 18 cots. In the future, South Australia will require 20 cots to meet projected demand.

This case study provides an example of the need to continually review the nature of services provided in light of population and practice changes. Clinical service planning is not a one-off activity. It must be a continuous review process.

Case Study Five

Responding to future demographic and clinical practice changes

Cardiovascular disease is a major health and economic burden for Australia, most commonly due to coronary artery disease and hypertension. The risk of developing the disease is associated with factors such as smoking, high blood cholesterol, high blood pressure, physical inactivity, obesity and diabetes.

Heart, stroke and vascular disease are the leading causes of death among Australians, accounting for 53,989 deaths (26,559 males; 27,439 females) or 42% of all deaths in 1996. Although death rates from heart, stroke and vascular disease are a much smaller proportion of all deaths among males (39%) than among females (45%), males are more likely to die prematurely from heart, stroke and vascular disease.

Service trends and forecasts indicate the following:

- Age adjusted cardiovascular mortality will continue to decline among both males and females.
- The prevalence of cardiovascular conditions will increase.
- Cardiology patients are predominantly post middle age and this age group is increasing 2.5 times faster than the growth of the total population.
- Demand for cardiology over the next 20 years will increase with the bulk of cardiology related diagnoses and procedures relating to people aged 45 years and over, and the largest projected increases are predicted for people of the same age group.
- The probability of developing coronary artery disease before the age of 65 is related particularly to lower socioeconomic status.
- With new medical technology advances, there will probably be development of the specialty to provide broader and more sophisticated services.

Therefore future demand for cardiology services needs to be assessed against a balance between continuing decline in cardiovascular disease in the young and relatively rapid growth in the number of people in age groups most likely to experience this disease.
A cardiology service usually comprises outpatient facilities, inpatient provision, a comprehensive range of non-invasive investigational facilities, cardiac catheterisation and angiography with a range of interventional cardiology procedures and surgery. Cardiology services are now reaching into the community to provide an interface with general practitioners and rural health services in order to improve the management of people with cardiac related diseases.

The following is presented as a possible scenario for the treatment and management of people with cardiac related diseases over the next five years. This scenario has been developed on advice from senior cardiologists in the South Australian public health system.

For the purpose of this exercise cardiac related conditions are divided into four categories:

**Cardiac rhythm disturbances** — fast and slow: It is anticipated that, with the ageing of the population, cardiac rhythm disorders will increase significantly. There will therefore be an increase in the use of permanent pacemakers and implantable defibrillators. Atrial fibrillation is currently treated with drugs but, with new intervention techniques, could become a 24-hour admission in some cases.

**Coronary artery disease** — acute myocardial infarction, unstable angina, stable angina: Currently the rate of angiography for myocardial infarction is 15% and it is expected to rise to 60%. While angiography as an elective procedure may remain constant, it will increase for unstable angina. However, new diagnostic techniques such as CT and MR angiography will make angiography without intervention safer and more accessible.

**Valve disorders**: Admissions related to valve disease will become more common with the ageing of the population and will often involve prolonged length of stay.

**Heart failure**: Heart failure will remain the most common reason for admission to hospital but, with the necessary support, a large proportion of this population can be managed effectively in the community in association with hospital based specialist doctors and nurses.

The effects of the above changes will be:

- increase in activity and changes in length of stay for arrhythmias and angiography procedures
- increase in cost per bed day
- shift from conservative to procedural treatment
- need for additional procedural facilities
- improved management of people with chronic cardiac conditions in the community (in 2001–02, 16,000 of the 26,000 cardiology related admissions to South Australian public hospitals were people in this category)
- no additional bed requirement if the following are put in place:
  - appointment of appropriately trained cardiac nurse practitioners to work with patients, their general practitioner and the cardiologist in a position of liaison between hospital and community
  - establishment of acute cardiac clinics (as opposed to chest pain clinics) equipped to triage effectively chest pain, suspected arrhythmias and suspected acute heart failure (such services will need to be linked to cardiac investigative facilities, including specialised imaging, arrhythmia analysis and biochemical investigations)
  - effective triaging in emergency departments
  - on call availability of trained technicians
This scenario indicates that future investment in the provision of cardiology needs to be in:

- procedural facilities and equipment
- community support structures
- strategies to improve front door management of patients presenting to emergency departments.

Although this scenario relates to cardiology, there are a number of other ambulatory sensitive conditions (e.g. diabetes and asthma) where investment in community based services and front door services can relieve the increasing demand on hospital beds.\textsuperscript{110}

DHS has completed four reviews and implementation plans:

- renal and urology services
- ‘Healthy Start’ (obstetrics, neonatology and gynaecology)
- emergency and trauma services
- mental health.

Each of these reviews has a clinical reference group to oversee implementation. Implementation of the mental health plan is being driven by DHS.

Four reviews have been completed but not yet implemented:

- cancer services
- cardiac services
- intensive care and retrieval services
- rehabilitation services.

GHR was informed of concerns regarding the planning process for all eight reviews including:

- use of outdated population data
- lack of community inclusion in planning and decision making
- lack of a systematic approach to the selection and development of clinical plans
- lack of a statewide approach that included and incorporated rural and remote clinical planning needs
- the need for the planning group to be chaired by an independent clinician.

GHR believes that DHS should adopt:

- broad principles for clinical planning
- the concept of statewide networked clinical services
- a framework for the development of clinical plans.

Clinical service directions should be underpinned by the following principles:

- Wherever possible the provision of services should be balanced between the needs of the community and the capacity of the system to meet those needs, recognising that clinical staffing shortages will continue in some areas.
• Low volume, high cost services should be consolidated to enhance safety, quality and financial viability.
• High volume, low cost services should be provided as close as possible to the people they serve.
• Services across all clinical groups should be provided on a networked basis to facilitate skill acquisition and maintenance, and recruitment and retention of clinical staff with improved service quality and patient safety.
• Hospital based health needs should be provided for as much as possible within each region.

Recommendation

3.12 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.

A common theme across all clinical plans was the development of networked clinical services. Networked clinical services are a model for health service delivery that formalises the relationship across the metropolitan area between metropolitan and rural and remote health services.

Networked clinical services can be described as the thread holding the system together.

Networked clinical services aim to improve coordination and integration of services. The model involves professional interrelationships, referral and support structures between units with emphasis on clinical management and partnerships.

A networked clinical service for a clinical functional speciality will be a virtual arrangement which:

• is responsible for the implementation of the clinical plan
• may be statewide or across any combination of regions
• provides clinical leadership for the service
• may be auspiced by a nominated region and have a performance requirement to support the networked clinical service
• is managed within existing resources
• encourages joint appointments and access opportunities for clinicians.

Networked clinical service groups (NCSGs) should comprise representation from the full range of acute and community based health professionals, develop business plans and provide leadership in best practice. GHR suggests that there are a number of clinical services which could be considered for development as networked clinical services, for example, emergency services, obstetrics and cardiology.

A clear planning and decision making framework is required. Chapter 4 addresses matters relating to clinical governance including the establishment of a clinical senate.

During the course of GHR a review of pathology services was begun and a steering committee established to oversee the process. It was anticipated that this review would be completed prior to the GHR report being handed down. This did not occur. However, extensive consultation did take place and it became apparent that the preferred way forward was to establish a networked pathology service.
**Recommendation**

3.13 DHS establish networked clinical service groups, as appropriate, including a networked group for pathology services.

GHR was informed that DHS considers all clinical service planning should be coordinated by DHS and conducted by a group of relevant clinicians and stakeholders. When a clinical plan is developed and the NCSG is formed, the group would be given responsibility for implementing the plan.

GHR believes the NCSG should have a chair appointed by the Chief Executive of DHS on advice from the clinical senate. The chair would provide the leadership required to develop a cohesive networked service and implement the plan.

It is advisable for the chair to be appointed for a defined term, provided with an agreed sessional payment and be responsible to the Chief Executive of DHS for this statewide responsibility.

**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 must be taken into account in delineating the services, and determining the volume of services each hospital should be funded to deliver. Methods of care delivery are constantly changing. For example, over the past 15 years there has been a significant reduction in the average length of stay, and the requirements for inpatient and day beds have shifted as a result. It is important for planners to use forward looking standards and expectations about clinical practice and care processes, and, of course, their safety and quality. In the current environment this must include issues such as:

- demographic and clinical changes
- current best practice clinical techniques
- the effectiveness of services
- local quality control and quality assurance mechanisms, including peer review
- external standards and external review, including accreditation
- capacity to maintain staff skills and knowledge
- involvement of consumers in the evaluation of services and planning improvements
- system-wide impact on the effectiveness and efficiency of service provision.

DHS has started work on developing SA service delineation guidelines including service profile principles.
The service delineation guidelines serve a number of purposes and are necessary to:

- describe the features and specifications which contribute to the provision of quality services
- provide a basis for the development of consistent specification schedules within health service agreements and contracts
- provide a consistency between planning, development, purchasing, monitoring and evaluation of services
- enable a consistent language which health units and agencies can use when describing health services
- support the implementation of clinical services planning outcomes.

The service profile principles include the following:

- Services will be provided in a safe environment and will not pose a risk to the community through inadequate levels of clinical staff, facilities or equipment, or patient numbers.
- Hospitals will operate as part of a system of health services and will work in conjunction with all other health units to meet the priority needs of the population in which the hospital is located.
- Low cost, high volume services should be provided as close as possible to the local community.
- High cost, low volume services should not be duplicated. Where these occur on more than one site they will operate within a network environment to ensure safety and efficiency
- All services will be provided as efficiently as possible.
- Services may change over time following community and clinical consultation, and implementation of clinical networks and regional structures.
- All health units will have a role in the teaching of undergraduate and postgraduate clinical students.
- All health units will support research activities through the provision of appropriate infrastructure relevant to the service profile.

The GHR is aware of the prolonged uncertainty regarding the service profile of TQEH. It is important that a clear and immediate decision is made to provide a way for TQEH to gain a more certain future.

The GHR has provided a framework within which service delineation can occur for all metropolitan hospitals including TQEH. The proposed primary health care focused system will mean changes for all metropolitan hospitals. It will include the provision of a range of hospital services for their communities as well as additional services with a focus on primary care and disease prevention to complement existing locally based community services.

It is in this context, and through application of the service delineation guidelines, that GHR foresees TQEH continuing to provide an emergency department, maternity services, intensive care and have a role in teaching and research. GHR hastens to advise that final service profile decisions can only be done with extensive consultation and detailed analysis. This work needs to progress as a priority with the guidance and advice of the proposed clinical senate, the statewide community council (see Chapter 4) and DHS Senior Executive.
**Recommendation**

3.14 DHS continue with the development of the service delineation guidelines on advice from the clinical senate and the state community council.

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**Population health networks**

Population health networks will be population specific. They include whole-of-government responses at Cabinet level, such as GHR’s Aboriginal and early childhood proposals (see Chapter 6). At the health portfolio level they may include regional, cross-regional and statewide population health networks as determined by regions or 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. Examples are provided in GHR’s Greenfields Modelling Exercise. There will need to be accountability for the achievement of specified outcomes.

**System enablers**

The proposed GHR system reforms require system enablers. These include effective and integrated technology, information management, communication systems, research and health futures which are addressed below.

**Information technology and telecommunications**

There are around 14,000 information technology users in the human services portfolio, 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.

This fragmentation has to change.

Improved health management requires the provision of accessible system-wide information. There is a need for greater connectivity of information across all levels of the system and between agencies, including public, private and community. Common systems and equity of infrastructure needs to be addressed. Statewide connectivity is crucial for the development of common records, sharing of information, clinical planning and for linking all services.

Of particular note, is the need for broadband infrastructure and wide area networks to facilitate state networking, especially in rural and remote areas. The implementation of a wide area network has begun in rural areas as part of the DHS information technology plan. This should be resourced as the first essential investment towards statewide connectivity and managed as a whole-of-state investment by DHS. This builds the essential building block for underpinning infrastructure so that all components of the primary health care system are connected.

There is inadequate or non-existent electronic exchange of information between health services. For example, the GHR Modelling Project for the southern metropolitan area identified one hospital service that advises general practitioners of patient admissions and discharges. While all hospitals in the state are required to provide discharge summaries to general practitioners, GHR was advised that these often arrive too late.
The situation is no better for other, state-funded services, such as community health services. They use a data collection system — the client management engine — which does not interface with hospital or general practitioner systems. In addition, all statewide services have their own systems, which are generally not accessible to other services.

Most general practitioners use a practice system, Medical Director, which does not exchange data with any other system. There is generally poor access to bookings and patient management systems across hospital and statewide services for patients and their carers or general practitioners.

There was general agreement throughout GHR consultations that development of a single electronic health record was a priority. However, questions of privacy and confidentiality were raised, including the right of consumers to have control over their health record and who can access the information. The degree to which individual consumer's privacy is protected and is perceived to be protected is crucial to the success of initiatives aimed at greater sharing of health information by electronic means.

This will require the rigorous application of policies and procedures to protect the privacy of individuals.

Legislation and supporting guidelines and codes are being progressively developed at national and state level. For example, DHS has developed a Code of Fair Information Practice outlining the roles and responsibilities of service providers and DHS. This code outlines what clients can expect in terms of the protection of their personal information. This is balanced against the genuine, controlled and legitimate use of personal information in providing and improving service delivery to consumers. Appropriate mechanisms will be required to enable individuals to give informed consent for the recording of, and the authorising of access to, personal information.

A range of legislation provides confidentiality provisions that restrict or prohibit disclosure of information. Examples include the Mental Health Act 1993, Institute of Medical and Veterinary Science Act 1982 and the Sexual Re-assignment Act 1988. The development of shared electronic client data will require review to ensure that data sharing will not breach any statutory confidentiality provisions.

The implementation of OACIS (Open Architecture Clinical Information System) in metropolitan hospitals is a positive step in working towards a single electronic health record. The extension of this to include primary care providers has been requested as a matter of priority.

DHS estimates approximately $40 million per annum is required to maintain current information management facilities in the health sector. Significant information technology and telecommunications investment is required to support the proposed health reform agenda. This must be examined as a matter of urgency and strategies developed to build on and to reinvest current resources towards connectivity in the first instance.

Recommendations

3.15 DHS review the existing statewide information technology plan and prioritise the resources required for statewide connectivity within five years.

3.16 DHS develop a plan to enable the establishment of a single electronic health record for each patient.
**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 then. 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 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. These works are overdue.

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 redirection of capital investment occurs to support establishment of appropriate community based primary care services. Similarly major and minor equipment requires strategic planning and investment.

A more strategic system-wide approach is needed for capital and asset resource decisions. Five key principles underpinning the ways forward are:

- greater emphasis on accrual accounting and reporting, including use of condition based depreciation
- costing of services to take account of full costs, including costs of equipment and other assets required to provide services
- a balance between capital and recurrent funding with a financial management system that incorporates forecasting of capital investment, replacement and upgrades
- benchmarking and performance indicators that include accountability mechanisms for investment decisions and asset preservation
- research into alternative ways of procuring assets (examples include private–public partnerships, or similar solutions, which can optimise the government’s ability to deliver the major capital infrastructure in a way that frees up capital for new priorities).

GHR recommends DHS investigate savings opportunities by adopting a facilities management approach to its minor works, maintenance, property services (including security) and ancillary services. Some private hospitals have successfully adopted this approach. The government has a number of facilities management arrangements that demonstrate savings of 15% over previous arrangements. The health sector should explore the feasibility of extending this approach across the public health system.

Provision of life cycle asset management should become part of service obligations and agreements at the regional level, ensuring service delivery and capital planning are in line with the primary health care focused system. This requires system-wide strategic planning and regional priority-setting processes to be in place. There is also a need to consider capital planning in the light of whole-of-government approaches. This means incorporating other government and non-government sector urban planning processes into forecasting health infrastructure requirements.

DHS is a key stakeholder in town and area planning. Relationships with regional development organisations, local government, transport and other key sectors at the statewide and regional level must be fostered. Planning needs to consider community access to physical infrastructure, taking into account population changes, socioeconomic determinants and rural and remote issues.
**Recommendation**

3.17 DHS implement a statewide capital investment plan to deliver the proposed health system reforms.

**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 and strengthening the evidence base for decision making. Research also provides 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.

Health sector employees involved in decision making in service sectors, planning and policy making must work together to collectively identify gaps in knowledge which could be met by research.

**Funding**

Change takes time. There are two markers for testing this assertion in relation to research.

First, the Bright Report acknowledged the quality of scientific and technical research in medical fields but doubted there was adequate data to assess the performance of the health system. It also noted the low level of sociomedical research.

Secondly, in the early 1980s, South Australia had been successful in attracting grants from the National Health & Medical Research Council (NHMRC) but fared less well with the Commonwealth Research and Development Grants Advisory Committee (RADGAC). The local Section 16 Research Grants Committee, named after a section of the SAHC Act, was intended to fund new work or explore possibilities for more effective health services, rather than to justify administrative preferences. Funding was limited, but it provided a start for some researchers, perhaps focusing on the applied and social enquiry side of research. 115

The first two of the funding sources mentioned above provide a classification of approaches to the generic term ‘health research’. The NHMRC represented the activity most life scientists had in mind when referring to scientific research.116 The public imagery of medical science, even then, to judge from newspaper and television pictures, emphasised work done in a laboratory and focused chiefly on invisible causes of illness or on treatments at tertiary hospital level. The pattern of funding was portrayed as disinterested, with all requests tested by a process of peer review.

RADGAC, by comparison, wanted the research to be done ‘properly’ but was as likely to accept a proposal because ‘it looks a good idea’ as because it was ‘methodologically sound’. Peer review played a role and often proponents with ‘a good idea’ would be put in touch with other researchers or health practitioners whom the committee thought could help turn the idea into a useful enquiry for the health system. There was as much interest in developing a new range of topics and new forms of enquiry as there was in any track record of the researcher. Proposals were more likely to arise from primary or secondary care settings than from the intensive, tertiary work of specialist hospitals.
Today there are some examples of research funding focus which have sought to support and develop a broader research focus. The establishment of the Health Inequalities Research Collaboration and movements by the NHMRC to support a broader research agenda, not just biomedical research, are two such examples.

There is a need to ensure that research focuses on enquiries that are of use to the health system. Research also needs to be balanced across the system. This raises questions as to what drives research activity now? What are the costs of that activity to the health system in South Australia and what benefits does the system gain from it?

**Research drivers**

Today publish or perish is a local reality: Australian academics who do not bring research grants to their institution or accrue points for their publications are unlikely to achieve promotion or tenure. The emphasis on track record in the award of grants probably has reduced the likelihood that young researchers will get a chance to test their own ideas.

South Australian university academics contribute to the interests of DHS by supervising work of higher degree students from DHS and its agencies. There is some continuing *pro bono* involvement of academics with the staff and activities of DHS and its agencies, and that is reciprocated, but the emphasis on grant-and-publish has diminished emphasis on public service issues. The ambivalence between enquiry and response to administrative direction continues today.

GHR has emphasised the need for a shift in emphasis from the supply side to the user side of health and human services. However, there appears to be limited opportunity for the exchange of ideas and information about enquiries.

**Innovation is the key**

Fostering the ability to come up with better and smarter products and services is the key to driving the future health system. It is also impacts on future economic growth in South Australia. Innovation is the single most important element in a successful modern economy. South Australia needs to use its strengths and advantages to generate new ideas and knowledge and develop new products and services for not only South Australia but the global market as well.

GHR supports advancement of the innovative skill base in the health sector as well as an increase in the health sector’s capacity to generate and apply new ideas and knowledge. Government must provide greater investment in research and development activities as well as scientific infrastructure and programs that retain and attract highly skilled workers. The government has made some inroads towards these goals through the establishment of the Economic Development Board, and the Science and Research Council.

The Science and Research Council has been meeting to develop a ten year strategy to capitalise on scientific research and development in South Australia. The health research sector must firstly develop strategic links with these groups in order to inform and influence their directions. Secondly, awareness of the work of these groups will assist strategic choices about the directions for health research.

GHR is aware of the need to establish high level expert strategic advice on emerging issues that provides clear articulation of research and training strategies, directions and priorities in population health, health and community services, and biomedical fields. These priorities should strengthen capacity and develop critical mass through collaboration. GHR supports the proposed establishment
of a high level statewide South Australian health and medical research advisory council, linked to the Science and Research Council.

Government should advance health education and training systems and ensure they are world-class. Universities are centres of research and innovation and are key elements of the state’s economic and social development. Coordination of research and innovation efforts through the Science and Research Council has only just begun. The council provides a platform for regenerating the relationship between government and the universities to improve the quality and delivery of higher education in South Australia. The government is also supporting a higher education council to assist in fostering institutional and cross-sectoral cooperation and collaboration.

**Recommendation**

3.18 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.

**Commercialisation**

In addition to innovation there must be a strong focus on commercialisation. This will ensure that high level research and development, such as in the biotechnology field, is converted into outcomes that are commercially viable and can attract investment. The government is already working closely with business and industry, advanced through the efforts of the Economic Development Board, and must assist business in identifying and accessing new ideas and innovations that relate to health care.

**Recommendation**

3.19 The State Government, with DHS, facilitate the attraction of venture capital to support the translation of health research into practice and products.

**Collaboration**

Biomedical and social enquiry can improve health outcomes, provided the enquiry is integral to the delivery of health care and human services, and there is good collaboration between biomedical, population health and service provision workers. While there is some excellent research conducted in South Australia, this can be improved by a stronger research strategy and priority setting.

There must be strong links, including formal collaboration, between biomedical and population health research sectors. It is imperative that research be seen as integral to the delivery of health care, and there must be an increase in the recognition of the role research can play in improving outcomes as well as providing a significant input into state economic development.

Smaller strategic investments and a focus on strong collaboration, efficiency and integration between research organisations and linkages to industry are meaningful ways to compete nationally and internationally. Effective cross-institution cooperation and sharing of large infrastructure can assist global competitiveness. As much cooperation as possible is needed to ensure that changing patterns of new technology are recognised and acted upon.
Access to research is critical.

**Recommendation**

3.20 DHS develop a web-based research clearing house to improve access to available research resources and current research, and to facilitate collaboration.

**Biotechnology**

The WHO has highlighted the growing potential contribution of biotechnology for health improvement.\(^\text{118}\) Some of these promising technologies include:

- molecular technologies for affordable, simple diagnosis of infectious diseases
- recombinant technologies to develop vaccines against infectious diseases
- technologies for more efficient drug and vaccine delivery systems
- technologies for environmental 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 and are highlighted in submissions to GHR.\(^\text{119}\)

The latest technologies and product advances can only be adopted in South Australia in health service environments with skilled clinical research staff linked into the international medical and bioscience community. The necessary attraction and retention of highly qualified staff is possible by providing an environment of enquiry and continuous improvement. Health services undertaking research can have significant economic outcomes for the state through intellectual property and industry development. Retention also requires competitive salary packages.

**Recommendation**

3.21 DHS provide appropriate incentives to maintain clinical research staff in South Australia.

**An example of collaboration**

Bio Innovation SA was established by the State Government, and has a strategic plan for bioscience industry acceleration. The key elements of this strategy are to:

- generate strategy and policy
- build the research engine
- enhance the entrepreneurial culture
- create the commercialisation structure and incentives
- promote and communicate South Australia’s bioscience capability globally.
Bio Innovation SA has identified a number of principles that form the approach to the economic development aspects of health and medical infrastructure, including:

- establishment of depth in a number of areas of scientific excellence, translating to a larger number of world class scientists working together in one particular field, preferably at the same location
- cross-institution cooperation and the resolution of common needs for infrastructure and services
- linking science through effective technology transfer into industry
- commercialisation towards start-up company formation — ensuring that the technology translates into local employment growth as companies can be financed via private or venture capital.

**Public and environmental health research**

Earlier in this chapter GHR discussed the commitment to a strong public and environmental health service. In relation to research, South Australia has a highly skilled and dedicated public health workforce, providing a solid foundation to build on and strengthen the state’s 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.

The recent development of the South Australian Institute of Population Health attempts to address this fragmentation. The institute provides a coordinated statewide network enabling effective links between universities and public service based public health practitioners. The function of the South Australian Institute of Population Health is to:

- strengthen the capacity in population health research, education and training through collaboration between academic, policy, planning and service providers
- promote innovation in population health practice and research through strong linkages with population health policy and practitioners
- develop South Australia as a centre of national and international excellence in population health research, education and training
- facilitate strategic inter-sectoral partnerships with population health stakeholders, including the community health sector and interstate partners.

GHR supports the development of this institute. However, there are other mechanisms through which population health research can occur, especially if a broader definition of research is employed. Many professionals working within the health sector in South Australia possess these broader skills and do not differ greatly from the formal social researcher. A great deal of what is needed to be known is often contextual. Systematic enquiry can inform the promotion of health and wellbeing by strengthening the evidence base for clinical decision making and provoking debate about policy options. As previously stated, GHR supports the development of a culture of enquiry across the health sector.

**Recommendation**

3.22 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.
**Health futures**

It is not possible to accurately predict the future. However, it 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 ‘superbugs’ 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 are the results 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 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. By being proactive in this area and examining the potential impacts for health care and health policy, the system can position itself to positively respond to future challenges.

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. Health care exists within wider societal changes and developments, and these need to be considered. This requires involvement from all fields and disciplines. The current work by DHS to establish a ‘thinkers-in-residence’ program will enable this capacity to be developed across the system.

It will be necessary to develop multiple processes to engage and develop thinking, and DHS will need to have capacity within its workforce to sustain and plan ongoing initiatives.

**Recommendation**

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.

**Example**

*How the health care system will address the needs of older South Australians*

The proposed health system reforms would allow regions to provide more appropriate responses to meet the needs of older people by:

- maintaining health and wellbeing in their locality through a primary health care approach based on local partnerships between providers
- providing an integrated health system that ensures needs are addressed in a seamless way without gaps in services, such as being discharged without appropriate local care planning
- providing appropriate facilities and service responses required to meet special needs.
These responses should reduce the number of people requiring acute hospital care for avoidable issues, enhance the capacity of people to manage their wellbeing successfully within their local community, and support the provision of services to address particular needs. In relation to death and dying, this may mean resourcing options to assist those who wish to die at home to do so, as well as providing capacity within appropriate facilities for those who do not want to die at home (see Appendix 5).

**SUCCESS STORY**

**ERA (Equity Responsiveness Access) Project**

The ERA Project aims to progress arrangements that promote more flexible and responsive home based care and support services for clients. The project is trialing a service improvement model in the Wakefield, Mid North and Gawler area of rural South Australia. The ERA service improvement model is a good example of how the South Australian health care system should look like in the future:

- **Client focused** - centered on identifying client needs at their first contact with the health system through trained and dedicated referrals/screening staff
- **Responding appropriately to identified client needs** – by better screening of the client at first contact using the Initial Needs Identification screening tool
- **Working towards offering a more seamless system of care** for people through the sharing of client information, with the client’s consent
- **Working towards improving integration and coordination** between the client, community health, non government organisations and other private providers and general practitioners by building on the collaborative links already established between agencies that provide a range of in-home support services to the Home and Community Care client group
- **Trialing a single entry point** for community health services on Yorke Peninsula
- **Responding to the needs of Aboriginal people** through the development of a cultural guide and service directory for workers.
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CHAPTER 4: ACCOUNTABILITY AND TRANSPARENCY

Objective
This chapter provides a framework that will deliver accountable and transparent governance of the health system, founded on the principles of community and consumer involvement and engagement.

To deliver accountability and transparency in the delivery of health services and the management of the health system, it is essential for consumers and community members to be included. This objective is based on two key principles:

- **The public health system is accountable to the public**
  People have a right to know, understand and access information about health system performance, quality and safety, and to expect transparency and accountability in the operation and management of the public health system. This means accountability around policy decisions and directions, accountability around funding and budget decisions and directions, and accountability for system planning and performance, including quality and safety. At a broad level, individuals, together with the health system and other arms of government, are accountable for the health status and health inequalities within South Australia.

- **The public has a right to have a say on public health system issues and directions**
  The right to have a say means the provision of opportunities for involvement across the health care system at all levels. This includes opportunities for community members to be involved in the design, directions and policies of their local health services as well as the right to be involved in decision-making processes at the whole-of-health-system level.

Case for change

Information and education
For the system to be accountable to the public, the public must have access to relevant 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.

To ensure that community members are given the opportunity to have a say at all levels of the system it is necessary that a clear mandate and expectation is given to all staff that community engagement is a priority. There also needs to be accountability, at all levels, for establishing opportunities for community engagement within the health system.

Accountable and effective management of public resources is a fundamental responsibility and challenge for government. In this era of increasing globalisation of world markets and trade, public sector management and accountability have become critical elements in determining the overall
effectiveness, efficiency and ability of organisations to ensure good governance and sustainable human development.

Accountability by government departments tends to be limited to responding upwards to central government. As such, the system of reporting serves the state not the public. Government departments prepare budgets and report expenditures to a central government agency, and reporting and accountability become a matter of routine rather than a cause for action. In the case of mandated information, the process can become an administrative game. Citizen participation in monitoring government services enhances transparency and accountability of both service providers and oversight institutions, and this is not possible without providing information, education and processes for involvement.

Accountability is not only a government obligation but also a necessary means to ensure responsiveness to the needs and rights of the population. Effective accountability and responsiveness can only be assured through the meaningful participation of communities.

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 determined through difficult choices in priority setting. Recent examples include investment choices in neonatal intensive care and the provision of an additional magnetic resonance imaging machine within the metropolitan region. These decisions are typically taken without any public acknowledgment 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.

The first challenge is to define the information that should be made public. GHR identified three factors that define the level of information made public:

- political will
- financial cost and the viability of producing information
- mandated reporting standards.

GHR was advised that the most prevalent argument against making information public at the local level is that it is of poor quality and people do not really care or have the time to know. GHR believes that poor quality of data does not justify limiting access to the public. Indeed, the lack of awareness of the population of the poor quality of information has maintained the status quo.

The second challenge is educating people about this information. Information alone will not necessarily have any impact. People need to be educated about the material, to be provided with an analysis of what it does and does not mean, and to be given the support to explore debates on what that information may mean for the future. An example of the failure of information alone to influence change is provided by the state of New York, USA, which had regularly published mortality rates by hospital and doctor. Market shares of the hospital with the worst and best outcome each year were unaffected by the publicity and neither individuals nor managed care groups responded to this information.
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. 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.

Views are divided as to the value and benefit of such activities. This division supports the need for continued debate and development in this area of activity. It is essential that this issue is addressed — it is a fundamental aspect of the cultural change that GHR is recommending for the health system.

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. It should be noted, however, that community engagement, particularly in the case of priority setting, is time consuming, demanding, challenging and requires a commitment to an ongoing process.

The establishment of community involvement in priority setting is a vexed issue for governments to manage. It is often argued that governments are elected to make these decisions on the behalf of communities. While many major public decisions of governments do involve community consultation mechanisms, the final decision rests with governments. However, on contentious issues GHR argues that it is a mark of good government that community views and preferences are explored. Most importantly an informed community on health issues would facilitate good policy decisions that would be difficult without community understanding and support. Good health policy can become good health politics.

The process of consultation, however, can be problematic for community members who often complain about the lack of feedback and lack of action post-consultation. A commitment to follow up must be ensured if there is to be community involvement in priority setting at statewide level.

There is a need for the public to be involved in debate and informed decision making in advance of health ‘dramas’ and ‘scares’ that regularly appear in the media. Failure to achieve this 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 continuing burden on the health system, continuing 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 and unwarranted repercussions. Neither of these claims can be substantiated. In comparison with international movements towards greater public accountability, South Australia needs to address issues of information dissemination on health system performance and accountability for decision making, policy directions and investment choices. This is in line with the Government’s response to the Public Sector Responsiveness Report.124

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 as well as excellent hospitals and health care systems. Nonetheless, health care is not
risk free. Even with the best intentions and 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.

Humans are not perfect. However, by routinely collecting and analysing data, and striving for perfection, it is possible to achieve continuous improvements in service. The men and women of South Australia's health system are truly committed to the wellbeing of each and every person with whom they come into contact in the health system, and the system needs to support and facilitate that commitment to quality.

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, 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.

It is questionable whether the continuous quality improvement focus of accreditation processes is sufficient to monitor the quality of services and success in contributing to the improvement of health status. It is equally questionable whether such processes meet the expectations of health care consumers or the broader community. This is not to devalue the contribution the accreditation movement has made to the Australian health care system. But is it sufficient?

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. In 1992 the direct hospital costs of preventable adverse events in Australia were estimated to cost nearly $900 million per annum. Moreover, people are now more consumer oriented and less deferential, and they 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. Every patient judges the performance of the whole health system by the quality of the care they receive from their local general practitioner, their local hospital, their local community nurse or their local community health service. There are inequalities across areas in waiting times for operations, in the time it takes for patients to receive test results, and in the number of people given screening tests. There are inequalities in clinical practice and in clinical outcomes. These are not the attributes of a quality system.

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 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 consumers, let alone to the taxpayer, is unacceptable. Consumers suffer if resources are not used to best effect, just as they suffer if quality standards vary.

The following case study highlights the importance of robust safety and quality systems for clinical services, underpinned by strong leadership and a supportive culture.

**Case Study Six**

King Edward Memorial Hospital is Western Australia’s only tertiary referral service for obstetrics and gynaecology. Between the years 1990 and 2000 there was a significant increase in the number of complex obstetric and gynaecological cases treated at the hospital, as well as significant organisational restructuring and upheaval in the hospital’s management. The appropriateness of King Edward’s obstetrics and gynaecological services was questioned during this period, resulting in a review that preceded the establishment of an inquiry that, over 18 months, investigated clinical, and management practices at the hospital from 1990 to 2000 and made recommendations to address service deficiencies.

**Key findings**

The lack of safety and quality systems at state, board and hospital level was evidenced by ineffective accreditation and credentialing systems, inadequate incident reporting systems, poorly performing statutory mortality reporting and investigation systems, and non-existent inter-hospital comparative data analysis.

The inquiry also found significant leadership, management and clinical performance problems including:

- a culture of blame, unsupportive of open disclosure of errors and adverse events
- lack of clarification of senior staff responsibilities and accountability
- non-existent safety nets or systems to effectively monitor performance and respond to performance issues
- ineffective or non-existent systems to ensure staff had the right credentials, training, support and performance management to meet the demands and skill requirements of their roles and responsibilities
- failure to meet the emotional needs of many women and their families, excluding them from decisions about care or failing to give them honest, complete and timely information when things went wrong
- failure to address serious and ongoing management and clinical problems that resulted in serious adverse events and poor outcomes for women and their families.

**Lessons learned**

The inquiry’s key findings raise important issues about leadership and culture, accountability and responsibility, systems for safety and quality, support and development of staff, and concern and compassion for patients and their families.

- To assure safe and quality care, governments, boards, health care leaders and managers must create an open and transparent culture, where people willingly discuss and address errors and system problems.
- Effective organisations have people at all levels doing the right thing. Organisational structures, regardless of their intent or design, can only be effective if people know and aim to meet their responsibilities and are held accountable for their actions.
- Effective leaders and managers ensure that their organisation has systems that effectively monitor the key aspects of its performance, and ensure timely and appropriate responses to performance issues.
• To do a good job, people need the right credentials, training, support, performance management and development, consistent with the demands and skills requirements of their roles and responsibilities.
• A caring, concerned health care service recognises the importance of involving patients and their families in care, provides information about care options, involves them in decisions about care and advises them openly and honestly when things go wrong.127

Community and consumer participation

In addition to the importance of the provision of information to the community and accountability for health expenditure there is 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. The Consumer Focus Collaboration, a national initiative aimed at encouraging and promoting a focus on participation within health, has developed extensive material and tools for use. This group has focused on consumers specifically, rather than the broader issue of community participation.

The collaboration’s summary document, The evidence supporting consumer participation in health,128 identified the following benefits of consumer participation:

• Active consumer participation in decision making in individual care leads to improvements in health outcomes.
• Access to quality information facilitates decision making and supports an active role for consumers in managing their own health.
• Active consumer participation leads to more accessible and effective health services.
• Effective consumer participation in quality improvement and service development activities in health services is achieved through the adoption of a range of methods.
• Effective consumer participation uses methods that facilitate participation by those traditionally marginalised by mainstream health services.
• Active involvement of consumers at all levels of the development, implementation and evaluation of health strategies and programs is integral to their success.

The positive role of participation in contributing to health and wellbeing outcomes has been detailed in research related to health promotion, community development, social capital and public health.129 130 131 132

Epidemiological research on psychosocial risk factors for poor health has identified some that appear to be mediated through an individual’s social circumstances, including isolation, lack of social support, poor social networks, levels of civic engagement, low self-esteem, high self-blame, and low perceived power and control.133

At present, community health centres, local government and a range of non-government and charitable organisations undertake a mix of work — which can be captured under the heading community development — that helps to build a community’s capacity to be proactive about their life and circumstances. These activities often involve a mixture of consumers and community members. Examples include work with targeted communities such as during urban redevelopment processes within culturally and linguistically diverse populations and single mothers, and supporting community action to improve environmental conditions. Within hospitals the greater focus is on consumers, and some hospitals, particularly those in the metropolitan area, are less likely to have a community to which they relate.
A participation framework also needs to address the particular issues and needs of specific population groups. Various populations come with different understandings, cultural values and belief systems. Health care tends to be provided as ‘one size fits all’. It does not. There is a need for flexibility and responsiveness to respond to diversity of need. This issue has been continually highlighted throughout this review and includes issues as simple as communication.

Issues of miscommunication in the provision of health services to Aboriginal people are significant and can result in poorer health outcomes. It is critical in the provision of health services that they adequately meet the needs of the person. Failure to do so can result in health risks due to inadequate care and management by the person of their health care needs as a consequence of failing to understand the directions given or even failure to access a service at all.

The provision of culturally appropriate and aware services is important and can only be accomplished 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 does not provide the answer to dealing with societies’ intractable social problems. It requires a commitment to a process and method of working. It is a fundamental aspect of democratic society and is one that can enhance, strengthen and develop community strength.

Public health practitioners give much attention to screening, immunisation, lifestyle changes, or risk-factor modification ... millions of dollars are committed to alleviating ill health through individual intervention. Meanwhile we ignore what our everyday experiences tells us, ie, the way we organise our society, the extent to which we encourage interaction among the citizens and the degree we trust and associate with each other in caring communities is probably the most important determinate of our health.

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

Effective involvement
The evidence, and indeed commonsense, makes it clear that participation is an important principle of democratic culture, of business and of good health service planning and delivery. The key question is how to effectively implement involvement strategies across the health system.

There are many barriers to community involvement. Involving the community effectively threatens and upsets existing power bases and authority by providing a mechanism for the status quo to be questioned. In South Australia this has been demonstrated in the past when the State Government ceased support for community advisory structures, specifically the health and social welfare councils and metropolitan regional health planning units in the late 1990s. The common view appears to have been that these structures became problematic politically. In relation to the health and social welfare councils, for example, the formal reasons given for funding cessation were as follows:

- There were only four health and social welfare councils, and they did not cover the entire state.
- Funds were not available to enable a council in every region of the state.
- The concept of an independent centralised consumer body was being considered as a replacement for the councils.
The last proposal has recently been established by SACOSS with initial funding from DHS. This funding has enabled the Health Consumers Alliance SA to become an incorporated body that provides an independent voice for health consumers.

During its consultations, GHR identified a high level of scepticism about community involvement in health. This scepticism comes from:

- lack of faith in public institutions and government commitment to community participation
- concern about who and why people get involved (self-interest versus community interest)
- concern about the professionalisation of community advisory groups to meet the needs of boards and managers — ‘using them as puppets’
- concern about the ability to maintain interest and involvement within communities, particularly rural areas in decline, and to ensure that minority and silent voices are effectively included.

Health is very cloistered. As a result some professionals and other officials find it hard to accept that both consumers and community members have a legitimate voice and role in determining the who, what and how of the health system. Consequently participation can be an afterthought or add-on rather than a principal commitment to a way of working. Participation requires significant time, resources, commitment, a willingness to question the status quo, to listen and to respond. It requires honesty and integrity to enable partnerships to be developed and maintained.

**Ways forward**

**Community engagement in priority setting**

There are numerous examples of community engagement in priority setting, both nationally and internationally, for example NSW, regional work on community priority setting, and work in Oregon (USA), Canada and England.

A range of mechanisms can be used to engage the community including:

- deliberative polling
- community values identification, for example the Canadian model of the citizens’ 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 assist the development and accountability of whole-of-government action in relation to 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 statewide level will need to be an ongoing process of development and there may be a variety of pathways explored over time. The commitment to the process of engagement is key. GHR believes deliberative polling can provide a good 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 around health investment choices.

Establishment of whole-of-government performance benchmarks (see Chapter 6) and health system performance monitoring (see later in this chapter) also provide potential opportunities for the community to become engaged. The development of indicators for system performance needs to be related to community expectations of what they want the system to deliver. Exploring the development of benchmarks and measures with the community provides a positive mechanism for involving and educating the public about the health system.

The commitment to community engagement at a statewide level is a commitment to a process. The work will not be finished simply because one good process has occurred. Work will develop over time and each activity should lead the way to other possible avenues of exploration. It does not mean the state must be able to perform at least one statewide community strategy each year. The focus must be on the development of quality practices that are valuable to the public and the health system. It is important that a first step is taken down this road. Where it will lead in the future rests in the partnership to be forged between the health system, the community and the government.

Deliberative polling provides a method for establishing and promoting public understanding and debate. It uses a representative population sample and undertakes an intensive process of debate and education. GHR believes that such a vehicle will provide the system with an opportunity to develop community understanding of the need for reform by focusing the subject of such an exercise on the issue of the never ending demand for health care versus the reality of limited public resources to meet such demand. Deliberative polling also enables the attention of the media to be used to further promote the debates and issues into the broader community.

**Recommendations**

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.

The overall objectives of the South Australian public health system are to ensure fair access to effective and prompt quality health care, and to have a health care system that strives to improve the health status of the population. To achieve this, there is a fundamental requirement for clear accountability and governance structures with transparency being the key element of any accountability framework.

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, communities and health services. The National Health Performance Framework provides a three-tiered approach that examines health status and outcomes, determinants of health as well as health system performance.

The framework should demonstrate progress on the overall goals of the South Australian public health system, on the key steps it must take to deliver those goals, and on the outcomes it is expected to achieve. It should, at the very least, consist of the following performance categories:

- **Improvement in health** — to reflect the aim of improving the overall health status and addressing health inequalities, which is influenced by many factors, reaching well beyond the public health system
- **Fair access** — to recognise that the public health system’s contribution must provide fair access to health services for people’s needs, irrespective of geography, class, ethnicity, age or sex
- **Effective delivery of appropriate health care** — to recognise that care must be effective, appropriate and timely, and comply with agreed standards
- **Quality and safety** — to reflect the aim of achieving the highest possible quality and safety in health service delivery
- **Efficiency** — to measure the way in which the public health system uses its resources to achieve value for money
- **Positive community experience** — to measure the way in which people who access the health system, and their families and carers, view the quality of the treatment and care they receive
- **Improved health performance of SA public health system** — to assess the direct contribution to improvements in overall health care provided by the health system.

The performance framework should 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.

Canada has undertaken significant work on the development of performance measures for the health system, and the relatively recent development of 14 indicators has provided a basis for accountability across the nation. Each jurisdiction in Canada is responsible for preparing a report on each of the indicators to provide a meaningful snapshot of what is happening right now within each province and territory in Canada. The 14 indicators fall within three broad areas of assessment:

**Health status**

- life expectancy
- infant mortality
- low birth weight
- self-reported health

**Health outcomes**

- change in life expectancy
- improved quality of life
- reduced burden of disease, illness and injury
Quality of service

- waiting times for key diagnostic and treatment services
- patient satisfaction
- hospital readmissions for selected conditions
- access to 24-hour, 7-day first contact health services
- home and community care services
- public health surveillance and protection
- health promotion and disease prevention

Recommendation

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

As indicated earlier in this report, 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 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 relationship 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. Information could include intervention rates, adverse events, waiting lists, a listing of all providers and their backgrounds, and other information of relevance to community members. Community information on the health system is an important element in ensuring the transparency of the system and enabling those outside the system to make comment on and understand the health system better.

It is important that this body is independent of 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.

The independent monitoring body would add to the roles of the Auditor-General and the proposed health and community services ombudsman by ensuring issues identified by these bodies were considered and actioned. There would be a need for appropriate linkages.

There are several options that could be considered for establishing such a body, including the development of new legislation or using the existing SAHC Act (see Chapter 7). The independent monitoring body would need to establish appropriate links with the community, health professionals and DHS.
Recommendation

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.

Attributes and functions of the independent performance monitoring body

- Provide an external and independent check on system performance and, initially, direct and support the GHR reform agenda as decided by government
- Provide an independent means of guaranteeing quality and safety
- Be directly accountable to and appointed by the Minister for Health
- Have members drawn from the community, business, the professions and academia
- Provide independent advice and support for the reform agenda
- Oversee continuous improvement of the health system, monitor progress and establish reform targets and timelines.

Clinical governance

Clinical governance represents an organisation-wide strategy for improving quality within the South Australian health system. The term clinical governance is used to denote the accountability of the organisation as a whole for clinical standards and safety. It also implies that clinicians (of all disciplines) must be involved in governance functions. However, responsibility and accountability for clinical governance must ultimately rest at the corporate governance level.

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.

DHS also has a role in supporting and monitoring the capacity of the South Australian health system to provide quality health care.

The setting and monitoring of standards of clinical care is an essential element of clinical governance. These standards cover:

- education, training and behaviour to ensure staff have the necessary skills and work cooperatively in multidisciplinary teams
- clinical effectiveness to ensure that care is appropriate
- risk management to ensure lessons are learned from adverse events
- user involvement to ensure consumers understand and are able to participate in decisions about care.

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.

There is a recognised need to involve clinicians (health care professionals of all disciplines) at all levels of decision making in the health system. 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.

**Recommendations**

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.

**Attributes of the clinical senate**

- Reports directly to the Chief Executive of DHS, thereby being integral to the effective functioning of the overall health system
- Receives executive support from DHS and access to benchmarking and clinical performance data
- Comprises a core of approximately 20 people from a mix of medical, nursing and allied health practitioners
- Has members selected by nomination for two-year terms in positions that are not representative of particular groupings or organisations
- Has a clinical senate chair appointed from the members by the Chief Executive of DHS for a two-year term

**Functions of the clinical senate**

- Monitors and sets benchmarks for quality and safety standards, analyses reports on health system performance and provides advice to the independent health performance monitoring body
- Provides advice on the agenda for clinical planning and recommends to the Chief Executive of DHS the approval of clinical plans and network clinical service group business plans

The clinical senate will also be in a position to provide advice on issues related to the workforce requirements, and research and training needs of the health system. The types of areas that the clinical senate may want to examine include:

- **Evidence based practice**
  
  Evidence based medicine has had a major influence on health care systems worldwide. Accessing and appraising evidence is becoming a core clinical competency. Although presenting evidence, or providing access to it, is a necessary condition for adopting new practices, it is not sufficient in itself. Health professionals are becoming increasingly clear that single measures,
such as general feedback, are not effective. Multifaceted strategies are needed. Techniques include input from respected colleagues, academic detailing, and individual audit and feedback. Clinical governance is also expected to address how good practice can be recognised in one service and transferred to others.

- **Professional development**

  Staff of a healthcare organisation will be the key to how it rises to the challenges of the new agenda. Firstly, good recruitment, retention and development of staff will make a major contribution. Secondly, staff must be supported if they are to practise well. Skills development, training and research, modern information technology and access to evidence are all-important. Thirdly, staff must participate in developing quality strategies and be encouraged to look critically at existing processes of care, — and improve them. Finally, valuing staff and letting them know that they are valued is a common feature of organisations that show sustained excellence in other sectors.

- **Data quality and information**

  The importance of clinical record keeping is well established. The collection and analysis of routine patient data are a central part of health services planning and administration. However, the emphasis in data collection has been on the number of treatments, length of stay and costs of care. There are substantial failings in the completeness of this clinical data. A renewed commitment to accuracy, appropriateness, completeness and analysis of healthcare information will be required if judgments about clinical quality are to be made and the impact of clinical governance is to be assessed.

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

**Community councils**

GHR heard claims that health unit boards represent the community. While health unit boards are made up of community members, 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 removing the need for health unit boards, GHR considers that a formal mechanism for community input at a 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 proposed that a statewide community council be established to provide for community input at this level.

There are a number of options on how community members could be appointed to regional councils. These include community election, appointment by the Minister for Health, nomination by an independent body such as the Health Consumers Alliance SA, local government or other bodies within the region, or by public call for self-nomination. While there are ‘pros and cons’ for each option, GHR believes a public call for nominations may be most appropriate in the first instance. Following the future development of the capacity and role of regional councils, it may be feasible to move towards community elections.
GHR believes there is a need to apply past learnings, for example the experiences of the metropolitan regional health advisory groups in the late 1990s. Some key principles that could be applied are:

- public call for interested members
- requirement for nominees to be able to demonstrate linkages to the community network(s)
- up-front investment in induction, education and training
- realistic expectations of the time required to build capacity
- understanding of the need for resourcing and support for councils as they develop and mature.

GHR proposes that the state community council comprise a mixed group of community members, including a proportion of members from regional community councils. It is considered that the mix of membership would need to be balanced between those from regional community councils and those not from regional community councils.

The role of the regional community council would be to:

- provide advice and input to the regional board on community needs and issues
- provide advice and input to the regional board on priority setting, based on community needs and issues
- advise the regional board on appropriate consumer and community participation mechanisms
- assist the regional board to develop and implement appropriate participation mechanisms
- ensure that the regional board has developed and undertaken appropriate and effective participation, with particular attention to participation by specific population groups
- ensure that community accessible information is disseminated
- establish linkages at the local level to ensure that particular local issues and needs are conveyed to the region.

The role of the state community council would be to:

- provide advice and information for the purpose of performance monitoring
- ensure that health performance monitoring information is provided in a community accessible format and disseminated, with education, at regional and local levels
- ensure that, in the development of health performance monitoring measures, appropriate opportunities are provided for additional community involvement in the council's work
- advise the Minister for Health on health issues and priorities from a community perspective.

In addition to these formal community committee structures, 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. This will provide community members and consumers with three levels of input into the health system:

- at the local level (through the community and consumer participation processes of local health units and services)
- through the regional community council
- through the state community council.
Recommendations

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.

Accountability and transparency framework
The above elements, linked together, provide the accountability and transparency framework illustrated in Figure 20.

Figure 20: Governance, accountability and performance management framework
Community and consumer engagement

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 signals 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
- services and programs.

This framework is illustrated in the Figure 21, together with some examples of the types of actions that could be taken under each of these headings.
Each of these areas is described in more detail below.

**Legislation**

In addition to the formal mechanisms for community involvement discussed above (community councils), there is a need for all health units and staff to adopt a culture driven by principles of community and consumer engagement.

The adoption of an explicit commitment to this principle within legislation provides a clear statement of expectation to the health system. It provides the public with the acknowledgment that participation is a fundamental part of health system reform. By adopting such a statement within legislation, the system is required to ensure accountability against this goal.

Clearly it is not necessary for the system to have legislation to require or deliver accountability for community and consumer participation. These processes should be established regardless of any legislative amendment. However, the symbolic importance of having a commitment to participation identified in legislation should not be underestimated.

**Recommendation**

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.

**Leadership**

GHR has found that, while many health units have a commitment to consumer and community participation, the activities tend to be ad hoc. There is a lack of formal system recognition of the importance of this work, typically considered as a lower priority in the broader scheme of health service delivery. There is a need for enhanced leadership to promote the importance of participation and to encourage the development of and commitment to quality practice in participation. GHR notes the establishment of the Community Engagement Unit within DHS. This provides an opportunity to facilitate leadership and support employees across the health system to develop quality participation mechanisms and strategies (see section on workforce below). Leadership should be fostered both in the community sector as well as within the health system itself.

**Recommendation**

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

**Structures, services and programs**

GHR noted a lack of accountability across the system for participation. While a commitment to participation appears in the general rhetoric of DHS and across health units, it does not appear to be backed up by accountability for action in this area.

 Provision of formal accountability mechanisms is essential if the general rhetoric around participation is to stimulate strategic action. The proposed state and regional community councils provide a significant step towards appropriate accountability structures.
Regions will need to develop appropriate structures to ensure that a range of consumer and community participation opportunities is provided to address the particular needs and interests of community members. These could comprise one-off, short and longer term mechanisms. For example, consumers may be involved in the design of a new service in their local area, in the design of a new health facility, or involved in a one-off evaluation of a particular program or initiative.

Incentives
At present it appears there is little external reward or recognition for quality participation processes that have been implemented and developed, nor are there many incentives for this work to be undertaken. There is little central policy support and often such activities occur without formal recognition or acknowledgment. The lack of support includes a lack of funding and a need to ‘fight’ for resources and time for staff to undertake this work, which tends to be undervalued relative to other health activities.

The framework for community participation outlined above is intended to provide incentives for activity. Legislation, leadership, and workforce and the accountability mechanism provide incentives for action in this area. Incentives should be developed as part of a workforce development strategy and may include, for example, the establishment of budget lines, recognition and rewards for good work, requirements through service and performance agreements, incorporation into job descriptions and promotion of this work through leadership across the system.

Workforce
GHR noted a variance in skill levels and knowledge across the health workforce on consumer and community participation. A wealth of material, tools and resources has been developed to assist people working in this area. These resources are readily accessible but have not been promulgated across the health system. Developing workforce capacity to deliver quality participation processes requires investment to train and encourage workers in the knowledge and use of participation tools and techniques. Teaching and training are critical.

Recommendation

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.

Public information and education
As discussed, information and education about the health system is fundamental to building capacity across the community to undertake meaningful dialogue about health system priorities. If a constituency to support change across the community is to be established, information and education are essential. A clear and concise strategy to address this issue is required. The establishment of the independent health performance monitoring body and the establishment of community involvement in health system priority setting will provide a significant role in delivering public information and education about the health system. These aspects will need to be included within a comprehensive strategy that addresses information and public education needs. It is important for the community to be involved and understand that, with limited resources, difficult political decisions often have to be made in health. Regions will have to take on responsibility for delivering local information within the context of the whole-of-system framework.
The recently incorporated Health Consumers Alliance SA has a role to provide a strong, independent and effective health consumer voice, to promote a just and equitable distribution of health resources, to promote public discussion about health priorities, services and relevant legislation, and to create an opportunity for health consumers to lobby for consumer issues. An independent health consumers group provides a potential vehicle for information dissemination and community education about the health system that is at arms length from government. This could also be very useful in the immediate term, given the lack of trust in institutions. It could serve an important role in building community capacity and providing peer support for consumers who wish to be actively involved in the health system.

**Recommendations**

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.


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126 Rigby K, Clark RB and Runciman WB, Adverse events in health care: setting priorities based on economic evaluation, Journal of Qual. Clinical Practice, 19, 7-12, 1999

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131 Winter I (Ed), Social capital and public policy in Australia. Australian Institute of Family Studies, Commonwealth of Australia, 2002

132 Syme SL, Control and health: a personal perspective, 1989

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135 Lomas J, Canadian Health Services Research Foundation, see www.cprn.org/cprn.html

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

137 Oregon Progress Board Achieving better health outcomes: The Oregon benchmark experience 2002 www.econ.state.or.us/opb/sitemap.htm


139 See Patients’ Voice www.nhs.uk


141 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’s www.healthcarecommission.ca


143 Canadian Institute for Health Information at secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=home_e

144 The Health Consumers Alliance SA has recently been established, auspiced through SACOSS, and supported financially through DHS
SUCCESS STORY

Drug Awareness Five Project

The Drug Awareness Five project was initiated by the Mid North Drug Action Team. A group of five young people from John Pirie secondary school undertook a SACE Community Studies Module and were mentored by the Drug Action Team Development Officer and the Rural Youth Health Project Officer. The aim was to provide an increased knowledge of the harmful effects of drugs and to assist in preventing the uptake of harmful drugs of young people in the school community.

This project involved working with the community, service providers, local businesses, schools and other young people and the planning and implementation of a whole of school survey, a TV advertisement and a “SMASHED” expo that directly reached over 800 young people. This project achieved positive outcomes for working in partnership with young people using a primary health care approach and resulted in the Mid North Regional Health Service winning the 2002 Australian Drug Foundation’s School Based Excellence Award.
CHAPTER 5: WORKFORCE DEVELOPMENT

Objective
This chapter identifies strategies that will help foster the development of the workforce, build greater flexibility and allow responsiveness to change.

Case for change

The future of work
There is a wide spectrum of views relating to the way people may work in the future, on 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:145

- 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 feminisation of work relates to increased employment of women compared to men, and at relatively higher wages than in the past. It is expected there will be increased numbers of women working as primary breadwinners and this may have important consequences for families.

Workers will become older and more skilled as more people go onto higher education. There is also likely to be a reversal of the trend toward early retirement by older workers.

There is expected growth in the health sector and personal services as well as some parts of the education sector, particularly higher education. Overall it is expected that labour demand will continue to shift away from work based on physical attributes to work based on knowledge and personal relations, consistent with the feminisation of work.146

It appears that the next few decades will see a workforce in the western world made up of more educated older women, using computers, who are in service sector jobs.147
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.

The United Kingdom’s National Health Service has begun to think about ‘designing the workforce today for tomorrow’s health service’. The following outlines what a health care practitioner would do in the future, within an acute hospital, and what a health care professional role in primary care would look like.

The main tenet to the framework outlined below is that the health care practitioner would be responsible for the majority of patient care in any care sector. The title health care practitioner reflects the knowledge and skills of the roles as well as to assist in the recruitment process.

<table>
<thead>
<tr>
<th>Future health care practitioner in the acute hospital</th>
<th>Future health care practitioner in primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The role would be designed to deliver the majority of care in the future medical unit. It encompasses:</td>
<td>The role would take up to 40% of general practice workload with significant overlaps between:</td>
</tr>
<tr>
<td>• junior doctor role</td>
<td>• roles of nurse practitioners and general practitioners</td>
</tr>
<tr>
<td>• nursing role</td>
<td>• roles of nurse practitioners and practice nurses</td>
</tr>
<tr>
<td>• professions allied to medicine, and speech and language therapy</td>
<td>• community nurses and practice nurses/nurse practitioners</td>
</tr>
<tr>
<td>• enhanced role in diagnostic tests and their interpretation</td>
<td></td>
</tr>
</tbody>
</table>

**Role content**

**Future health care practitioner in the acute hospital**

- Assessment of patient’s condition
  - case history
  - observations
- Physical examination and diagnostic tests
- Diagnostic and treatment plan
- Provisional diagnosis
- Development and implementation of patient treatment plan
- Ongoing assessment and management, including advanced life support and stabilisation
- Admission and discharge — decision to admit or discharge on the basis of a scoring system

**Future health care practitioner in primary care**

- Trained to manage own case load in a wide range of conditions:
  - patient assessment
  - patient history
  - physical examination
  - diagnosis
  - development and implementation of treatment plans

**Conditions**

- asthma, diabetes, hypertension, hormone replacement therapy, family planning, elderly check, minor acute and wound management, self-limiting conditions, paediatrics surveillance, immunisation and vaccination.
Shaping the future of work roles does not have to be limited to health professionals. A future trained care assistant 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 turnover.

These ideas will be expanded in the section entitled New ways of working, later in this chapter.

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. Each employee plays a key role in the delivery of health services to the public. 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 health service in South Australia encounters periodic workforce crises, with ad hoc responses to supply problems. Workforce shortages at times can jeopardise service delivery.

GHR is of the view that the health care workforce has been largely unplanned and has developed in an ad hoc, fragmented fashion in response to service changes. Responses also tend to be dominated by the views of individual professions which operate in silos.

GHR was informed of the working conditions for some health professionals. Doctors who work in medical practice at all levels have to deal with excessive hours of work. Nurses and allied health professionals also work long hours. Shift work is a feature. Incidental extras and unpredictable overtime, often unpaid, occurs alongside episodes of intense work and a lack of regular breaks. These long working hours contribute to levels of stress and impact on decisions made by professionals to seek alternative employment.

The way in which work is performed in the health system has changed dramatically. The work is physically harder, workloads are heavier, work is more complex, the population needs are more acute, there are insufficient community support services available, there are fewer informal care networks and there is less down time available for workers. Put simply there is no redundancy in the system.

The workforce, in contrast to these dramatic changes, has struggled to make alterations to the way work is performed and, as a result, not responded effectively to these changes. This pace and quantum of change experienced by the health workforce has caused the workforce to become stressed, and for employees to leave the health sector. Retention of a skilled workforce is a much more important issue than recruitment.

A consistent theme throughout GHR consultations was trust. At the operational level workers stated that they received such inconsistent messages regarding policy and processes that they no longer understood the parameters within which they were to work. Middle and senior managers repeated this story. Distrust appeared to GHR to be pervasive throughout the health system in South Australia. Another aspect of this distrust was reflected in the cynicism towards GHR itself. The workforce questioned whether there is real commitment to change even though the need for systemic change is recognised throughout the health system.

One of the solutions to these issues is to change the way in which the workforce functions. Complementing this change would be the creation of healthy work environments to develop the health sector in South Australia as an employer of choice. Creating healthy work environments includes addressing job security, reward systems, training and career advancement opportunities, and
participation in decision making. Relationships between peers, employees and employers are important. These provide links between:

- work environments
- employment relations
- industrial relations
- healthy outcomes for workers and organisations.

Nurses are subject to severe professional restraint and denied career opportunities. Many nurses choose to work in management, academia or leave the field altogether. Job satisfaction and remuneration increase as doctors’ skills increase but this does not happen for nurses and allied health workers in the public health system.

In summary, the workplace culture has inhibited the ability of the workforce to adequately respond to the technological, environmental and social changes of the past generation. Staff roles may not align, resulting in consumer needs not being met. Education, as well as work practices, is located within professional silos, which result in demarcations and may inhibit meaningful work. This silo approach to work practices needs to change. Care is fragmented, affecting the quality and safety of services. As a result consumers are sometimes confused, and issues of quality and safety are becoming more prevalent.

South Australia has significant difficulties in recruiting and retaining appropriately skilled members of the health workforce. This problem is amplified in rural and remote areas. There are difficulties in providing career opportunities within some pockets of the health workforce, and in rural and remote areas the provision of ongoing training and peer support creates difficulties. Supply through training and education is not effectively related to employer demands.

The general practitioner workforce, particularly the rural workforce, is ageing as is the rural specialist workforce. Older medical practitioners are forced to work longer hours, as younger practitioners choose to work more flexibly, often with shorter hours and with the intention of retiring early.

Generally there are shortages in rural and remote areas and in the Aboriginal health workforce. The workforce is operating in a global market where there is increasing competition for resources. For example, Australia has relied heavily on the recruitment of overseas trained doctors to provide services in rural and remote areas.

A report on general practice workforce numbers, due to be completed by the Australian Medical Workforce Advisory Council (AMWAC) this year, will most likely recommend an increase in training places for general practice registrars. This will go some way to addressing the issue. Conversely, the outlook for nursing care in Australia, as well as New Zealand, the United Kingdom, Canada and the United States, is very bleak. Most of these countries are undergoing international recruitment campaigns for nurses. This current crisis, like the expected future general practice crisis, is largely due to poor planning and the inability of the health system to retain skilled nurses.

In addition, public dental services in South Australia are in crisis due to extreme staff shortages. In last year’s graduating student dental class, only 20% remained in South Australia, the majority choosing more attractive positions interstate. There is an urgent need to address these issues, including provision of nationally competitive salaries.
South Australia’s relatively small population also adds to the difficulty of obtaining a critical mass of workforce.

Another issue raised was the emphasis always placed on medical and nursing staff issues. Shortages in these areas are more visible and therefore allied health shortages are perhaps not given the focus they require. This is a particular issue when attempting to refocus the system to primary health care and community based services.\textsuperscript{154}

There is a history of deficient health workforce planning in Australia, mainly due to the different levels at which responsibilities for funding operate. These different levels of responsibilities impact on the delivery of health services, the education system, industrial relations system and registration of professionals. There are few links between workforce, service delivery and infrastructure planning.

There is an urgent need for a national approach to health workforce planning that encompasses data collection, research, assessment, planning and decision making on health workforce education and training, workforce distribution, and recruitment and retention initiatives. The recently released Australian Health Care Agreement Reference Group report highlighted this need.\textsuperscript{155} The report recommends a new national approach to workforce issues. GHR welcomes this direction. It is clear that it has been difficult for states and territories to achieve results individually.

GHR had difficulty obtaining and verifying data on health sector staffing because of the different levels of system sophistication within health units and professional bodies. Despite some areas having systems in place, these systems could still not generate the data required by GHR. This reflects the overall lack of central strategic management and accountability for the health workforce.

GHR has seen a pervading culture of risk aversion and restrictive practice operating within the health sector. There is a lack of strategic decision making and a lack of clear lines of accountability. This was also evidenced in the Fahey report.\textsuperscript{156} Factors that interact to enable or constrain achievement of positive outcomes for employees, organisations and consumers include:

- the work environment and the human resource practices that shape it
- job design and organisational structure (including technology)
- employment relationships (trust, commitment and communication)
- industrial relations.\textsuperscript{157}

In summary, the key issues facing the health workforce are:

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

Workplace culture
GHR believes that 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 six strategies:

- a healthy workforce
- positive identity and culture of innovation
- stewardship
- trust
- shared leadership
- shared responsibilities.

A healthy workforce
There is a need for a workforce strategy that will assist in providing the ingredients for a healthy workforce and address the range of issues that impact on the trust and culture of the workforce. GHR believes the attributes of a healthy workforce include:

- democratic leadership
- middle management with human resource skills
- incentives and rewards provided for best practice
- relevant performance targets, for example staff satisfaction, staff turnover, sick leave
- support for workforce research
- redundancy in the system to support training
- industrial democracy and employee democracy
- local solutions to meet local needs
- organisations that are learning organisations.

Efficiency, effectiveness and leadership of the highest quality is critical. Leadership is needed to allow strategic development of policy and practice for health workforce and training issues. Leadership should be visible and have authority.

At present there is no specific high profile portfolio or position providing leadership and accountability for South Australia’s health workforce. GHR recommends reforms be put in place to provide the basic structures for visionary leadership and efficient and effective management of the health system. Visionary leaders will be the builders of a new health system, working with imagination, insight and boldness. They will be social innovators and change agents, seeing the big picture and thinking strategically and they will find a higher synthesis of the best of both sides of an issue and address the systemic root causes of problems to create real breakthroughs.

Recommendation

5.1 DHS and health services provide management training and development to ensure effective leadership capacity and creative responses to change.
Positive identity and culture of innovation

A positive identity for South Australia has been raised in other venues in relation to economic development and social planning. A culture that promotes a sense of value and of hope, and a positive outlook encourages innovation and inspires action. While many people are sceptical of the value of addressing such a ‘loose’ notion, GHR is of the view that there is a need to reinvigorate South Australia’s positive identity and culture of innovation.

Too narrow a focus in relation to workforce development can lead to limited opportunities for intellectual pursuits. This in turn makes it extremely difficult to recruit, and particularly retain, excellent staff.

Within the health system, GHR recognises the importance of valuing and acting on innovation across the field. There is a need to recognise the important and valued contributions staff — across the health system and in related professional groups — make to health care. Innovators and leaders in all aspects of health, including research, clinical care, community development, health promotion, early intervention, public health and policy development, need to be encouraged, supported and rewarded for their efforts and contributions. More importantly the system needs to recognise and implement those initiatives that have proven successful.

GHR was reminded during the consultation phase that many good ideas, programs and initiatives never seem to get beyond the pilot or local level and there continues to be a lack of transference of good ideas across sectors. There is a need to work out how to best celebrate and disseminate achievements and best practice (see Chapter 3).

Stewardship

In the current climate of distrust it is going to be extremely difficult to introduce any reform. Reform needs to start within DHS, and some planning for this process has begun. A climate of trust needs to be generated and clear messages sent that accountability would start from the centre. This form of governance is commonly referred to as stewardship.

Stewardship is:

- to hold in trust for another
- to preside over the orderly distribution of power
- accountability without control or compliance.

Stewardship as a governance strategy is not prescriptive nor bureaucratic, nor is it blame driven. It is the search for the means of experiencing partnership and empowerment and service. The South Australian health system needs to set in motion systems and processes that are in accord with the principles of stewardship.

The underlying value of stewardship is a commitment to service. Authentic service is experienced when:

- there is a balance of power
- there is a primary commitment to the larger organisation
- each person joins in defining the purpose and culture of the organisation.
Effective stewardship is therefore dependent on:

- a culture of trust
- accountability and transparency
- shared leadership.

**Trust**

It is the belief of GHR that trust can return to the health system with:

- governance structures which facilitate working as a system
- clearly defined accountability, transparency of decision making and performance standards
- shared leadership.

The process of developing this reform agenda has raised the hopes and expectations of everyone in the health system; ‘… but can we trust that it will happen!’ and ‘until I am convinced, I will sit back and wait’ has been the recurring response in GHR’s consultations.\(^{159}\)

Distrust can result either from a lack of confidence in an organisation or a person’s ability or capacity to achieve the agreed outcomes or from the level of commitment to carry through the agreement. This indicates that to display that one is trustworthy requires not just being reliable but also having the necessary skills and resources. In other words, don’t promise what you can’t deliver!

Individual public servants are required to work to a public sector code of conduct. In the future the health system as a whole could develop and apply a code of conduct which is grounded in and owned by all staff.

**Shared leadership**

Leadership can be explored as a social process, something that happens between people. It is not so much what leaders do, as something that arises out of relationships. As such, it does not depend on one person but on how people act together to make sense of the situations that face them. The belief that a single person called a leader or manager can lead the way to a successful future is a myth. Acts of leadership must come from others in the organisation.

The pressure and stress that people in leadership positions face is enormous. Today, it is highly unlikely that a single person can provide the necessary leadership for all issues. Those in designated leadership roles and those who are followers need to let go of that expectation and embrace new ways of leading.

There is a commonly held view that an individual who has the experience, knowledge, skill, charisma, vision, decision making ability, interpersonal skills, respect, stature, role (position) etc. will provide the leadership for the organisation. People who seek leadership positions, or who occupy such positions, are typically expected to have all of these characteristics and all the answers. It becomes easier to understand why people choose not to seek such roles, and even easier to understand in the health care system. The health care industry is possibly the most complex industry in the world and leadership in it requires shared leadership not seen elsewhere.

Shared leadership implies that the management team takes on responsibility for leadership. Rather than perpetuating the belief that a single individual with enormous leadership abilities, who is the formal leader, can lead the way to a successful future, there is a need for other individuals, who are group members, to take on leadership responsibilities as well.
Shared leadership does not abdicate the formal leader’s accountability. It does imply a shared responsibility for problem identification, solutions, and action taking. Skills such as team building, conflict management and building a new culture are among the skills leaders need to build organisations that can successfully compete in today’s highly competitive and changing economy.

One of the barriers to shared leadership is the inability or unwillingness to take risks. The failure to take risks can have a paralysing effect on the individual’s and organisation’s ability to learn. Those in leadership positions need to create a climate that will encourage others to take risks, to confront the formal leader and others in the organisation, to disagree, and to exhibit acts of leadership. Today’s workforce is insular and plays it safe because there is no encouragement or reward for taking risks. In addition, current systems design does not encourage shared leadership.

It takes courage to put forth a viewpoint that is different from the prevailing or dominant thinking of a group. It is the responsibility of the individual to put forth their idea, an act of leadership. It is the group’s responsibility to set up norms and an environment that supports the notion of risk taking and sharing of leadership. The concept of shared leadership offers a way of increasing risk taking, innovation and commitment that can create an organisation that is responsive, flexible and successful.

In summary, this shift in the leadership model from emphasis on the formal leader to a shared leadership model is subtle, powerful and essential. The designated leader can no longer do it all. The stress, the complexity of the issues, the urgency for better decisions (not perfect decisions) places a burden on leaders that few are willing to shoulder or able to effectively resolve alone.

**Shared responsibilities**

The State Government cannot solve all workforce and training issues. Many policy areas require input from the Commonwealth Government or decisions by professional bodies. For example, in the next ten years, Australia wide, there will be a shortage of general practitioners.

The Australian Medical Association highlighted this fact to the Commonwealth Government through work conducted by Access Economics. It estimated the overall shortfall of general practitioners, both Australian and overseas trained doctors, was between 1200 and 2000 full-time equivalent general practitioners. The rural shortage is estimated at 700 and urban shortage at 500.

Ideas to address this situation in the long, medium and short term almost entirely rely on the Commonwealth Government. Within the scope of the state are initiatives that include providing professional and family support to rural and outer urban general practitioners, as well as providing retention incentive payments for those general practitioners approaching retirement. However, these initiatives would need to be implemented collaboratively with the Commonwealth.

Table 7 illustrates where some of the responsibility and accountability lies in relation to health workforce and training development. It demonstrates that, in partnership with various stakeholders, South Australia can effect change in some areas of workforce related policy but in some areas the potential influence of the state is weak.

Simply increasing workforce supply will not solve the workforce problems discussed. There is a need for significant workforce reform to be undertaken, because the methods for organising the workforce have not changed. Remuneration and rewards remain largely unchanged, training and educational locations and numbers have been on average similar, and workforce morale is of concern. In addition, policy development in workforce planning has not altered. A comprehensive approach to the complexity of the workforce and training issues must be undertaken.
### Table 7: Commonwealth and state policy responsibilities for health workforce and training development

<table>
<thead>
<tr>
<th>Area of policy</th>
<th>State responsibility</th>
<th>Commonwealth responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection and monitoring</td>
<td>Department of Human Services, Health units, Community agencies, Nurses Board, AMA, Divisions of General Practice, Allied Health (SA), Medical Board of SA</td>
<td>AIHW, Health Insurance Commission, Rural Doctors Workforce Agency, AHWOC, AMWAC</td>
</tr>
<tr>
<td>Setting number of undergraduate positions</td>
<td>Universities with industry provide advice to the Commonwealth</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Setting number and mix of postgraduate positions</td>
<td>Relevant colleges and universities, along with industry and government, provide advice to the Commonwealth</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Setting education fees</td>
<td>Universities</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Determining curriculum</td>
<td>Universities — faculties of medicine, health sciences/nursing</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>Determining and establishing training curriculum</td>
<td>VET/ universities, National Industry Training Advisory Board (ITAB), Industry</td>
<td>Australian Medical Council</td>
</tr>
<tr>
<td>Assessment and accreditation of curriculum/preregistration courses</td>
<td>Nurses Board, Medical Board</td>
<td></td>
</tr>
<tr>
<td>Registration and licensing for SA and mutual recognition</td>
<td>(Regulatory bodies), Nurses Board, Medical Board, Allied health boards</td>
<td></td>
</tr>
<tr>
<td>Ongoing competency assessments</td>
<td>Individual through self regulation, Employers, Universities, Professional Boards, Registered training organisations (RTOs)</td>
<td>Medical colleges, Nursing College</td>
</tr>
<tr>
<td>Audits of competency to practice</td>
<td>Nurses Board</td>
<td>Australian Nursing Council</td>
</tr>
<tr>
<td>Assessment of overseas qualifications</td>
<td>Nurses Board, Medical Board</td>
<td>Australian Nursing Council</td>
</tr>
<tr>
<td>Practice standards</td>
<td>(Regulatory bodies), Nurses Board, Medical Board</td>
<td>Australian Nursing Council</td>
</tr>
<tr>
<td>Scopes of practice</td>
<td>Employers (Regulatory bodies), Nurses Board, Medical Board</td>
<td>Australian Nursing Council</td>
</tr>
<tr>
<td>System financial incentives</td>
<td>Department of Human Services</td>
<td>Medicare</td>
</tr>
<tr>
<td>Recruitment and retention programs</td>
<td>DHS, Employers</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>Job design</td>
<td>Employers</td>
<td></td>
</tr>
<tr>
<td>Enterprise bargaining</td>
<td>DHS, Unions</td>
<td></td>
</tr>
</tbody>
</table>
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:

*The Economic Development Board (EDB) believes the greatest influence on population growth is a strong economy with strong jobs growth. Achieving this is essential to reversing current population trends.*

*The EDB believes that as well as pursuing strong, sustainable economic growth, the state should adopt policies to actively promote population growth and offset the ageing demographic profile.*

*The EDB recommends that the State Government develop a population policy. It further recommends that the government set a goal of achieving a population growth rate in line with the national growth rate.*

Predicting the future

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

There are several ways in which future health workforce needs can be modelled and forecast:

- **Supply forecasting** counts the number of personnel at any given moment and projects forward in time, based on maintaining the level of resource. It assumes that need cannot be less than the current supply, regardless of any changes in the external environment.

- **Utilisation or demand forecasting** attempts to match the counting exercise with some measure of population use.

- **Needs based planning** starts with demographic and health risk information about the population that matches to levels of service use matched to numbers of personnel.

- **Benchmarking** looks at communities with the lowest number of personnel per population (including capital inputs) where there are optimum health outcomes. This ratio is then used as the benchmark for other communities.

None of these methods can ever hope to accurately predict workforce numbers required in the future because none of these methods can account for all internal and extraneous factors.

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. It may avoid the mistakes made by previous predictions or models for the future.

The methodology of backcasting can assist in the development of indicators to provide avenues for new information to be acted upon, allowing continual adjustment of the migration path. The use of indicators allows decisions to be made in light of what is now known. This methodology for planning may be worth exploring further. Much has been written about its potential uses and ability to more accurately predict the future than current methods.
Coordination of information

Some form of workforce planning and policy development is preferable to either a more competitive, market-based approach to determining workforce numbers, distribution and skills, or reactive policy development arising from industrial processes. Skills shortages in a number of areas demonstrate clear market failure.

Effective workforce coordination will provide an opportunity to establish an ongoing capacity for prioritising workforce issues and undertaking workforce planning, strategy development and problem solving.

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, community, 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. 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. Intellectual, financial and political resources are required to change the focus from the current ad hoc planning to coordinated planning. This will require a new structure, preferably a planning body within DHS.

A workforce planning group would develop policy and programs that would directly affect health workforce issues and allocate strategic funding to support these initiatives. It would also be responsible for dealing with issues relating to health practitioner regulation, including developing policy initiatives and legislative frameworks for current and emerging health professions such as Chinese medicine and complementary therapies.

The forecasting component of this group would have responsibility for developing models and undertaking service demand and workforce forecasting. The forecasting section could have responsibility for developing and maintaining corporate required demographic data for use by DHS. Purposeful effort would then be made to collect, analyse and provide regular reports on critical issues including recruitment, distribution and remuneration of health care providers.

The development of positive relationships between providers and users of the workforce, and universities, TAFEs and the health system is a key issue in ensuring strategic workforce planning.

This approach to workforce planning has been recommended in a report commissioned by the Commission on the Future in Health Care in Canada in October 2002. The report outlined several roles that the health workforce planning group (in their case an external agency) could undertake.
It is envisaged that this approach, modified according to need, is appropriate for South Australia. Roles for the workforce planning group within DHS could include:

- **Environmental scanning** — Collect personnel numbers (how many, where they work, what they are providing, what they are being paid) and climate surveys.

- **Trend identification** — Identify trends in numbers, movement interstate, potential issues in medical specialties. Based on this information, identify early changes in practice styles, educational changes and legislative changes and outline their impact on the workforce overall. This would allow for prospective planning instead of retrospective planning.

- **Best practice clearing house** — Gain best practice information about integrated planning processes, collaborative education models and recruitment and retention.

- **Planning tool development** — Develop tools for integrative health human resource planning.

- **Indicator development** — Develop leading indicators for the health of the workforce and develop balanced scorecards in this area.

- **Model development** — Develop models for planning health human resource capacity to be made available to communities and regions and for use within DHS.

- **Public reporting** — Report publicly on the state of South Australia’s health workforce.

- **Participation in joint national planning** with other states as well as the Commonwealth. Health workforce planners, state and Commonwealth officers, currently provide support for the exploration of national workforce planning models and for sharing information on models across jurisdictions. In future, all states will work together to discuss and determine the most appropriate workforce planning model for the health workforce. This includes:

  - workforce planning models that have been used to date
  - input on the experience of workforce planning activities and models used in the health workforce, apart from the medical workforce
  - engaging in and contributing to the necessary technically detailed discussions about the use and merit of these models.

- **Knowledge transfer laboratory** — Identify current national and international trends and research in relation to the health workforce and facilitate its use in policy and planning activities.169

The health workforce planning group would also have an additional role in providing a focus point for cultural change. This will assist in shifting the emphasis from management of supply to a holistic approach to workforce management. The group would work in partnership with existing external agencies that collect workforce data, such as the South Australian Nurses Board, Australian Institute of Health and Welfare and the public sector unions, to produce customised reports useful for planning and policy decisions.
**Recommendation**

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.

**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 of staff
- **streamlined workforce planning and development** which stems 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
- **more flexible deployment of staff** to maximise the use of their skills and abilities.

Due to changes in the way health care services will be delivered — with greater emphasis on collaborative practice, teamwork and networks of providers — traditional scopes of practice will need to change. This indicates the need for new roles for nurses, general practitioners, pharmacists and allied health practitioners, as well as the potential for new health professions to emerge. Action and leadership from DHS is required to coordinate work on skill-mix changes and development of new
types of health care workers. For example, progress could begin immediately in employing non-
medical personnel for some primary care activities. One of the areas of work recommended by GHR
to be undertaken by the proposed health workforce planning group is determining the feasibility of
developing a future clinical workforce similar to that of the United Kingdom’s National Health Service
Futures Project.171

**Education and training**
The higher education sector and the 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.172
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.
Both the VET sector and higher education sector are adept at cultivating relations with employers.
A strengthened VET sector could have the potential to free up universities from the pressure to be more
vocational which appears to be undermining their quality and depth.173

Currently the responsibility for setting undergraduate and postgraduate numbers lies with the
Commonwealth. This responsibility should be expanded. The profiles of programs and number of
positions need much wider discussion and a coordinated state and Commonwealth approach.
A review of the current health education and training system is needed to ensure health care providers
are able to work effectively in the new primary health care system.

In terms of determining curriculum, the South Australian Government must have more influence.
The mechanism could be provided by the health workforce planning group. Working collaboratively
with universities, this group could 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**
Historically, metropolitan models of service provision have been applied to rural, regional and remote
settings, often with limited success. This is not surprising given the diversity of South Australia’s rural,
regional and remote communities.

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 work must begin attracting people in more mature age groups in these areas.

**Recommendation**

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

The introduction of generic rural health practitioners may assist in addressing some of the problems experienced by rural and remote health workers. An innovative new postgraduate program to encourage rural health practitioners to broaden their skills and upgrade their qualifications is set to begin in Queensland in 2003. The University of Queensland is offering the program by distance education, and it is hoped it will also help to keep practitioners in rural areas by providing them with a career path.

The project was initiated in 2001, when the former Commonwealth Department of Health and Ageing and Department for Education, Training and Youth Affairs agreed to jointly fund the University of Queensland to develop a graduate entry distance education program specifically for nursing, allied health and emergency health professionals who practise in rural and remote areas. The project aims to enable practitioners with a degree in health-related science such as physiotherapy, speech pathology, audiology, human movement studies, nursing, psychology or pharmacy, to undertake a set of core competencies through a distance education program. These competencies would include at least four new skills, in addition to those in the basic undergraduate degree. The range of competencies offered includes counselling, advanced life support, emergency dental procedures, limited prescribing and medication counselling, physiotherapy, occupational therapy, speech pathology and audiology. It is anticipated that graduates from the course will work collaboratively with general practitioners, located either in the same town or in a distant location.

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 case load 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 rural and remote Australians.

**Recommendation**

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.

**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, for example, 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 Aboriginal health worker training is funded over three to five years. Annual funding in South Australia 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 appropriate and 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:

- feeling isolated and being the only representative of a minority group where the majority lack knowledge of Aboriginal culture
- negative and sometimes derogatory attitudes of university staff and health workers
- 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
- low self esteem which is reinforced by failure.

These barriers require addressing in order to ensure that the numbers of Aboriginal people undertaking nursing education and graduating are increased.

Aboriginal workers across the health system reported experiences of racism within the workplace. There is a need for the health system to recognise this and take action to ensure that such attitudes are addressed. At present there is ad hoc provision of cultural awareness training and this should be extended across the system. It is recognised that simply providing training is insufficient. Systemic racism, not just towards workers but also towards consumers, must be addressed through effective leadership and management.

Recommendation

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.
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 better 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 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.

Recommendations
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.

Process re-engineering
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. Process re-engineering has been defined as ‘fundamental rethinking and radical redesign of business processes to bring about dramatic improvements in performance’. Redesign of business processes, associated systems and organisational structures can achieve a dramatic improvement in performance. 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.
Planning and managing change, both cultural and technological, will be one of the most challenging elements in the implementation of GHR's recommendations. Understanding the key areas of change management will be critical to its success. Process re-engineering will assist in this process.

**Recommendation**

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

The health workforce planning group proposed in this chapter must provide new and innovative solutions to industrial issues. The group needs to begin with addressing the decline in employee participation and aim to create democratic workplace environments that are satisfying for government, providers and employees.

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.180

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.
FOOTNOTES


146 op. cit Freeman.R p.167

147 op. cit Freeman.R p.188


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

150 AMA, Media Release 26 November 2002

151 Response 77 to the GHR Discussion Paper October 2002

152 See Submission Nos 141 & 310 to GHR

153 SADS correspondence to GHR February 2003

154 See Submission No 85 to GHR

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SUCCESS STORY

Chronic Disease Self Management Program

This project was a community based demonstration project that aimed to develop a local model of Chronic Disease Self Management for Aboriginal people through participation of families and community members. Clients were recruited for the program in Ceduna and surrounding areas with support provided through Ceduna Koonibba Aboriginal Health Service and the Ceduna Regional Health Service Program. Clients were also recruited through the Port Lincoln Aboriginal Health Service in Port Lincoln.

The partnership included Ceduna Koonibba Aboriginal Health Service; Pt Lincoln Aboriginal Health Service; Eyre Peninsula Division of General Practice; Flinders Human Behaviour and Health Research Unit, Health Promotion SA and Department of Human Services.

Over a one-year period, 60 Aboriginal people with type 2 diabetes, in two remote regional centres, participated in a self-management program.

The project demonstrated that participation in a diabetes self-management program run by Aboriginal Health Workers was successful in identifying problems and defining client orientated solutions. This process has been implemented within routine care at the Pt Lincoln Aboriginal Health Service.
CHAPTER 6: HEALTH INEQUALITIES AND HEALTH AS A HUMAN RIGHT

This chapter examines health inequalities and their relationship to the social determinants of health. It identifies the need for whole-of-government action to address the social determinants of health. The chapter also explores in greater depth a number of specific population groups whose health, wellbeing and health care needs require particular attention. A number of key directions are identified to address the specific needs of these population groups.

Health inequalities

The purpose of the health system is to deliver health care. The health system has a significant role in health prevention, promotion and early intervention. However, the majority of resources are focused on providing interventions to address disease, illness and injuries. In reviewing the health system it was necessary to explore the social, economic and physical environments that give rise to poor health, disease, illness and injury.

Prevention must be the first focus of any health system. The prevention of disease, illness and/or injury delivers a healthier population. This review has been undertaken in an environment where the health system is under immense pressure. It is not possible to talk about reforming the health system without exploring the antecedents to 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 in the state.

Objective

The objective of this section is to provide a framework that will enable the social, economic and environmental factors that give rise to poor health outcomes to be addressed.

Case for change

The health and wellbeing of populations is related to a range of socioeconomic factors, including income levels, disparity between the least and most well-off, employment, education and transport, to name a few. There is also an emerging evidence base around the role of culture in relation to health and wellbeing outcomes.\textsuperscript{181, 182}

The work of Sir Douglas Black,\textsuperscript{183} and the more recent works of Acheson,\textsuperscript{184} and Wilkinson and Marmot,\textsuperscript{185} have been used by the United Kingdom 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.
GHR believes that while health services are responsible for ensuring the delivery of services which meet the 'illness' needs of the population, that response must occur within the broader framework of a community that is focused on developing and sustaining healthy environments.

Health is the responsibility of all South Australians, supported by whole-of-government action, commitment and accountability for addressing the socioeconomic determinants of health. The Minister for Health and DHS are accountable for the quality, safety and outcomes of health care and have a lead role in prevention, promotion and early intervention for health.

It is necessary for a whole-of-government approach to be taken if the social determinants of health are to be addressed, and if a vision for a health promoting society is to be established.

The principles upon which this approach is based include the following:

- All people have a right to health.
- Health and wellbeing outcomes are linked to the social, economic and physical environment.
- Health care services are one of many factors that contribute to health and wellbeing.
- The public has a right to know and understand the influences on health and wellbeing and their own level of responsibility.
- The public has a right to expect accountability from government, including health, for its actions.

**The solid facts: Social determinants of health, World Health Organization**

Even in the richest countries, the better off live several years longer and have fewer illnesses than the poor. People’s lifestyles and the conditions in which they live and work strongly influence health and longevity. There are a number of factors that have been identified which influence health and wellbeing outcomes, including those below.

**The social gradient**
People from lower socioeconomic backgrounds usually run at least twice the risk of serious illness and premature death than those from the highest socioeconomic backgrounds.

**Stress**
Stress harms health. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful effects on health. The lower people are in the social hierarchy of industrialised countries, the more common these health problems become. Institutions that give people a sense of belonging and of being valued are likely to be healthier places than those in which people feel excluded, disregarded and used.

**The early years**
Slow growth and lack of emotional support during the early years of life raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Poor social and economic circumstances present the greatest threat to a child’s growth and launch the child on a low social and educational trajectory.

**Social exclusion**
Social exclusion creates misery and costs lives. Processes of social exclusion and the extent of relative deprivation in a society have a major impact on health and premature death. The harm to health comes not only from material deprivation but also from the social and psychological problems of living in poverty.
Work
Stress in the workplace increases risk of disease. Evidence shows stress at work plays an important role in contributing to large differences in health, sickness, absence and premature death. Several workplace studies in Europe show health suffers when people have little opportunity to use their skills, and low authority over decisions. Having little control over one’s work is strongly related to an increased risk of low back pain, sickness absence and cardiovascular disease.

Unemployment
Job security increases health, wellbeing and job satisfaction. Unemployment puts health at risk. Evidence from a number of countries shows that, even after allowing for other factors, unemployed people and their families have an increased risk of premature death.

Social support
Friendship, good social relations and strong supportive networks improve health. Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued, and has a powerful protective effect on health. Social cohesion — the existence of mutual trust and respect in the community and wider society — helps to protect people and their health. Societies with high levels of income inequality tend to have less social cohesion, more violent crime and higher death rates.

Addiction
Individuals turn to alcohol, drugs and tobacco and suffer from their use, but the wider social setting influences use. Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health. Alcohol dependence, illicit drug use and cigarette smoking are all closely associated with markers of social and economic disadvantage. Trying to shift the whole responsibility on to the user is an inadequate response. This blames the victim, rather than addressing the complexities of the social circumstances that generate drug use. Effective drug policy must therefore be supported by the broad framework of social and economic policy.

Food
Healthy food is a political issue. A good diet and adequate food supply are central to promoting health and wellbeing. Shortage of food and lack of variety cause malnutrition and deficiency diseases. Excess intake (also a form of malnutrition) contributes to cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental caries. Food poverty exists side by side with food plenty. The availability and cost of healthy, nutritious food is an important public health issue.

Transport
Good transport systems can assist in creating both quality of life and health by reducing reliance on motor cars, encouraging the use of public transport, cycling and walking. This will promote exercise, reduce fatal accidents, increase social contact and reduce air pollution. Good public transport systems can promote community safety by increasing pedestrian activity and ensuring access to required services.

As discussed in Chapter 1, South Australia has relatively high levels of poverty compared to other states and territories, and the link between poverty and poor health outcomes is well demonstrated. South Australian data demonstrates significant geographical variance in health outcomes, with particularly poor health outcomes in the lower socioeconomic regions and conversely significantly better health outcomes in higher socioeconomic areas. The death rate of people across metropolitan Adelaide varies significantly, even after adjusting for differences in age and sex profile.
The impact of social determinants on health and wellbeing outcomes for population groups cannot be ignored. The health system cannot continue to respond to the underlying social determinants of health in isolation.

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. Other sectors have an important role, and a partnership approach is required to link state action on social determinants of health with the Commonwealth, private sector, non-government and community members.

People living in neighbourhoods with poorer health status also have a number of similar characteristics related to socioeconomic status. Health related behaviour, such as smoking, dietary habits and physical activity, are also associated with socioeconomic status. Studies on the Australian population have found people with low socioeconomic status are:

- less likely to be physically active
- more likely to smoke
- more likely to consume high levels of alcohol
- less likely to buy, prepare and cook healthy food.

There are clear indications that neighbourhood specific characteristics can significantly influence health independently from socioeconomic and psychosocial status.

Locational disadvantage results from lack of access to services, transport and amenities, and there are locational disadvantages related to physical environments (e.g. the health impacts of the lead smelter and foundries at Port Pirie and contamination from factories in Adelaide’s north-western metropolitan area). The importance of urban environments in contributing to quality of life is well documented in the literature and the Healthy Cities Program has been developed from this basis:

… the principle that health can be improved by modification of the living conditions — the physical environmental, social and economic factors that affect or ‘determine’ our health. The home, the school, the village, the workplace, the city are the places or ‘settings’ where people live and work. The health status is often determined more by the conditions in these settings than by the provision of health care facilities.

To develop communities that positively contribute to health and wellbeing it is necessary to work outside the health system. Social, economic, and environmental elements must be considered and assessed in terms of their impact on health and wellbeing. Clean air and water, healthy food, transport systems, education, employment, housing, safety and security, and green environments all impact on health.

Policies in these areas can contribute positively or negatively to health inequalities. For example, access to health services is dependent on a comprehensive community transport system. Any reduction in community transport would have a flow-on effect to health as well as other human services.

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. This would ultimately reduce the health inequalities that exist today.
Ways forward

The significant link between socioeconomic factors and health outcomes, and growing concerns about environmental management and other quality of life issues, has led to many attempts overseas to ensure that national performance incorporates more than just gross domestic product.

In Canada, legislation known as the Canadian Wellbeing Measurement Act was put forward under the Seven Generations Initiative. The initiative is focused on ensuring that decisions made today will benefit the community seven generations ahead.

"There is a tradition in some societies to consider the interests of the next seven generations whenever decisions are being made. For the modern world to do the same would mark our passage to maturity."

Canada identified three key stages to implementing such an approach.

1. defining society’s values in a way that is consistent with the long-term wellbeing of people, communities and ecosystems; and creating and publishing a set of measures based on those values which would regularly tell whether things are getting better or worse
2. assessing policy and legislation for their impact on the next seven generations
3. creating policy and legislation to improve long-term wellbeing.

The Canadian Wellbeing Measurement Act was intended to provide for the first stage of this approach and sought to ensure the development of, and provide for the publication of, measures to inform Canadians about the health and wellbeing of people, communities and ecosystems in Canada.

Through a large community consultation process, Canada identified indicators that matter to its citizens and developed a quality of life citizens’ report card.

The United Kingdom has developed specific health targets to address inequalities (reducing infant mortality differences between social classes and reducing the gap in life expectancy at birth between social classes with the greatest difference) together with a cross-government expenditure review to ensure investment by all government portfolios in areas with the poorest health outcomes.

In New Zealand, a social report card has been developed to provide a similar role to that of the Canadian citizens’ report card.

"The social report reflects that social wellbeing does not happen in isolation, and provides an integrated picture of the impact of economic, social and environmental policy on the quality of people’s lives. The social report also underscores the inter-dependency of these sectors — a well-performing economy and a healthy environment are central to the long-term social wellbeing of New Zealanders, which in turn is critical to our long-term economic success and prosperity."

In Oregon, social indicators have been developed on the basis that the social and economic wellbeing of citizens depends on the interconnectedness of quality jobs, a sustainable environment and caring communities. Oregon has identified seven benchmark categories — the economy, education, civic engagement, social support, public safety, community development and the environment — under which sits a comprehensive set of indicators. Specific health measures sit under the broader category of social support. These benchmarks have been linked to government programs and performance, and cover a wide range of social and economic issues.

Tasmania has also been working on the development of goals based on the long-term social, economic and environmental goals of the population. This work is intended to guide decision making...
at the highest levels of the public service. Tasmania Together\textsuperscript{195} has set a vision for the state that includes 24 goals and 212 benchmarks of most concern to the people. These concerns were identified through a two-and-a-half year process of community consultation.

The consultations identified that Tasmanians want to live in safe, clean communities, with jobs and prosperity for everyone, and they want the world to be aware of their skills in areas such as the arts, education and technology. This focus will be used to assist in the delivery of health and wellbeing outcomes for all Tasmanians.

The directions of this work are essentially about quality of life within communities. Quality of life is intimately connected with health and wellbeing and provides a mechanism for ensuring whole-of-government investment in the development and maintenance of healthy and health producing communities.

DHS has done some developmental work around the establishment of health and wellbeing indicators as the first stage of building up a quality of life measurement framework.\textsuperscript{196} This work could be built upon to establish whole-of-government benchmarks. There is also an opportunity to align with the more recent work of the SA's Economic Development Board and the Social Inclusion Unit.

The State Government’s Social Inclusion Unit, which is attempting to tackle South Australia’s pressing social issues, recognises that issues such as poor health, crime rates, problem drug use, poverty and decreased social cohesion are related.

The development of benchmarks, beyond health, is vital if a whole-of-government investment strategy into sustainable and healthy communities is to be made. Measurement must be tied to action and investment across government. If South Australia is to progress, and if health care debates and issues are to move beyond questions of numbers of beds and numbers of hospitals, it is vital that strategic investment approaches are taken to social health and wellbeing. This means a focus on employment, education, environment, transport and culture, as well as health care. The need for whole-of-government performance benchmarking, linked to individual departments and the budget process, has been noted by the Economic Development Board\textsuperscript{197} and is supported by GHR.

There is also a need to develop partnerships with other levels of government (local and Commonwealth) and the private sector to enable a strategic approach to health inequalities.

Accountability is essential. Social targets need to be developed collaboratively, with communities and with support across government portfolios.

Leadership by portfolio officials is necessary. Even more important is ministerial leadership through a Cabinet level body to bring together those ministers whose portfolios impact on the social determinants of health. Appropriate membership around this table is vital to ensure that the determinants of health can be addressed. This means including many of the departments that fall outside commonly held ideas about what constitutes ‘human services’. There is a need for transport, business, tourism together with health, housing, education, social welfare, planning and others to be at the table.

Health action zones could be used to enable prioritisation of regions. For example, the two or three regions with the poorest health outcomes could be targeted through a whole-of-government action and investment strategy aimed at addressing some of the key socioeconomic factors influencing the poor health outcomes in those regions, or a particular population group could be chosen. Aboriginal health should be the starting point for whole-of-government investment (see section below).
In order to advance a focus on investment in healthy communities it will be necessary, in the first instance, for the State Government to develop:

- a united vision (i.e. a whole-of-government strategic plan)
- common measures (i.e. benchmarks or targets to be achieved)
- shared strategies (i.e. each government department has strategies to facilitate the achievement of whole-of-government benchmarks)
- outcome based evaluation (i.e. no longer limiting measurement to products, such as school expenditure or numbers of hospital beds, but outcomes such as literacy levels and reduced hospital admission for people with asthma)
- strategic partnerships with the Commonwealth, local government and private sector to foster support and assistance for the above directions.

What is clear is that we must start to act methodically in all areas of policy making to put what we do know into practice. Although we must do more research to reinforce and expand our knowledge, we have enough information to start now. This will require resources and bipartisan whole-of-government support.

While the large burden of disease requires continuing investment in health care, we must move beyond alleviating damage once it has occurred and invest significantly in preventative health efforts. 198

**Recommendations**

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.

**Health as a human right**

**Objective**

Human rights are legally guaranteed, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity.

**Priority population groups**

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.

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. 199 Health as a human right means universal access to adequate health care, but also access to education and information, and the right to food in sufficient quantity and good quality, to decent housing and to live and work in an environment where known health risks are controlled.
Most Australians have enough to eat and drink, they receive secondary education, have access to health care and welfare services, are properly housed, are not harassed by the state for holding different views to it, are free to move in and out of the country, to practise their religious or cultural beliefs, have their privacy protected, and live in a relatively safe and healthy environment.

Nonetheless, Australia, like all other countries, does have human rights blemishes and ongoing work is required to guard against human rights abuses.

The purpose of this section is to specify several population groups and particular health areas where the right to health requires specific effort. As indicated previously, a range of social, economic and environmental factors impact on people’s health and quality of life. The right to health is not equitably distributed.

GHR has identified the following population groups for priority attention:

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

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

**Early childhood**

**Case for change**

*If there is to be a competent, economically successful and dynamic society in South Australia in 30 years time, the most important action government can take now is to make early childhood development a high priority.*

The period of early childhood, through to the early years of school, is unique. It is well established that the early years, particularly the first three years, are fundamental for the development of future wellbeing. Stimulating positive interactions with adults and other children during this period are more important for positive brain development than previously realised. The foundation for competence and coping skills that affect learning behaviour and health is formed over these early years.

A poor start in life increases the chance that a baby will grow into an adult who has poor physical and mental health, a lower standard of education, fewer job opportunities, greater likelihood of drug and alcohol addiction, greater participation in crime and earlier death. In addition, it is well established that a baby’s optimal health and development can be significantly affected *in utero* by such factors as nutrition, smoking and drug use by the mother.

A range of risk and protective factors for early childhood development has been identified from international longitudinal studies in the United Kingdom, United States and Canada.

Important risk factors for early childhood development include perinatal stress, inadequate prenatal and postnatal care, poor attachment, harsh parenting, abuse or neglect, family disharmony, conflict or
violence, low socioeconomic status, parents who have been isolated from family and community supports, poor nutrition and parental mental illness or substance abuse. 206

There is evidence of a number of key risk factors present in South Australia, all of which require addressing from a whole-of-government approach:

- The National Centre for Social and Economic Modelling has found that SA has the highest poverty rate of any state, estimating that around 17% of all children are living in poverty. This equates to nearly 70,000 children. 207
- SA has a higher than average rate of children under 15 years living in one parent families, and the economic disadvantage of one parent families is highest in SA with only 42% of parents employed. 208
- 16% of babies born to Aboriginal mothers are of low birth weight, more than double the proportion born to non-Aboriginal mothers. 209
- In 1999, 17.8% of adults reported some form of domestic violence by a current or ex partner. Children witnessed 46% of all incidents and 30% of incidents were experienced by women who were pregnant. 210

Domestic violence and abuse was raised repeatedly with GHR. GHR was advised that a significant number of women who attend hospital emergency departments are likely to have experienced domestic violence at some time in their life. 211 A high prevalence of physical, sexual and emotional violence has also been reported in people attending general practices. 212 This is of particular concern given evidence that one of the best predictors of the risk of domestic violence and abuse is previous experience of violence and abuse. For example, for women who have a history with a current partner the likelihood of future violence becomes higher if they also experienced or witnessed violence or abuse in childhood. 213

A recent research study at the Lyell McEwin Health Service, Noarlunga Health Services and The Queen Elizabeth Hospital 214 over a three month period suggested that more than 50% of women interviewed were identified as having experienced domestic violence at some time in their lives, 18% of all women interviewed were identified to be currently in a violent relationship, and at least 6% — and up to 19% — of women interviewed attended emergency departments for reasons related to domestic violence.

The impact of domestic violence and abuse goes beyond immediate injury. Those affected are more likely to suffer, among other problems, anxiety and depression and use health services more often than people who have not been subjected to domestic violence. The experience of sexual abuse as a child has also been linked to later development of psychological disorders, drug abuse and dependency.

Important protective factors include secure attachment to family, family harmony, supportive relationships with other adults and community involvement.

GHR was advised that investment in the health and welfare of children, young people and their families strengthens protective factors and is a preventative health measure that can reduce poor health outcomes and health and other system costs in the longer term. It is an investment for their future as productive and healthy members of the community. 215 One recent study estimated that, for every one dollar invested in early childhood and parent support programs, $7 could be saved later in life — in health, crime, police and prison costs. 216

Given the critical importance of children’s early years and the range of factors that impact on their development and future as productive and healthy members of the community, GHR believes that early
childhood should be a priority for a coordinated whole-of-government approach. There are many examples of cross-portfolio projects operating between health and other portfolios at the local level. There is, however, significant room for improvement to ensure optimal service coordination and accountability for specific early childhood outcomes across all relevant portfolios.

In terms of the health portfolio, GHR believes that current health services for children and families in South Australia are fragmented and poorly integrated across acute and primary care services. There are many services focusing on children and families across the community and acute care levels. However, GHR was advised of service gaps and significant overlaps. In the main, there is poor inter-agency cooperation and poor linkages between services. Parents are often left with a major task of negotiating the maze of disjointed services to piece together the services they require.217 From a consumer’s perspective, services appear to be ill-defined, some poorly located in terms of access, and not responsive to individual needs. It is important that health services are coordinated to maximise their positive impact on young children and their families.

Ways forward

GHR believes early childhood should be a priority for a whole-of-government approach to ensure coordination and focus across government, and provide clear accountability for specific outcomes. This approach should target children and their families starting from prenatal through the first eight to ten years of their life. There should be a strong early intervention and prevention focus, particularly on the social and economic factors impacting on health and wellbeing of children and families.

An early childhood population health network, comprising representation from relevant portfolios including health, welfare, housing, education, justice and transport, should be established to support this approach (see Chapter 3).

GHR recommends the development of selected specific cross-government targets. From consultations, GHR’s recommended high priorities for consideration are violence, abuse and childhood nutrition and obesity.

In relation to the health portfolio, DHS should incorporate whole-of-government early childhood targets into its statewide health policy directions. Regions should be responsible for ensuring integrated and coordinated health services, including development and support of cross-portfolio and cross-program partnerships and relationships. GHR envisages local early childhood networks developing as required. There are already examples currently operating, such as the southern metropolitan child health network which comprises a range of members from acute and community based health services and the education portfolio. There are also examples in country regions with community based child development units involving a wide range of portfolios and non-government partnerships.

During the final stages of the GHR, DHS announced the establishment of The Early Childhood Services Initiative with the objective, inter alia, to develop a model of early intervention and a whole-of-government approach to achieve improved outcomes for children. The GHR strongly supports this initiative.

Recommendation

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.
Aboriginal health

Case for change — a national emergency

Aboriginal people’s health in South Australia is totally unacceptable. There is no room for complacency. In no other population group are the social, economic and environmental determinants of health so well exemplified. Poverty with poor diet, poor lifestyle, stress and anxiety is a major cause of poor health.

The following story is well known and reiterated in numerous reports:

- In 1998–99, average life expectancy of an Aboriginal male at birth in South Australia was 55 years. This has not improved over the past ten years — and is alarming when compared to average life expectancy of the rest of the male population in Australia of 74.3 years — and is increasing.
- Infant mortality rates per 1000 live births are 15.2 for Aboriginal people and five for the general population. The health of Aboriginal infants has improved, although from a low baseline, with most of the gains occurring 20–30 years ago.
- Death rates for Aboriginal people are nearly three times higher than the general population, and rates of low birth weights are twice that of non-Aboriginal people.
- There is a higher prevalence of diseases such as diabetes, hypertension and a range of communicable infections in Aboriginal people than in the general population. Mental illness and harmful substance use rates are also higher. Diabetes death rates are eight times higher than the general population, respiratory deaths are four times as high and circulatory conditions almost three times higher — unacceptable statistics for treatable and preventable conditions.
- Hospital utilisation rates for Aboriginal people stand out as dramatically higher than for non-Aboriginal people (double the rate for non-Aboriginal people in 1998–99). This is partly a result of poor access to primary care services but also a reflection of the compounding impact of the social disadvantage that Aboriginal people suffer, for example in employment, home ownership, education and income.

National data demonstrates the social factors that affect Aboriginal people’s health. Here are some examples:

- 10% of young Aboriginal people of 18–24 years attend post-secondary education, compared to 28% of the total population.
- Household weekly income per capita is $158 for Aboriginal people and $310 for the total population.
- Aboriginal people’s unemployment rate is 22.8%, compared to 9.3% for the total population, and Aboriginal people are three times as likely to be employed as labourers.
- Imprisonment rates for Aboriginal people are 12 times higher than the total population, with 1663 Aboriginal people per 100,000 imprisoned, compared to 139 per 100,000 for the total population.

Aboriginal health funding is also an issue. The Productivity Commission cites a recent study that found recurrent expenditure on health services across Australia in 1998–99 was equivalent to $3065 for an Aboriginal person compared to $2518 for a non-Aboriginal person. This is due to higher use of hospitals. The Productivity Commission reported that these higher rates reflect poor access to primary care services, particularly general practitioners. Under the pharmaceutical benefits scheme and Medicare benefits schedule, for every dollar spent on non-Aboriginal people, 33 cents and 41 cents respectively were spent on each Aboriginal person.

Aboriginal people comprise 1.6% of the total SA population but only 0.6% of the state health budget goes to specific Aboriginal health services. Many argue this is disproportionately low given their poor
health status. However, increased funding needs to be considered within the context of improving Aboriginal people’s quality of life, including basic services such as sanitation and water supply, responsibility being through the Minister for Government Enterprises and Minister for Local Government. Other critical factors are electricity and justice issues as well as employment, education and housing.

There is significant activity regarding Aboriginal health, wellbeing and quality of life at state, Commonwealth and community level in South Australia. There are many high level agreements and formalised partnerships between interested parties and many targets. Targets set by the Australian Health Ministers Advisory Committee, Stolen Children and Aboriginal Deaths in Custody are some examples but there are many more. There are some good news stories but overall little progress is being made. There is no coordinated approach or performance accountability at the whole-of-government level.

Agencies nationally and in South Australia strongly criticise the way governments respond to Aboriginal people’s needs. GHR has received strong reports of systemic racism across the health system. Some anecdotal examples follow:

- There is entrenched racism in the workforce and a lack of willingness by managers to deal with the racist attitudes of staff.
- Aboriginal people working in mainstream services feel useless and used. They feel they are only used to bring in Aboriginal people in order to boost numbers accessing mainstream services. Aboriginal people then find themselves with a reputation for having a poor work ethic and not staying in jobs.
- Aboriginal people have restricted access to mainstream services; they are referred to Aboriginal health services.

While all these examples were raised in specific forums with Aboriginal people, GHR understands that these are indicative of system wide problems.

Funding of Aboriginal programs is often short-term and spasmodic and there is rapid turnover of staff. Confidence is hard to build in these circumstances. There are barriers to access mainstream services, such as a lack of understanding and appreciation of Aboriginal culture, which contribute to the continued poor health outcomes for Aboriginal people. Mainstream services need to make significant changes if Aboriginal people are to feel more comfortable about accessing them. Examples of strategies include employment of more Aboriginal workers, posters with Aboriginal faces and messages in waiting rooms, and Aboriginal specific health and wellbeing programs.

Aboriginal people advise that Aboriginal community controlled health services are more culturally responsive than other health services to their complex needs and are therefore preferred. Evidence shows that a model of health service delivery using salaried doctors employed by Aboriginal health services is a more culturally appropriate approach to clinical care integrated with primary health care.

Aboriginal people have a right of choice between community controlled and mainstream health services. However, GHR was informed that Aboriginal community control and/or ownership of health services have made the most significant contribution to improvements in the use of primary care services by Aboriginal people. In addition, Aboriginal control and ownership of health services is particularly critical in rural and remote localities where it is often difficult for clients to access mainstream health services, either because there are none or, where they do exist, language barriers, remoteness, transportation and cultural inappropriateness deter their use.
The Aboriginal health reform agenda focuses on strengthening the shift to personal and community empowerment, the right of Aboriginal communities to take responsibility for their own affairs at a time and pace suitable for them supported by the necessary resources and training, and acceptance of the obligation for governments to change the way they engage with Aboriginal communities in the provision of services.231 Key areas needing to be addressed as part of the health reform agenda are:232

- full and effective participation of Aboriginal people in decisions affecting funding allocation, distribution and service delivery (GHR also strongly recommends the need for senior Aboriginal representation on key health system performance management and review committees)
- ensuring genuine collaborative processes with the involvement of government, non-government funders and service providers to maximise opportunities for pooling of funds, as well as cross-government and cross-jurisdictional approaches to service delivery
- improving the collection and availability of data to support informed decision making, monitoring of achievements and program evaluation.

Partnerships must continue to be fostered between Aboriginal communities and mainstream service providers at all levels. Fundamental principles, such as those contained in the Iga Warta Principles233, need to be entrenched into all levels of program development and delivery. The principles, included in all DHS service agreements, are:

- sustainability — in funding and programs
- an emphasis on prevention
- recognition of the environmental determinants of health
- empowerment of Aboriginal families and communities
- cultural respect
- service coordination and linkages between regions and Adelaide.

The reports, recommendations and required reform agenda have been stated and restated over the years. GHR was advised that people are aware of which programs and services can make a difference. What is needed is their implementation. As expected, many of these programs and services require a whole-of-government approach.

**Ways forward**

Many of the recommended ways forward focus on the key message to GHR about the need to develop trust, and the type of strategies required to build such trust, between Aboriginal communities and the general population.

GHR stresses the importance of nurturing trust between Aboriginal people and the general community. Trust is a two-way process and the responsibility of all parties to address. The development of trust goes hand in hand with the building of community capacity. As one Aboriginal person advised GHR:

> To be an Aboriginal person is not a health risk, it is about how life impacts on that person in the community and how it affects their self esteem. 234

Aboriginal people consistently raised the issue of trust during consultations and provided examples of requirements and actions to improve trust. These included a history of positive experiences and relationships with people built on mutual respect, recognition of Aboriginal people and their views, improving the status of Aboriginal people through membership on committees and groups which are genuinely involved in service planning and decision making; and access to and treatment by services on the same basis as the general population.
GHR recognises that the development of trust requires patience and is a long-term process. It is clearly a critical precursor to building community capacity and making a real difference in the health status of Aboriginal people.

GHR believes there are four critical enablers to achieve improvements in the quality of life for Aboriginal people:

- a whole-of-government approach and accountability framework
- services which promote quality of life and social connectedness in terms of community capacity building and enhancing family and kinship relationships and support
- clear identification of Aboriginal funding and strategies to better use existing resources in the first instance
- population health governance for Aboriginal communities.

The last three points are described for the health portfolio but the concepts are equally applicable across government.

**Whole-of-government approach and accountability framework**

The quality of life of Aboriginal people should be a first priority area for whole-of-government action. It is considered to be the way forward to ensure the breadth of social, economic and physical factors are effectively addressed.

Using the broad framework described earlier in this chapter, the vision for a whole-of-government approach includes:

- Cabinet responsibility for setting of high level whole-of-government benchmarks and targets
- relevant portfolios through ministers and departmental CEs being accountable to Cabinet for contributing to benchmarks and targets with required specific measures and reporting requirements clearly articulated; GHR believes that benchmarks and targets should be developed within a tight time frame of three months, they should be few in number and provide clear and challenging goals
- establishment of an Aboriginal population health network to support the whole-of-government approach, comprising representation from relevant portfolios such as health, employment, welfare, education, justice, regional development and transport (see Chapter 3)
- within the health portfolio the distribution of funds to be the responsibility of regional health boards, in partnership with regional Aboriginal health advisory committees (AHACs), which in turn are informed through their informal and formal regional networks.

This approach ensures:

- the highest platform for Aboriginal people's quality of life and acknowledgment and commitment at Cabinet level of the need to address the problem as a key priority
- coordination of programs across portfolios and a coordinated and high level accountability framework
- that the breadth of factors that impact on Aboriginal people's quality of life are addressed
- consistency with the Aboriginal health reform agenda, enhancing full and effective participation of Aboriginal people in funding allocation, distribution and service delivery decisions, including strengthening opportunities to address barriers to accessing mainstream services.
Given the Commonwealth’s involvement in Aboriginal health funding, continued negotiations with the Commonwealth for the focus of funding, program coordination and target alignment would also be required.

**Recommendation**

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.

**Focus on community capacity building and enhancing family and kinship relationships**

GHR received consistent messages on the need to promote quality of life through building individual, social and community capacity at both physical and emotional levels.

Many Aboriginal people have become disconnected from their families, their kinship groups and most importantly their land. Aboriginal people face many challenges in their day to day lives which seriously impact on their physical and emotional wellbeing and resilience. Those who are most at risk of early death and serious health problems are often not well connected to systems of support.

In order to make a difference, services need to be developed that support family and social connectedness, building kinship ties and promoting a stronger sense of community ownership. It is difficult to overestimate the importance to Aboriginal people of the need to be connected, to be part of a social fabric. These types of services aim to build social networks for people where they have broken down and to reconnect Aboriginal people who have become disconnected from their families or communities. Such programs are essential to the development of sound emotional, social and physical wellbeing. They should work side by side with public and environmental health strategies as well as broader programs focusing on such areas as education and employment.

Over recent years, the Commonwealth and state governments have funded a number of programs focusing on kinship, mentoring and family support. GHR supports the evaluation and further development of these models as a matter of priority.

Funding allocation decisions for specific programs should be informed by Aboriginal health research funded through such bodies as the National Health and Medical Research Council and from operational program evaluations.

**Aboriginal funding and strategies to better use existing resources**

GHR considered Aboriginal funding at the whole-of-government level and specifically for the health portfolio.

GHR supports increased funding across relevant government portfolios. However, there are complexities associated with determining the quantum of required additional funds.
By example, within the health portfolio, one approach is to consider the issue from the perspective of:

- horizontal equity (people with equal health status should receive the same level of investment) versus
- vertical inequity (people with different levels of health status than the general community should receive a level of investment required to achieve equal health status for all).

The principle of horizontal equity is clear and well understood. The principle of vertical inequity, which is relevant to Aboriginal health status, is also clear but problematic when considering the quantum of funds required to redress inequalities. Should, for example, a 20% differential in health status of a particular population group compared to the general population require 1.2 times additional funding over and above the general population investment or significantly more? The factors impacting on this issue are complex and there is no clear answer.

Based on 1998–99 national health expenditure data, South Australia spends $2350 per Aboriginal person and $935 per non-Aboriginal person. This equates to 2.5 times more per capita on Aboriginal people who have a life expectancy 20% lower than the general population and a death rate three times higher. There continue to be no discernible health improvements. Should this mean, therefore, that South Australia spend a further 20%, 300% or higher amount per capita on Aboriginal people to achieve improvements?

Furthermore, as discussed in this report, health outcomes are not solely about health services. A broad range of other equally important factors such as education, housing and employment play strong roles. Whatever the quantum of increased funding identified, the question becomes what percentage of increased funds should be managed through each portfolio to best address the social determinants of health.

In relation to the health portfolio, GHR supports strategies, in the first instance, to better target existing funding for Aboriginal people. This can be achieved in two ways.

Firstly, the population health funding model recommended by GHR assumes that health care resources are distributed on the basis of relative need of the population to be served. The percentage of Aboriginal people is one of several key factors weighted for the purpose of defining the quantum of funds required to serve geographic regions. Other weighted factors include socioeconomic status, and rural and remoteness, both of which include many Aboriginal people. These weightings will clearly benefit regions with Aboriginal people.

Secondly, and equally important, are governance accountability strategies such as the establishment of a key output class for Aboriginal health against which each region is required to report, and clear performance agreements with regional health boards. These strategies should link with whole-of-government targets and benchmarks and are described later in this section.

GHR stresses the need for more detailed work to be undertaken on the quantum of additional Aboriginal funding. In the first instance, this requires all portfolios to identify their current level of investments in improving Aboriginal people’s quality of life. In relation to the health portfolio, this work should take into account the funding impact from the application of the recommended population health funding model for the state and recommended accountability strategies at the regional level.
**Recommendation**

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.

**Population health governance for Aboriginal communities**

Central to the Aboriginal reform agenda is the achievement of self management and the building and support of community controlled governance structures. GHR has used this as the guiding principle when considering governance reforms for Aboriginal health which cover AHACs and Aboriginal community controlled health service boards of management.

The reform agenda and governance developments specific to Aboriginal services are described in the previous section. They require close consideration within the context of any changes to mainstream arrangements. This will ensure that the AHACs, Aboriginal health services and mainstream services work in partnership to achieve positive outcomes for Aboriginal communities.

GHR believes that the recommendations in this section will address many of the Aboriginal reform directions, in particular building community capacity to assist Aboriginal communities to take responsibility for problems, enhancing full and effective participation of Aboriginal people in decisions affecting funding allocation, distribution and service delivery, and strengthening opportunities to address barriers to accessing mainstream services.

Many recommendations in this section are detailed as GHR views Aboriginal health as a critical issue requiring such specific attention.

As a general principle, GHR supports all incorporated bodies under the control of regions. However, at this time, GHR recognises the current reform agenda and governance developments specific to Aboriginal service provision. As a result, GHR has focused on opportunities to improve partnerships between current Aboriginal governance arrangements and mainstream services, and strengthening Aboriginal governance and funding mechanisms.

It is important that the recommended ways forward are considered within the context of the key government and non-government partners working together to improve the health and wellbeing of Aboriginal people in South Australia. Partners working with the State Government include the Commonwealth Government, Aboriginal and Torres Strait Islander Commission (ATSIC) and the Aboriginal Health Council of SA (AHCSA), and all have relationships with AHACs and their development over time. Any recommended changes should therefore involve these parties in their implementation. This is particularly the case for the Commonwealth Government, given its various conditions attached to Aboriginal health funding contributions to the state.

**Regional governance**

Currently, there are seven rural and remote regional AHACs in line with the seven rural and remote health regions. There are no metropolitan AHACs.

There is strong support for regional governance arrangements with Aboriginal programs being overseen from a regional perspective rather than on a health unit by health unit basis, which is currently the case, where Aboriginal health is often a very low priority.
Aboriginal groups stressed that whatever structures eventuate, AHACs and Aboriginal community controlled health service developments should be maintained and strengthened. GHR also recognises the importance of maintaining and strengthening the Aboriginal Health Council of SA as the key statewide body representing Aboriginal community controlled health services and advising on Aboriginal people’s health and wellbeing in general. GHR was advised that AHACs consult and work closely with a range of other key Aboriginal groups and bodies, such as ATSIC, regional councils and the Office for Aboriginal and Torres Strait Islander Health. This should continue to occur to ensure AHACs are well informed of issues in their regions.

There was strong support for continued relationships between AHACs and regional health boards and that such relationships should be a partnership approach, as specified in the draft memorandum of understanding (MOU) which is currently being developed between AHACs, the Aboriginal Health Council of SA, regional health boards and DHS.

Similarly support was given to extending AHACs to metropolitan regions (configurations to be consistent with mainstream regional developments) and to maintaining the current configuration of rural and remote regional AHACs, irrespective of any changes to mainstream regions. GHR’s proposal for six country health regions will mean the existence of two AHACs in the new North and Far West Region, if existing country AHACs remained. Given the geographic size of the recommended new region, GHR considers sub-regional arrangements may be necessary. This could be workable as long as AHACs coordinate their relationships with the regional health board in that specific region. AHAC and regional health board relationships are discussed later in this section.

A key issue raised in several consultations was the need for an entity or function to focus on the remote area needs of Aboriginal people to ensure these needs are recognised and incorporated in service planning. The proposed North and Far West Region covers remote areas and through the population health funding model will receive significant funding weightings for a range of factors, including its Aboriginal populations. This increased funding will assist regions in implementing such priorities in the future.

The use of legislation as a mechanism to protect AHAC numbers and their legitimacy was supported as well as the need for appropriate resourcing to assist them in developing skills and progressing their local or regional issues.237

**Recommendation**

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.

**Sitting fees**

In several consultations, inconsistencies were raised in the application of sitting fees for most AHAC community representatives compared to regional health board representatives.
GHR understands that DHS is considering the AHAC issue within the context of an overall review of sitting fees for community members on all boards and ongoing advisory groups across the portfolio.

**Recommendation**

6.7 Regional health services provide adequate funding support for Aboriginal health advisory committees, including appropriate sitting fees for Aboriginal health advisory committee meetings.

**Representation on regional health boards**

Currently, there is one AHAC representative with voting rights on each rural health board. The representatives are often accompanied by another Aboriginal person without voting rights. There is a need for better representation of Aboriginal people on regional health boards to assist in building capacity and in recognition of the poor health status of Aboriginal people compared to the general population.

This may mean that regional health boards have a minimum of two Aboriginal representatives with voting rights, or a different form of engagement may be negotiated.

Regional health board representation from AHACs was seen as an effective way to support information flow and continued strong links between the two bodies. The source of representation should be decided on a region by region basis to ensure that representative arrangements recognise the impact of remoteness and the different perspectives of traditional communities. Nonetheless, in the event that Aboriginal representation was also considered outside of AHACs, it would be important to ensure close links with AHACs.

**Recommendation**

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.

**Funding and performance accountability**

There is strong support for clearly identified regional Aboriginal health budgets, coordinated and managed through the regional health boards.

Currently, financial and funding accountability for Aboriginal programs rests with individual health units and there is a lack of transparency of funding allocated for Aboriginal health services and programs in regions. Several AHACs provided examples of Aboriginal funding being levied to pay for management and infrastructure costs within health units. They also reported that Aboriginal funding can also be used to fill the gaps in other services and this was being justified because “Aboriginal people access mainstream services, therefore Aboriginal funding can be accessed by mainstream services”.  

GHR supports the establishment of a new program category (key output class) for Aboriginal health upon which each region is required to report. Mainstream services need to establish information systems to enable reporting against specific Aboriginal funding.
Some AHACs argued that AHACs should be the Aboriginal health regional fund holders, rather than regional health boards. GHR considers that, in the first instance, funding decisions for Aboriginal services by regional health boards should be made in partnership and negotiated with regional AHACs. The question of fund holding needs to be addressed as part of the further development of the role of AHACs.

AHACs generally support population needs based funding. This is conditional upon adjustments for specific population issues (e.g. traditional and remote area needs and transient and seasonal populations, which can be significant in number, and service requirements in such places as Port Augusta, Ceduna and Coober Pedy) and guaranteed minimal levels of funding being provided where there are small communities. GHR was also advised of concerns about the reliability of ABS census data for Aboriginal populations which is used for planning purposes.

Annual budgets and short-term grants create a vicious cycle for Aboriginal agencies. There is a lack of funding certainty and many staff are dependent on short-term grants for their employment. A significant amount of time is spent on applying for short-term grants, and it is difficult for agencies to plan beyond the annual funding cycle. This short-term focus also makes it hard to attract and retain Aboriginal workers and helps to perpetuate the perception of a highly transient Aboriginal workforce. Confidence in the health system is reduced as a result.

GHR believes that funding processes should ensure, at a minimum, that agencies have a relatively stable core funding base to assist in longer term service planning. There is strong support for a multi-year health budget cycle for Aboriginal health services, as a matter of priority. DHS may also be able to advocate for longer term funding arrangements at Commonwealth level (multi-year budgets were addressed in the first section of this chapter).

Currently, the relationship between AHACs and regional health boards is mainly based on goodwill. There are efforts to clearly define roles and responsibilities through draft MOUs which provide a mechanism for all parties to develop regional health plans reflecting priorities identified by local Aboriginal communities. It also requires AHACs and regional health boards to provide annual reports to DHS on activities and developments to advance health and wellbeing priorities for their region.

AHACs support performance agreements being negotiated between AHACs and regional health boards, with clear service improvement plans and performance measures, and benchmarks that regions are required to report against on a regular basis. GHR stresses that detailed consideration of performance measures is critical and that they should address both process and health outcome targets. Particular emphasis should be placed on strategies to increase access to mainstream services.

The development of performance agreements with regional health boards recognises the key role of AHACs as the focal point for advice and guidance on all issues relating to Aboriginal health and wellbeing within their region. This would also ensure maintenance of effort in Aboriginal programs as well as keeping the issue of Aboriginal health and wellbeing high on regional agendas.

This arrangement supports one of the key aims in the Framework Agreement on Aboriginal and Torres Strait Islander Health which has been in operation for several years — to promote greater accountability in relation to outcomes in Aboriginal health and wellbeing. Strategies in the agreement include health service agreements with mainstream services for reporting on their use of funds, and specific outcomes for Aboriginal health.
Such relationships between regional health boards and AHACs should also assist in ensuring remote area health issues are not lost or misunderstood in overall service planning, an issue that was raised during consultations.

To further strengthen accountability, GHR believes that the Iga Warta Principles should also be articulated in performance agreements and operationalised across all health services, for example through senior executive job descriptions and performance evaluations.

**Recommendations**

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.

**Freedom of choice**

One of the main aims of the Framework Agreement on Aboriginal and Torres Strait Islander Health is ‘improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the level of need’.

Nonetheless, concerns were raised about situations where Aboriginal people have been denied access to mainstream services and advised to attend their Aboriginal health service nearby. Most prefer to use Aboriginal controlled health services but Aboriginal people, like other members of the community, should have freedom of choice. Mainstream agencies have a responsibility to ensure that their services are accessible to all Australians.

There are examples where mainstream services are based in Aboriginal health agencies and vice versa. These arrangements should be fostered and encouraged. Access to mainstream services should form a component of the proposed performance agreements between AHACs and regional health boards, as described earlier in this chapter.

**Aboriginal community controlled health services incorporated under SAHC Act**

Of the eight Aboriginal controlled and/or owned health services currently operating in South Australia, two Aboriginal health services — Pika Wiya Aboriginal Health Service (Port Augusta) and Ceduna Koonibba Aboriginal Health Service (Ceduna) — are incorporated under the SAHC Act. The remaining six, located at Yalata, Alice Springs, Coober Pedy, Adelaide, Oak Valley and Port Lincoln, are incorporated under different legislation. All services receive varying levels of state and Commonwealth funding. A requirement of Commonwealth funding is that services need to be incorporated bodies and therefore have boards of management.
GHR believes that the two Aboriginal health services incorporated under the SAHC Act should have the opportunity to decide between:

- reflecting regional governance arrangements recommended for mainstream services
- retaining boards of management with explicit exemption under the proposed new health system legislation.

Given the current Aboriginal reform agenda, potential Commonwealth funding implications and other management and employment related matters, this decision should be made in consultation with DHS.

**Recommendation**

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

**Infrastructure support**

All Aboriginal community controlled health services receive varying levels of State Government funding. Aboriginal community controlled health services incorporated under the SAHC Act (Pika Wiya and Ceduna Koonibba) receive more infrastructure support than those services incorporated under other legislation. Pika Wiya and Ceduna Koonibba Aboriginal health services have access to State Government support, such as human resources, and advice on industrial relations and legal matters. Other services buy in such expertise as required, at significant cost.

GHR believes that extending access to such support services would seem to be a useful contribution that could be considered by DHS, while recognising that there may be legislative and other barriers to overcome.

**Recommendation**

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.

**Prisoner and offender health**

**Case for change**

The health profile of people in contact with the correctional services system, both in the prison environment and community based corrections programs, is of major concern when compared with the health profile of the general population. This is as true for South Australia as it is nationally and for all other countries.

Many offenders have complex and chronic health problems as well as other issues, including accommodation, finances, family relationships and mental illness. As a result there is considerable interface between justice and health, as well as other portfolio areas.
The health profile for prisoners in South Australia based on South Australian studies and studies elsewhere\textsuperscript{241} reveals the following.

For male prisoners:

- 75% have alcohol and other drug problems
- 70% are smokers
- 50% have an antisocial personality disorder
- 37% are hepatitis C antibody positive
- 31% are hepatitis B core antibody positive
- 30% are pathological gamblers
- 25% have attention deficit and hyperactivity disorder.

For female prisoners:

- 81% have post traumatic stress disorder
- 75% have been physically or sexually abused
- 66% are hepatitis C antibody positive
- 42% are hepatitis B core antibody positive
- 39% have previously attempted suicide
- 38% have drug related problems
- 36% have a previous admission to a psychiatrist or mental health unit
- abnormal pap smears results are 10 times the community rate.

A recent review of case loads in community based correctional supervision programs in the southern metropolitan region of South Australia showed that 15% of clients had a history of treatment for a mental health disorder. A study of psychiatric patients at TQEH indicated 36% of these patients had a criminal conviction.\textsuperscript{242} A review of all community corrections files of clients on community based orders indicates a significant proportion (21%) may have a mental disorder and rates are higher among Aboriginal clients. In addition, co-morbidity with alcohol and other drug problems was estimated at 64%.\textsuperscript{243}

The Aboriginal population comprises 1.6% of the total adult population of SA but approximately 17% of the prison population.

A 1996 survey of inmates carried out in New South Wales found:\textsuperscript{244}

- Aboriginal prisoners were twice as likely to be exposed to tuberculosis as non-Aboriginal prisoners
- high rates of hepatitis C infection among Aboriginal people, particularly Aboriginal women
- 57% of Aboriginal males identified that they used alcohol at a harmful level, compared with 29% of non-Aboriginal males.

A recent study in the South Australian correctional system found all Aboriginal women had experienced domestic violence and had mental health issues.\textsuperscript{245}
Death rates among the community corrections population in SA are up to six times greater than the general population. For the 25–34 year age group, the annual death rate is 9.34 per 1000 supervised offenders, compared with 0.98 per 1000 for the general community. Among this offender cohort, 44.2% of deaths were attributed to accidental overdose (typically combinations of alcohol and various drugs), 14.3% to suicide and 14% to motor vehicle accidents.

GHR believes that the health problems for this population group must be addressed as they reflect broader social and public health issues in the community. Apart from the clear health inequalities experienced by this population group, continued focus on the general community will be pointless unless the health problems within the prison and community corrections system are addressed.

Some of the key issues for the prisoner and offender population are discussed below.

**Increased numbers and changing profile of people in prison**
There is an increasing number of people within the South Australian prison system, in particular a high level of prisoners, both male and female, held on remand awaiting trial or sentence. This changing profile (remandees versus sentenced prisoners) is accompanied by increasing complexity in observed health problems. In 2001, of 3348 people discharged from prison in SA, 50% spent less than 15 days in prison, 64% less than one month and 84% less than three months. Of all prisoners discharged during 2001, in excess of 80% had a prior history of imprisonment.

South Australia currently has the second highest remand rate in the nation (43.5 per 100,000 against a national average of 29.3). Some of the possible reasons for the increased rates are an increase in the volume of recorded crime with a flow-on effect through the criminal justice system, and changes in the characteristics of apprehended offenders (including an increase in the number of defendants charged with more serious offences and/or who have more prior convictions). Irrespective of the reasons, the prison health system was designed and resourced to accommodate mostly sentenced prisoners who represent a ‘constant’ population where health issues can be managed over time.

GHR was advised that prisoner numbers are anticipated to increase significantly with changes in policy towards longer sentences for a range of offences and police targeting of recidivists. To that end, the State Government has announced plans to build a new women’s prison with approximately 40 beds and add 50 new beds at Mobilong; it has begun the development of a business case for a new men’s prison.

GHR was informed by health and correctional services staff that increases in numbers had created a backlog of medical reviews, with some prisoners entering and leaving a facility without being reviewed. In addition, the increased numbers and associated churning of prisoners have increased pressures and changed the demands on the prison health system. Responding to mental health/impairment issues and accessing mental health services have been identified as pressing issues. While health and justice agencies are collaborating, GHR received strong arguments for more specialist and psychiatric nursing resources.

**Service fragmentation and resources**
The SA Prison Health Service is managed as a campus of the Royal Adelaide Hospital and provides medical services for people within the state prison system. Health care delivery is fundamentally by general practitioners and is considered primary and preventative in nature. This is an anomaly, given that the service sits within a tertiary care institution management framework. However, the service reports major benefits with the current arrangement, including infrastructure support and professional relationships with tertiary institutions.
GHR was advised that health services for prisoners are fragmented, with multiple service providers. There is poor coordination and no overall governance arrangement for these services.\(^{251}\)

Funding to prisoner health services cannot be easily identified and most health service providers do not specifically tag budgets for prison services. The SA Prison Health Service and the Department for Correctional Services have budgets of $5.2 million and $240,000 respectively for 2003–04. The Forensic Mental Health Service has a total budget of $6.5 million for mental health clients and prisoners. GHR was advised that some five beds of the 30-bed mental health facility are used for prisoners. However, detailed resources for prisoners are not clearly identified.

Other health services that provide support for prisoners, such as SADS, DASC, Child and Youth Health, Pika Wiya Aboriginal Health Service and community health services, do not have identifiable budget lines for prisoners and offenders, and do not collect separate data for prisoners.

GHR was advised that the lack of defined budgets impacts on the level of services provided and accessible to prisoners,\(^{252}\) as well as on staff development opportunities. One submission stated that the SA Prison Health Service has been under-resourced over many years and that one reason for this relates to poor information systems upon which to base planning.\(^{253}\) GHR was advised that improvements to information systems are being addressed, including implementation of a detailed client database.

**Linkages and continuity of care**

Health services for prisoners and offenders are currently focused on institutional care, rather than taking a population based primary health care approach to service needs for people associated with the correctional services system, regardless of whether they are incarcerated or not.

The Department for Correctional Services’ current budget is $125,000 for community based health services for people in its community corrections programs. However, when people leave the prison system there is no continuity of health care nor are there programs to assist them to reintegrate into health services in the community.

*On release from prison, no one picks them up. There are issues of housing, post community rehabilitation and integration back to community life. Most drug overdoses and deaths occur within the first week of release from prison.*\(^{254}\)

In 2002, an MOU was signed between the Minister for Correctional Services and the Minister for Health for the provision of health services for prisoners. It covers the SA Prison Medical Service and services provided by other DHS entities, such as the Forensic Mental Health Service, SADS, DASC, mental health services and a range of other required services. There is no agreement about services for offenders who are not incarcerated, apart from the above MOU making reference to provision of community psychiatric services for people on probation, parolees and others in the care of Domiciliary Care and Rehabilitation Services (DCS).

DCS reports significant gaps in the availability of mainstream health services to community based clients who have a mental health disorder and difficulties in accessing other required health services. For some offenders, failure to access or maintain treatment (e.g. methadone, psychiatric medication) can result in them re-offending.\(^{255}\)

**Ways forward**

It is clear from the submissions and consultations that changes to the current system are needed.
In line with a population and primary health care approach, GHR recommends the establishment of a community based health service within the health portfolio. The service should have an expanded role covering institutional and community based primary health care and support. The community based functions should cover correctional services clients in community based programs and individuals released from the correctional system. This expanded role requires the inclusion of a range of allied health workers to the SA Prison Health Services’ staffing mix to assist with services to people in prison and their transition back into the community. These changes are recommended to ensure the required focus for this population group, the best possible outcomes for the individuals concerned and the best use and coordination of resources.

The service should have statewide responsibility for this population group and be resourced from existing DHS and DCS service delivery resources for prisoner and offender health services. Additional funding will be required to meet increasing pressures and proposed expanded functions. The community based service will provide strong links with other primary care services to assist in the transition from prison to community. The service should continue to foster working and academic relationships with the RAH, universities and other services. Such arrangements must be clearly articulated in service agreements.

**Recommendation**

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.

**Health of the homeless**

The multi-factorial nature of disadvantage that often leads to homelessness requires an integrated and coordinated approach to health care delivery in order to address the particular needs of this population group. People who are homeless frequently experience problems with physical health, addictions, violence and mental health. Homeless people lack social supports and social networks, and issues of isolation and loneliness impact on their health and wellbeing.

Health services for the homeless require coordination with providers rather than competition (for funding) between providers. In developing services, the issues of accessibility and barriers to access need to be considered. For example, GHR has been advised that some general practices do not want homeless people on their books. There is an increasing lack of availability to bulk billing practices, and there are problems with waiting times and service quality. Dental care waiting lists can be up to two years and extractions can often be the norm.

Experience in South Australia shows that there are certain strategies that have proven effective in working with this particular population group. Strategies include:

- locating services in outreach locations
- building on trusting relationships with non-government service providers
- providing residential services within a community setting rather than an institutional setting
- multiple responses to working with domestic violence.
While it is difficult to count the number of homeless in South Australia, or to gauge their health needs, there have been efforts made to quantify them. The Australian Youth Homelessness Census 2001 showed that 8.4% more youth aged 12–18 were homeless today than seven years before, when the last youth census was conducted. It found:

- homelessness rates varied significantly across the states and territories with SA having a rate of 17 homeless per 1000 youths compared to NSW and Victoria which had a rate of 10 homeless per 1000; the national average is 14 homeless per 1000 youths
- numbers of homeless youths remaining in school were low for most states — SA 40%, NSW 42%, Victoria 51% and ACT 58%.

Health care for the homeless is provided through an array of government, non-government and charitable services. It, like many other services, is poorly coordinated and integrated. If there is to be successful intervention in prevention and early intervention on homelessness, it is essential that health services are linked into policy development and implementation at a whole-of-government level. The work of non-government agencies in providing supportive services to homeless people must be recognised. Non-government services are in a better position than government agencies to be able to support and develop positive social support networks for homeless people.

GHR notes and supports the current work of the State Government Social Inclusion Unit in seeking to address homelessness through whole-of-government action on early intervention and prevention, including the development of appropriate housing policies.

**Recommendation**

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.

**Mental health**

GHR supports the general directions of South Australia’s mental health reform but is concerned that a number of key areas have not been fully implemented. In order to maintain the momentum of the reform in mental health and to ensure early intervention and a community based approach, the following areas must be given priority.

**Parallel capacity**

- Further funding is needed to build community based service capacity before reducing institutional size, along with a guarantee that funding for mental health will not be reduced as a result of any future system reforms.
- An agreed reinvestment strategy should be put in place to support the application of any savings accruing from deinstitutionalisation of community based support services.

**Capital and service development plan**

- A five year, funded capital and service development plan for community based rehabilitation, extended care and forensic services, should be developed and agreed.
- Such a plan must recognise and plan costs for maintaining existing mental health facilities to an appropriate standard during periods of services development, in particular stand-alone sites such as Glenside Campus and Oakden.
Mental health services should be planned and delivered in a manner that acknowledges the need for organisational, structural and clinical cultural competence regarding the needs and expectations of minority groups in the community, in particular the Aboriginal community.

Mental health services should commit to building effective intersectoral partnerships and increase the capacity of Aboriginal people, families and communities to promote their own health.

Legislation

There should be a comprehensive review of the interrelationship between the Mental Health Act 1993, the Criminal Law Consolidation Act 1935 (mental impairment and related provisions), and the Guardianship and Administration Act 1993 to ensure that the judicial, correctional and health systems response to mental disorders created by this legislative framework are in keeping with the future directions and outcomes of the proposed GHR and mental health reforms. This review must meet two objectives — defining and protecting the rights of those with mental disorders, and balancing these rights with the community’s legitimate expectation to be protected from harm.

Workforce

A comprehensive mental health workforce strategy, which includes significant investment in workforce development, training and education strategies to meet the demands of a reformed mental health system, should be developed, funded and implemented.

There should be support and agreement to develop a comprehensive human resource plan and industrial relations strategy to guide implementation of organisational and workplace changes.

Improved service system coordination

A comprehensive, integrated telephony infrastructure — including funding for the implementation of the recommendations for a 24-hour mental health crisis, emergency triage and assessment call centre — should be developed and implemented.

Community mental health reform

Increased focus is needed on improving mental health literacy and reducing stigma and discrimination against people with mental illness.

There should be further development and funding of a comprehensive and flexible clinical treatment system that supports general practitioners and community based treatment options.

There should be community based alternatives to institutional care and increased emphasis on the provision of flexible packages of support to meet the broader support needs of people living in accommodation settings of their choice.

There should be significant investment in growing the capacity of the non-government service sector to meet the psychosocial and disability support needs of people recovering from mental illness.

Linkages between specialist mental health services and general health and human services, particularly primary health care, should be developed.

Community consultation and communication

The directions of current reform initiatives should be supported by development of community debate that is informed by facts about mental illness and the active engagement of a broader spectrum of community leaders.

GHR supports the importance of investing in mental health promotion, illness prevention and early intervention as a critical component of the overall mental health reform strategy.256
A recent national report highlights the need for real monetary investment, accountability and sustained innovation. The report points out the failure of implementation rather than the failure of policy.

**Recommendation**

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.

**New arrivals (refugees)**

**Case for change**

People can migrate to Australia under several different programs, including business, employer nomination, family member (reunion), skilled, special category and humanitarian. In 2000–01, the Department of Immigration and Multicultural and Indigenous Affairs recorded 64,592 settler arrivals in Australia. Of these, 4.5% (2906) settled in South Australia. These figures include 665 refugees who came from various African countries (Sudan, Eritrea, Ethiopia, Rwanda, Sierra Leone and Liberia), the former Yugoslavia, Afghanistan, Iran and Croatia. The United Nations Convention defines a refugee as someone who:

> Owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable or owing to such a fear is unwilling to avail himself of the protection of that country …

Although the number of refugees has been tied to the number of temporary protection visas (TPVs), as the number of TPVs reduce, it is possible that the number of refugees will increase. Until the advent of TPVs, South Australia typically received about 800 refugees per year. For the foreseeable future, countries of origin of refugees are expected to be the same.

Research reported in August 2002 indicates that, taken as a population, migrants enjoy very good health on arrival in Australia and continue to do so (an outcome of health screening prior to arrival and that migrants generally tend to be younger). The exception to this is people who are humanitarian entrants (refugees). They experience poorer physical and psychological health than the general migrant population. While migrants may come with dreams and hopes for a better life, refugees often come with nightmares.

The physical health of refugees correlates closely to the circumstances in which they have been living, both in the country of origin and immediately prior to arrival in Australia. For example there tends to be:

- a high incidence of poor dental health due to poor nutrition, poor dental hygiene, limited dental care and possibly torture
- a higher than average incidence of chronic medical conditions such as skin complaints, chronic pain and high blood pressure
- a high incidence of delayed growth in children
- a higher incidence of communicable diseases such as tuberculosis, hepatic and parasitic infections
• a lower rate of vaccination for communicable diseases such as polio, measles and rubella
• a lower level of knowledge about preventative medicine such as dietary balance, reproductive and sexual health, breast examination and cervix screening.

Migrants tend to experience higher psychological stress than the general population as a result of the major life changes experienced through migrating. Psychological distress is more significant for refugees who (by definition) have experienced stressful situations that may have involved torture and trauma. Further, refugees may have been physically dislocated from their country and culture of origin, sometimes for many years in refugee camps, before arriving in Australia.

The settlement process for refugees can be further complicated by:

• low levels of English proficiency
• poor understanding of the Australian health, legal and social service network
• frequent reluctance or inexperience of relying on people outside their immediate family, and often a mistrust of government
• a desire to continue some cultural practices that are inappropriate in the Australian context, for example female genital mutilation
• families tending to have more children than the Australian average
• lower levels of qualifications or employment experience recognised by Australian employers, compromising economic independence and increasing reliance on welfare
• limited experience of managing a home and finances, which impacts on capacity to maintain private tenancies.

Temporary protection visas
Since March 2000, DHS has assisted 2133 people holding TPVs who have been released from detention centres in South Australia. It is estimated that 35–40% of people released will settle interstate. In recent months few people with TPVs have been released. Future numbers will be determined by the number of unauthorised entrants and both the state and Commonwealth response to them.

All of the above comments about the health of refugees apply to people who hold TPVs with the important addition that mental health issues are even more significant. There are serious questions about the manner in which people are detained and the consequent mental health impacts.

Another factor that compromises mental health is the nature of the TPV. In most instances it is for three years and there is considerable uncertainty about what the future holds. This is in the context that people with TPVs are not offered the same settlement support services as refugees, in particular there are no funded English classes or funded access to the job network. Nor are they eligible to sponsor family members or leave Australia and return at a later date.

There is a group of unattached minors (about 70) for whom there are additional issues by virtue of their age and lack of family support.

Ways forward
The Commonwealth is responsible for refugee settlement services. There are concerns that the funding model can lead to fragmentation of services and there is no explicit requirement for these services to collaborate with state funded services. There is considerable tension concerning people with TPVs who require considerable state resources, for the above reasons. The Commonwealth steadfastly refuses
to provide this assistance. There is significant cost shifting from the Commonwealth to the state. There is a requirement for adequate funding from the Commonwealth for all new arrivals, and negotiations with the Commonwealth to improve service delivery are necessary.

DHS does not have a policy framework concerning the provision of human services for new arrivals. Health cannot be considered in isolation from a range of other settlement tasks. New arrivals policy needs to be developed which outlines expectations concerning access to, equity with and integration of mainstream services.

Services should be offered in the context of a primary health care framework to enable a focus on health promotion, illness prevention and community capacity building. This is especially important in relation to promoting mental health. This framework should also place emphasis on collaboration between services which is critical given the plethora of services that confronts new arrivals.

Currently, there are several agencies responsible for the provision of different aspects of settlement. Initial services for new arrivals should be offered via a one-stop-shop. This could be an entry point to a range of human and settlement services with the express purposes of addressing immediate issues and working with new arrivals to link them to mainstream services. There needs to be a formal coordination process that is properly funded and managed. There needs to be a systematic approach by DHS to building the capacity of existing community based services, such as community health services and general practitioners to meet the needs of new arrivals. All service providers need assistance to ensure effective services including funding for interpreters.

Many organisations are funded by the State Government to provide services to a small population group. It is suggested that the effectiveness of this approach to funding be explored. If it is to continue, non-government agencies should be required as a condition of funding to collaborate with other service providers. Roles and responsibilities of organisations providing services to new arrivals need to be clarified so funds are used most effectively and service providers can be held accountable for the effective use of those funds.

DHS needs to ensure appropriate mechanisms are in place with the Commonwealth to enable negotiations around appropriate levels of Commonwealth funding for new arrivals and collaborative approaches to address the need for improved service delivery.

**Recommendation**

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.
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234 AHAC, AHCSA and ATSIC meeting with GHR, March 2003

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236 The Framework Agreement on Aboriginal and Torres Strait Islander Health was first signed in 1996 and updated in 2001. It requires parties to the agreement — the state and Commonwealth governments, ATSIC and AHCSA — to work together to improve the health and wellbeing of Aboriginal people. The Commonwealth Government's interest in Aboriginal health is provided through the SA Office of Aboriginal and Torres Strait Islander Health, ATSIC's focus is on environmental health and infrastructure and AHCSA is the peak body for Aboriginal health and wellbeing in SA, representing the Aboriginal community controlled sector at a state and national level.

DHS established AHACs in 1996 to support Aboriginal representatives on the (then) newly established country regional health boards and to ensure all Aboriginal communities had a voice. AHAC roles have evolved over time and are described in the draft memorandum of understanding between AHACs, regional health boards, AHCSA and DHS, which is currently being negotiated. In addition to supporting Aboriginal representatives on regional health boards, AHACs are accountable to the communities they represent and are the focal point in providing advice and guidance to, among others, regional health boards and DHS on all issues relating to Aboriginal health and wellbeing within their specific region.

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CHAPTER 7: CHANGE MANAGEMENT AND IMPLEMENTATION

Objective
This chapter discusses the need for change management to lead the health reform process and provides direction on priority recommendations that start the process, address current service issues and impact positively on health inequalities.

Change management

Systemic reform
The South Australian health system needs urgent systemic reform. The system can no longer travel the path of inaction and denial. It can no longer give in to the vocal self-interested minority. It can no longer fiddle on the edges of the health system.

Systemic reform is a process, not an event. Intervening in one part of the system will affect the rest because of the intrinsic interconnectedness. Failure to recognise this in recent times has resulted in a system described during GHR as ‘projects and pilots, bits and pieces’.

If change in the South Australian health system is the goal, then conventional approaches will not suffice. Real systemic reform is more of a transformation — initially of resources and structures but more of 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. Many public and private organisations have shown how change can be led and managed.

Systemic change:

- involves all the parts of the system, changes an organisation’s way of doing things and addresses underlying issues rather than focusing on surface problems
- requires thinking with a system’s perspective and addressing the whole system, including policies and practices at all levels
- involves new relationships among people and institutions, with collective dialogue and decision making rather than hierarchical arrangements.

All stakeholders, consumers and the community must be involved and work collaboratively towards improving health status. Constancy of purpose is essential for systemic change. The turnover among leaders and reformers, and competing demands for limited resources, creates the need for the
sustainment of a critical mass of people who consciously mobilise support for the change process. Without this continued support the system will be in danger of reverting back to its old form.

Promising reforms falter because of lack of coherence. Coherence means an integrated, comprehensive approach to change in which all components are organised around a clear set of desired outcomes and a common vision. To ensure success, those leading the reform must reach beyond themselves to involve the public and other key stakeholders in a broad commitment to change.

One of the most daunting obstacles to change is the widespread cynicism among health providers about reform. Providers typically break into factions whenever deep, system wide change is considered. Those most committed to change never make up more than 25% of the system. Internal tensions are created within the workplace between those who support reform and those who do not. The resulting divisiveness can derail even the most promising reform efforts.

Health professionals who want to promote effective and lasting improvements need to recognise that there are legitimate reasons for some of this cynicism. Many have seen efforts to reform come and go over the years. People have put significant energy into those efforts only to see the reform fail. Skepticism about reform is not about ill will but rather negative experiences of unsuccessful attempts at reform in the past. The workforce questions whether there is real commitment to change even though the need for systemic change is recognised throughout the health system.

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 by the health sector and a potential constituency for support will be lost. Worse, a potential hurdle to reforms will be created.

While systemic reform of the health industry is not easy, 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.

Health professionals find it hard to portray systemic reform in terms that resonate with the community because systemic reform is complex and abstract. Widespread support for reform hinges on creating an informative dialogue between the health system and the public.

**Key systemic reform messages**

Health workers and the public have given strong support to the primary health care recommendations, and resultant government action to reform can create a constituency for change in the community. Reorienting the system to enhance the focus on primary care is a significant change. Consumers know that prevention must be the first step and that prevention is better than a cure. Secondly, a strong primary health care sector will enable consumers to be treated in their homes, or as close to their homes as possible. This enables consumers to retain their autonomy and dignity. The last place people want to go is hospital but, when they do, safe and high quality care is rightly expected.

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-tech medical equipment used in microsurgery and transplants and the clinicians who perform lifesaving surgery tend to be found in hospitals. These are newsworthy events. The prevention of heart attacks, lung cancer or the prevention of public health outbreaks such as food poisoning does not tend to attract attention. They cannot be seen and there is no one person who has been saved who can be easily placed in front of the media to talk about the wonderful life saving treatment they received. The reality though is that 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. For example, advances in medical care make it possible for a range of health care needs to be provided in a community setting. However, if budgets remain tied up with the provision of hospital care, it will not be possible to implement such changes. Over the past two years more than 400 people attended the Flinders Medical Centre emergency department on more than 10 occasions each, totalling 4500 visits. Some of these people had suffered anxiety attacks but because there is no one to manage their anxiety in the community they have kept presenting to the hospital. This produces a cycle of dependency resulting ultimately in the need for greater investment in hospitals — an inefficient solution.

The public instinctively knows prevention is better than a cure. GHR believes the public will respond very favourably to a government initiated system reorientation that will strengthen primary care, preventive 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 past 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. These issues rank well above acute care in hospitals.

Unfortunately, the community is largely disempowered in health matters. Insiders make the decisions and the community is typically excluded. GHR recommendations 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 and make it more difficult for the vocal and the powerful to pre-empt the debate and 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 responding reactively to crisis after crisis, and the demands will not stop. However demands can be managed wisely and fairly.

If the initial reform process can focus on these four issues — primary care; participation structures and processes; the clinical senate; and information and communication strategy — implementation would have a much greater chance of success.

**Key systemic reform enablers**

Five key enablers for reform have been identified. They are information technology, capital assets, an effective motivated workforce, partnerships and research.

Information technology connects the system and facilitates effective communication and efficient information transfer. This capacity is urgently required, particularly if the major consumer attributes of the system are to be achieved. The cost of implementation is high but the price paid for not rolling out
statewide IT connectivity is even higher. The lack of system connectivity is a major contributor to structural inefficiency and the inability to maintain standards of care.

The lack of a statewide capital development plan has resulted in continued patching of the system, and even the patching is not always where development is required or in the form required. The continuing focus on hospital beds has impeded the development of community based capital facilities. A systemic approach to capital planning based on informed modelling of health service requirements will, over time, inevitably result in a more cost-effective system. It should also be noted that capital development is an effective driver of change.

Reform of the workforce is an essential ingredient to systemic reform. Low morale, cynicism and mistrust currently pervade the system and must be halted. Implementation of the recommendations of GHR, and a commitment to a continuous systemic reform agenda, will give the right signals to the workforce and provide them with the encouragement they need and want. There is the potential to make the South Australian health system an employer of choice. There is a need to invest in the health workforce and promote the development of a new workforce profile that can meet the challenges of the future.

Successful reform of the South Australian health system will be reliant on the extent to which effective partnerships are established. This report highlights the need to, not just engage, but also support the non-government sector, the private health sector — including general practitioners, volunteers and family carers — and the higher education sector. Active participation with Commonwealth, state and local governments is essential if health inequalities are to be addressed.

The 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.

Health sector employees involved in decision making in service sectors, planning and policy making must work together to collectively identify gaps in knowledge which could be met by research.

**Implementation**

**Management of the systemic reform process**

GHR has actively pursued a consultative and transparent review process. It has practised what it has preached by engaging all levels of the workforce, key stakeholders, consumers and the broader community in the thinking, analysis and debate on the key issues confronting the South Australian health system today and into the future. It is important that this momentum is not lost. The process of reform must include and involve the system in determining how the reforms should be implemented. Transparency and inclusion are starting points for engendering trust and reducing the cynicism that pervades the health system.

The concept of shared leadership has been put forward by GHR. It implies that all management teams take responsibility for leadership. Shared leadership does not abdicate the Chief Executive's accountability. It does imply a shared responsibility for problem identification, solutions and action. Skills such as team building, conflict management and building a new culture are among the skills leaders need to build successful organisations. Those in leadership positions need to create a climate that will encourage others to take risks, to confront the formal leader and others in the organisation, to debate and to exhibit acts of leadership. The concept of shared leadership offers a way of increasing risk taking, innovation and commitment, and creates an organisation that can be responsive, flexible
and successful. This leadership must keep focused on the vision of a better health service and not be distracted by day-to-day crisis management.

DHS has a commitment to developing internal capacity to drive the proposed reform agenda. The establishment of the DHS proposed health reform unit (HRU) is a priority. HRU should be responsible for facilitating the reforms. It should not itself be the reformer nor should it own the agenda. The reform agenda must be owned by the system. HRU must mainstream the reform agenda to drive change. It is the role and responsibility of the system to implement the reform agenda. Through mainstreaming, reform activities are taken up more efficiently and effectively. The capacity of the system to manage reform activities will be enhanced, which will enable a sustained reform process to be developed.

HRU will need to have access to a significant communications capacity. As previously mentioned, the government requires a major information and communications strategy to lead and manage the health debate. Given reform will be an ongoing activity, a communications unit should be established within DHS with its first responsibility to work with HRU to develop an information and communications strategy.

An ongoing requirement will be to evaluate the impact of the reform agenda. An early task for HRU will be to facilitate development of key performance indicators and evaluation tools.

As implementation will be lengthy and the change process considerable, it is highly likely that one or more key stakeholders or participants in the change process will leave, for various reasons. A formal process needs to be identified at the start of the project to cater for these situations and to ensure adequate handover of responsibilities, and sufficient time for orientation and induction.

**Analysis of recommendations for reform**

GHR has indicated from the outset that the process of review and development of the GHR report are relatively easy in comparison to implementation. Approvals, business plans, impact assessment of recommendations, priority setting, sequencing, communicating, taking the first step, project management, monitoring, evaluation, progress reporting, managing change and, of course, maintaining energy levels, motivation and momentum, are just some of the activities associated with implementation.

It is not the intention of GHR to dictate what implementation processes should be put in place but rather to give some indication of the priorities, possible sequencing and relative duration of recommendations.

A critical pathway analysis was conducted and recommendations were categorised according to whether they had predecessors (i.e. an additional action was needed prior to the recommendation being implemented) and whether the recommendations required additional funds. Each recommendation was then considered in light of the ease or difficulty of implementation, its rating as a system reform priority, its capacity to influence change, and whether legislation or change to legislation would be required.

The result of this exercise is in Appendix 6.
Priority reform agenda
The final stage was to select the recommendations which should be implemented in the first three months and which would be:

- an extension of work in progress
- within the capacity of DHS
- acceptable to the community and health system stakeholders
- a message that change is going to occur.

These recommendations fell into three groupings, the essential first steps to:

- developing a framework for the future
- positively impacting on health inequalities
- addressing current service reform issues.

The priority recommendations are as follows.

Framework for the future

- Secure parallel funding (R3.9)
- Statewide IT connectivity (R3.15)
- Statewide capital investment plan (R3.17)
- Clinical senate (R4.6)
- Independent monitoring body (R4.4)
- Community inclusion (R4.1; R4.7; R4.8; R4.9)
- Performance management framework (R4.3)
- Establish regions (R2.1)
- Develop governance arrangements (R2.12)
- Population health funding model (R2.4)
- Population service planning model (R2.6)
- Primary health care policy (R3.7)
- Networked primary care services (R3.5; R3.8; R3.11)
- Public and environmental health division in DHS (R3.4)
- New legislation (R2.13)
- Health call centre (R3.2)
- Commonwealth–state commission (R3.3)
- Futures forum (R3.23)
Health inequalities

- Aboriginal three-year funding (R2.10)
- Aboriginal workforce development (R5.5)
- Whole-of-government: Early childhood and Aboriginal quality of life (R6.1; R6.2; R6.3; R6.4)
- Mental health (R6.15)
- Homelessness (R6.14)
- Establish metropolitan AHACs and performance agreements between AHACs and regional health boards (R6.6; R6.8; R6.10)

Current system reform

- Managing metropolitan hospital workloads (R3.1)
- Clinical planning and clinical networks (R3.12; R3.13)
- Service delineation (R3.14)
- Public information (R4.12)
- Statewide workforce planning group (R5.2)

It was also important to audit these recommendations against the principles given GHR within its brief. The principles are:

- improving quality and safety
- community participation
- strengthening primary health care
- service integration and coordination
- whole-of-government approaches to improve health status
- ensuring efficiency and effectiveness

Table 8 provides an audit of the priority recommendations against these principles.
<table>
<thead>
<tr>
<th>Framework for the future</th>
<th>Health inequalities</th>
<th>Current system reform</th>
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| **Improving quality and safety** | • Secure parallel funding  
• Clinical senate  
• Clinical planning and clinical networks  
• Independent monitoring body  
• Performance management framework  
• Public health division in DHS  
• Workforce planning group  
• Community inclusion strategies | • Secure parallel funding  
• Whole-of-government: early childhood and Aboriginal quality of life  
• Mental health reform  
• Community inclusion strategies  
• Networked primary care services | • Secure parallel funding  
• Statewide capital planning  
• Clinical senate  
• Clinical planning and clinical networks  
• Public health division in DHS  
• Managing hospital workload  
• Service delineation  
• Workforce planning group  
• Mental health reform  
• Community inclusion strategies |
| **Community participation** | • Independent monitoring body  
• Primary health care policy  
• Networked primary care services  
• Community inclusion strategies  
• Statewide IT connectivity  
• Public information  
• Establish regions  
• Develop governance arrangements  
• New legislation  
• Metro AHACs; performance agreements between AHACs and regional health boards | • Metro AHACs; performance agreements between AHACs and regional health boards  
• Develop governance arrangements | • Networked primary care services  
• Community inclusion strategies  
• Statewide IT connectivity  
• Public information  
• Health call centre  
• New legislation  
• Mental health reform  
• Metro AHACs; performance agreements between AHACs and regional health boards  
• Develop governance arrangements |
| **Strengthening primary health care** | • Secure parallel funding  
• Statewide IT connectivity  
• Health call centre  
• Commonwealth-state commission  
• Statewide capital planning  
• Networked primary care networks  
• Community inclusion strategies  
• Workforce planning group  
• Establish regions  
• Develop governance arrangements  
• Population health funding  
• Primary health care policy  
• Public health division in DHS | • Secure parallel funding  
• Public health division in DHS  
• Aboriginal three-year funding  
• Commonwealth-state commission  
• Whole-of-government: Early childhood and Aboriginal quality of life  
• Mental health reform  
• Homelessness  
• Develop governance arrangements | • Secure parallel funding  
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Indicators of reform
Implementation of the GHR proposed reform agenda would require as a prerequisite the development of performance indicators. This section provides a starting point by offering a set of indicators for the first, third and fifth years of implementation. The indicators are not comprehensive, nor has any work been done to determine the means for measuring achievement against these indicators.

The first and third year indicators assist in ascertaining the extent to which the reform systems and processes are in place. The fifth year indicators have been written in terms of desired community outcomes.

At the end of first year of reform there will be:

- regional health services and regional CEs in place
- devolution from DHS of operational component (assumes staff transfer) to regional health services
- movement of support staff from health units to appropriate regional health services
- community consultation plans and processes in place
- state and regional community councils in place
- at least one primary care network in place in each region
- evidence of some shift of ambulatory services from acute sector to community
- metropolitan AHACs established and functioning effectively
- effective performance agreements between AHACs and regional health boards
- whole-of-government benchmarks for early childhood and Aboriginal quality of life
- strategies for achieving whole-of-government benchmarks developed by all government departments
- the clinical senate in place
- an independent health system monitoring body in place
- a new primary health care policy which is being implemented
- demand management strategies implemented
- some clinical plans and clinical networks implemented
- Aboriginal three-year funding in place
- a public and environmental health division within DHS.

At the end of the third year of reform there will be:

- a Commonwealth–state health commission
- a performance management framework developed and being used
- benchmarks produced by the independent monitoring body and at least two performance reports published
- a population health funding model being applied and adjustments made to accommodate South Australia’s requirements
- demand management strategies taking effect and the pressure on emergency departments and hospital beds reducing
- service profiles developed by each regional health service
- hospital role and function studies developed and accepted
- IT connectivity across the health system
• additional primary care networks in each region
• primary care centres established
• regional clinical governance structures and processes operating effectively
• new legislation
• statewide capital plans and capital development in line with the redefined role and function of health services across the state
• a framework and tools for population planning being used by the regions
• evidence that there has been a cultural shift in the workforce reflected in the focus on population outcomes rather than institutions and professional groups
• a process of community involvement in priority setting which is positively contributing to public debate on what the priorities are for health expenditure
• workforce development in community capacity building which has become an ongoing activity
• continuing progress in implementing the mental health strategy with a significant increase in community based services
• a strategy for the homeless which is being implemented
• regionalised statewide services
• only two levels of governance.

At the end of fifth year of reform

• 24-hour access to a primary care provider will have improved because more services will be in a primary health care setting, in the home or in an easily accessible local facility.
• There will be a wider choice of primary care providers available locally.
• Consumers will not have to undergo the same test multiple times for different providers.
• Consumers will be able to make a range of appointments with clinicians, for diagnostic tests or treatment with one phone call.
• There will be continuity of program delivery because of a reduction in project based funding by the Commonwealth and the state.
• Basic personal facts and history will be provided to each health professional through a secure shared system, including common assessment processes.
• Primary care services will be more adaptive to the needs of the Aboriginal and culturally and linguistically diverse populations.
• There will be a coordinated approach and access to primary care, emergency services and specialist services.
• Consumers will be able to make an easy transition from primary care to specialty care.
• There will be easy to understand information about quality of care and clinical outcomes for making informed choices about provider and treatment options.
• There will be additional services designed to enable people to be treated in the community rather than in hospital.
• High quality care will be provided through networked clinical services designed to deliver care in local, regional and central settings.
• Consumers will see a reduction in administrative personal.
• Consumers will see improved continuity of the workforce.
• People with chronic disease will be contacted routinely to ensure problems are identified before they occur, with provision of education, in-home assistance and training in self-care to maximise independence.
• There will be improved provision for the needs of an ageing population, by support in the home, early intervention strategies, improved recuperation (step down) and rehabilitation facilities and, where necessary, respite beds.

• Health professionals will be informed of the consumer’s hospitalisation, diagnostic or treatment procedures, drugs prescriptions, referrals to other health units or other service responses through the secure shared system.

• The community will be contributing to the debate about where investment in health services should be occurring.

• The community will be informed of the rationale for resource allocation.

• The community will see a greater emphasis on health promotion and disease prevention.

• The community will have access to health system performance information.

• There will be fewer stories in the media reporting on ‘waiting lists’; ‘need more beds’ or ‘workforce shortages’.

**Recommendation**

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

**Legislative change options**

**New legislation**
The scope of the changes proposed in the recommendations of GHR’s final report makes it highly desirable for there to be new legislation to replace the SAHC Act. Matters to be covered in new legislation would include the following.

**Objects**
It is useful to have a statement of objects. These are statements of principle that should set the tone for the administration of the legislation. They represent the values underpinning the legislation and provide a framework (and limitations) that give coherence to the provisions and would need to reflect the principles to support a primary health care focused system. There is also a requirement to articulate the responsibility of regional health services for the health of their population.

**Interpretation**
Parliamentary counsel will draft the definitions they consider necessary for the purposes of the Act. However, given that the definitions (together with the objects and powers and functions) are what define the scope and limitations of the Act, guidance needs to be given as to what is to reflect and support a health care focused system.

**The Minister**
With the drafting of a new Act, either the range of central powers and functions can be conferred on the Minister, with power to delegate (which is generally the current drafting practice), or the opportunity could be taken to delineate the roles and functions more clearly so that the day-to-day management of the department and relationships between the regional health services and the department clearly reside with the Chief Executive.
**DHS and Chief Executive**

DHS and Chief Executive functions are those established under the *Public Sector Management Act 1995*. The Chief Executive should be subject to the control and direction of the Minister in the administration of the Act and should have a power of delegation, in particular to regional health services.

**Agreements with regional health services and health service organisations**

There should be provision for the Chief Executive of DHS to enter into agreements with regional health services and any other health service organisations to which funds are allocated directly by DHS (as opposed to local service units and other health service organisations whose funds are allocated by the regional health services).

**Statement of policies and strategies**

There should be a requirement for the Chief Executive of DHS to prepare, for the Minister’s approval, a statement of policies, strategies and guidelines for implementing a system of health service delivery in accordance with the objects of the SAHC Act. This should include principles for community and consumer participation, with specific reference to Aboriginal communities. It should include reference to clinical governance and safety and quality oversight.

**State community council**

There should be a requirement for the Minister to establish a State Community Council. The council should be of a size determined by the Minister, with membership as determined by the Minister, but should include members of the regional community councils, so long as the proportion of latter members does not exceed half the total membership.

**Regional health services**

Regional health services can be established by various mechanisms. One approach would be for the Act to deal with all matters to do with their establishment and operation (i.e. give them their existence, spell out detail of board membership, powers and functions and all other operational matters). Another approach would be essentially to continue the current approach whereby some substantive matters are in the Act and other matters are covered in a constitution.

There should be a requirement that boards administer regional health services in accordance with the agreement between the regional health service and the DHS Chief Executive, as in force at the time, and approved health policies and strategies.

**Power of direction**

The SAHC Act confers on the Minister a power of direction over incorporated hospitals and health centres. The power is limited so that a direction cannot be given to affect clinical decisions relating to the treatment of a particular patient; sale or disposal of land, buildings or equipment not held by the Crown; employment, transfer, remuneration, discipline or termination of a particular employee (the employment-related limitations mirror those in the *Public Sector Management Act 1995*). Directions must be gazetted.

A similar power of direction over regional health services should be included in the Act. It would be more consistent with the proposed scheme of the Act for the power to reside in the chief executive, regional health service. However, if it is to be regarded as a power of last resort, when other tools of management have failed, then consideration could be given to it residing in the Minister.
**Staff of the regional health services and local service units**  
There should be a requirement that each regional health service have a chief executive officer appointed by the board of the regional health service with the approval of the Chief Executive of DHS.

**Community participation**  
The Act should impose a requirement on a regional health service to ensure the involvement of communities and, in particular, Aboriginal communities, in advising on health needs and priorities.

**Regional community councils**  
The Act should require the minister to establish a regional community council for each regional health area.

**Aboriginal health advisory committees**  
There should be a requirement for the minister to establish an Aboriginal health advisory committee for each regional health area.

**Health system performance monitoring commission**  
Provision should be included in the Act to establish this commission, set out its membership and term of office, and provide for it to employ staff (or, with the approval of the Minister, make use of public service or regional health services staff).

**Transitional issues**  
In order to implement GHR’s recommendation that all incorporation of hospitals and health services under the SAHC Act be dissolved and their functions assigned to regional health services, provision would need to be made in the Act for that to occur. There would need to be provision for vesting property, rights and liabilities of the previously incorporated health units in the regional health services (after due diligence processes) and for the transfer of staff.

**No legislative change**  
If it were considered that the process to achieve a new health services Act would be too protracted and would risk losing the momentum for change that has built up over the period of GHR, then the focus would have to be on what could be done within the existing legislative framework.

**Objects**  
The objects of the SAHC Act are stated relatively briefly and include some that are relevant to the recommendations of GHR. Without amendment, there would be no articulation of some of GHR’s key directions and values (e.g. specific reference to population health, addressing health inequalities, community participation through community councils and Aboriginal health advisory committees, independent monitoring, and services with a focus on human values that seek to optimise the health of communities).

**Definitions**  
The definitions of ‘health centre’ and ‘health service’ have accommodated (in country areas) incorporation of regional health services. However, services are restricted to those with a particular health focus which, without amendment, may not accord with current thinking and GHR’s views on what ‘health services’ should encompass. They may also not be robust enough to accommodate the role of regional health services as envisaged by GHR. Also, incorporated health units are currently not able to engage in business activities of a commercial nature through the formation of a company.
**The Minister**
The Act confers a range of powers and functions on the Minister. In practice, most of the powers and functions have been delegated by the Minister to the Chief Executive of DHS and the department has subsumed many of the functions previously carried out by the South Australian Health Commission.

The powers of the Minister are significant. The power of direction has been used sparingly in the past and has tended to be regarded as a power of last resort rather than a day-to-day management tool. However, as indicated below, reduction in the number of separately incorporated health units by amalgamations and dissolutions under the current Act can only occur with the consent of the bodies themselves.

The constitutions of health units are subject to approval by the Minister, which gives the Minister a power of veto (this has been delegated to the department). However, the Minister has no power to amend a constitution. This is within the jurisdiction of the health unit.

**The Health Commission**
While the overall structure of the Act has remained essentially as it was initially enacted, the commission no longer carries out the functions it was originally established to perform. Essentially, DHS, not the commission, provides the policy and operational interface with the incorporated health services and has the high level policy and strategic planning role.

If it is desired to reconstitute the commission as the proposed independent performance monitoring body, some of its existing functions would enable it to operate in that way and others should be delegated to DHS to ensure that responsibility is clear for important public and environmental health matters. Without amendment to the Act, the name ‘South Australian Health Commission’, with all of its previous connotations, will persist for the new performance monitoring body.

**Advisory committees**
There is power under the Act (s.18) — which has been delegated to DHS — for the Minister to appoint advisory committees which may, of their own motion, investigate and report on any matter in relation to which the committee was established. It would be possible for the State Community Council and Aboriginal health advisory committees to be so appointed, but this would not give it the specific legislative profile envisaged by GHR.

**Incorporated health units**

**Hospitals and health centres**
The Act provides for the establishment of hospitals and health centres as incorporated bodies under the Act. A hospital must provide live-in services as part of its services; a health centre can but need not. A primary health care focused system may include services which fall outside these definitions.

The Act provides a process for incorporated health units to be amalgamated or dissolved, and a number of amalgamations have occurred (especially in country areas). However, amalgamation and transfer of the whole undertaking to another body, or dissolution and disposal of assets, can only occur if the health unit’s board consents to this occurring. Notwithstanding the significant momentum for change which has built up during the period of GHR, an assumption that over 70 boards will seek to amalgamate, at least in the short term, may not be realistic. In order to facilitate change, amendment to the Act would be necessary.
Regions
The Chief Executive of DHS has delegated powers and functions under the Act to regional boards (but not the power to direct a health unit).

The role of regional boards could be expanded to encompass providing (rather than just funding) health services, to take account of GHR’s recommendations, so long as it was within the overall scope of the Act. However, as outlined above, amendments to constitutions must be at the request of the incorporated health unit (and that includes regional boards). Dissolutions and amalgamations must be at the request, and with the consent, of the boards both in relation to amalgamation or other configuration changes of regional health services, and in relation to the dissolution of individual health unit boards to become amalgamated with the regional board. In order to facilitate change, amendment to the Act would be necessary.

Metropolitan regional health services could be established using a similar process to that used for the establishment of country regional health services. However, as outlined above, dissolution of the individual health unit boards to become amalgamated with the regional board can only be at the request and with the consent of the boards.

The metropolitan regional health services’ constitutions should require the establishment of regional community, including Aboriginal community participation mechanisms and clinical governance mechanisms.

Amendments to legislation
If it is considered that the limitations of the existing legislative framework will not adequately progress the objectives of GHR, consideration could be given to pursuing some legislative change but on a smaller scale than envisaged with the creation of new legislation.

Objects
The objects should be broadened to reflect the proposed primary health care focused health system.

Interpretation
Broadening of some definitions should be considered, to the extent parliamentary counsel determines appropriate, to the scope of change of the legislation under this option.

The Health Commission
Provisions could be included to abolish the Health Commission, transfer the public and environmental functions to the Minister (who could delegate them to the Chief Executive) and establish a health system performance monitoring commission, along the lines suggested for new legislation.

State community council
Provisions could be included to require the establishment of a state community council along the lines suggested for new legislation.

Aboriginal health advisory committees
Provisions could be included to require the establishment of Aboriginal health advisory committees, along the lines suggested for new legislation.
In conclusion

South Australia, unlike almost all other states in Australia and other countries, has not been able to significantly reform its governance arrangements in the health system to date – despite efforts by both Labor and Liberal governments.

An inherent tension exists between the desire for governance which focuses on the health needs of the population on the one hand, and resistance to the amalgamation or dissolution of individual health unit boards on the other. In my view, this is holding back the state and, perhaps more importantly, holding back the health of the community.

John Menadue AO 262
FOOTNOTES

261 GHR Working Paper Drafting guidelines for new health legislation April 2003

262 Menadue J Health and Governance: A Path to Population Health — Hospital Silos or a Health System? Speech presented March 2003
GLOSSARY

Benchmark
A systematic approach to improving health and social care services by identifying best practice, and bringing in a program of change to improve a service beyond a known fixed point of quality or performance. It may involve comparison of local services with similar service elsewhere.

Bulk billing
When a general practitioner charges Medicare directly, accepting the Medicare benefit as full payment.

Capacity building
An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.

Capacity
The totality of the levels of service provision within a local health and social care economy — beds, staffing, clinics etc (the structure) and the means by which they are used (the process) within the context of the demands experienced.

Casemix
A means of classifying hospital patients to provide a common basis for comparing cost effectiveness and quality of care across hospitals.

Chronic
Persisting over a long period.

Clinicians
The totality of health professionals including nurses, allied health professionals, physicians, surgeons, general practitioners and other medical specialists.

Early intervention
Strategies that will impact positively on the development or health status of people who are discovered to have, or to be at risk of developing, a condition or other special need.

Equity
Fairness. Equity in health means that people’s needs guide the distribution of opportunities for wellbeing.

General practitioner
A medical practitioner who provides primary, comprehensive and continuing care to patients and their families within the community. (Royal Australian College of General Practitioners)

Health promotion
A comprehensive political and social process, where action is directed towards changing social, environmental and economic conditions so as to alleviate their impact on public health. Also a process of enabling people to increase control of the determinants of health and thereby improve their health.
**Health status**
A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards.

**Human right**
Human rights are principally concerned with the relationship between the individual and the state. International human rights treaties are binding on governments who ratify them. Declarations are non-binding. United Nations conferences generate non-binding consensual policy documents, such as declarations and programs of action.
There are three different types of rights:
(1) The fundamental freedoms or classical civil liberties
(2) Ethnic and religious rights
(3) Socioeconomic rights
( WHO Health and Human Rights Publication Series Issue 1, July 2002)

**Indicator**
A specific measure for assessing progress towards goals; a statistic or other unit of information that reflects, directly or indirectly, the performance of an intervention, facility, service or system in maintaining or increasing the wellbeing of its target population.

**Inpatient**
Person admitted to hospital or health facility.

**Long-term unemployment**
Unemployed for 52 weeks or more as a percentage of the total number of unemployed.

**Medicare**
Medicare is Australia’s universal health insurance scheme introduced in 1984. Australia’s public hospital system is funded jointly by the Commonwealth, state and territory governments and is administered by state or territory health departments. The Health Insurance Commission administers the Medicare program which includes enrolments and benefit payments.

**Non-government organisations**
Private, not for profit, community managed organisations that receive government funding specifically for the purpose for providing community support services.

**Opportunity cost**
What one is prepared to offer up in place of a better alternative.

**Outcome**
A measurable change in the health of an individual, a group of people or a population, which is attributable to an intervention or series of interventions.

**Outpatient**
Person who receives medical, surgical, allied health or diagnostic services who is not formally admitted to a hospital at the time of receiving the service.

**Population health**
A philosophy of promoting health and reducing the incidence of preventable disease and disability by improving access to opportunities and prerequisites for good health.
Prevalence
The proportion of the population with a disease or disorder.

Primary care
Care which provides integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practising in the context of family and community.

Primary health care system
A system with a population focus, that addresses the social determinants of health, includes intersectoral approaches, focuses on health promotion, illness prevention and early intervention, ensures equitable access to health services, and has a community involvement and a participation approach to health care.

Public sector
The part of government concerned with providing basic services. The composition of the public sector usually includes such services as the police, military, public roads, public transit, primary education and healthcare for the poor.

Quality of life
An individual's perception of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns.

Risk factors
Those characteristics, variables or hazards that, if present for a given individual, make it more likely for this individual, rather than someone selected at random from the general population, to develop a disorder.

Self sufficiency
Capable of providing for one's own basic needs. In the case of urban areas, self-sufficiency of health services would allow people to access at least 70% of services locally.

Social capital
The degree of social cohesion which exists in communities; the processes between people that establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit.

Social determinants of health
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.

Socioeconomic status
Relative position in the community as determined by occupation, income and education.

Standardised mortality rate
The number of deaths in the population within a year expressed as a percentage of deaths that would be expected if the population concerned had experienced the same sex and age related specific mortality rates as those recorded for a population as a whole.
**Statistical local area**
A spatial unit within the Australian standard geographical classification developed by the ABS for coding data of areas within Australia. It is a standard geographical area for many statistical purposes. Several statistical local areas can combine to form an LGA.

**Vector**
An organism (often an insect) that transmits a pathogen or disease.

**Whole-of-government approach**
Government initiatives to encourage closer working relationships between departments and agencies and between the levels of government to meet a common end.

**Wide area network**
A long-distance network that uses leased lines to connect computers to local area networks.
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>AHAC</td>
<td>Aboriginal Health Advisory Committee</td>
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<td>AHCSA</td>
<td>Aboriginal Health Council of SA</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMA</td>
<td>Australian Medical Association South Australian Branch</td>
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<td>Australian Medical Workforce Advisory Council</td>
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<td>Aboriginal and Torres Strait Islander Percentage</td>
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<td>Child and Adolescent Mental Health Services</td>
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<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HCCC</td>
<td>high cost and complex case</td>
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<tr>
<td>HRU</td>
<td>health reform unit</td>
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<td>IRSD</td>
<td>Index of Relative Social Disadvantage</td>
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<tr>
<td>IMVS</td>
<td>South Australian Institute of Medical and Veterinary Science</td>
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<td>KPMG</td>
<td>Klynveld Peat Marwick Goerdeler</td>
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<td>LGA</td>
<td>local government area</td>
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<td>LMHS</td>
<td>Lyell McEwin Health Service</td>
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<td>MBS</td>
<td>Medicare Benefits Scheme</td>
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<td>MHD</td>
<td>Metropolitan Health Division (South Australian Department of Human Services)</td>
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<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
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<td>NATSEM</td>
<td>National Centre for Social and Economic Wellbeing</td>
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<td>NCSG</td>
<td>networked clinical service group</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>NHS</td>
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<td>NT</td>
<td>Northern Territory, Australia</td>
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<td>OACIS</td>
<td>Open Architecture Clinical Information System</td>
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<td>Pharmaceutical Benefits Scheme</td>
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<td>RADGAC</td>
<td>Commonwealth Research and Development Grants Advisory Committee</td>
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<td>Royal Adelaide Hospital</td>
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<td>RDNS</td>
<td>Royal District Nursing Service of SA Inc</td>
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<td>RGH</td>
<td>Repatriation General Hospital</td>
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<td>RHS</td>
<td>regional health service</td>
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<td>SA</td>
<td>South Australia</td>
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<td>SACOSS</td>
<td>South Australian Council of Social Services</td>
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<td>SADS</td>
<td>South Australian Dental Service</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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<tr>
<td>SAHC</td>
<td>Act South Australian Health Commission Act 1976</td>
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<tr>
<td>SHine SA</td>
<td>Sexual Health Information Networking and Education South Australia</td>
</tr>
<tr>
<td>SMR</td>
<td>Standardised Mortality Ratio</td>
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<tr>
<td>SPPH</td>
<td>Strategic Planning and Population Health Division</td>
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<tr>
<td></td>
<td>(South Australian Department of Human Services)</td>
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<tr>
<td>SLA</td>
<td>statistical local area</td>
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<td>TQEHT</td>
<td>The Queen Elizabeth Hospital</td>
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<td>TPV</td>
<td>temporary protection visa</td>
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<td>VET</td>
<td>vocational education and training</td>
</tr>
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<td>Vic</td>
<td>Victoria</td>
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<td>WCH</td>
<td>Women's and Children's Hospital</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>
APPENDIX 1: Task groups

Community participation

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Wilson, Dr Richard, Chair, South Australian Drug and Alcohol Services Council

Health care models

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Williams, Dr Helena, Medical Director, Southern Division of General Practice
### Information Technology Telecommunication and Capital

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- **Dundon, Mr Ray,** Consultant, KPMG

#### Executive Officer
- **Hunter, Ms Miriam,** Executive/Research Officer, GHR Secretariat
- **Seaman, Ms Vicki,** Executive/Research Officer, GHR Secretariat (to September 2002)

#### Members
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- **Exton, Mr Derek,** Project Director, Asset Services, DHS
- **Frank, Dr Oliver,** GP
- **Grillo, Mr Mike,** Executive Director, Government Information and Communication Services, DAIS
- **Jackson, Mr Peter,** Director, Asset Services, DHS
- **Jacquier, Mr Doug,** Chief Executive, Community Information Strategies Australia
- **Halkett, Mr Ian,** Chief Information Officer Information Management Services, DHS
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- **Moffat, Mr David,** Aboriginal Services Division, DHS
- **Nielsen, Mr Tom,** Regional General Manager, South East Regional Health Service
- **Paice, Mr Barry,** Director, Capital Management Branch, DHS (Vic)
- **Patterson, Mr Ken,** Director, IT Infrastructure Services, DAIS
- **Robinson, Mr Phil,** Chief, Division of Mental Health, WCH
- **Skipper, Mr Rob,** Intelesys Consulting Pty Ltd
- **Tattersall, Mr Geoff,** Chief Executive Officer, Noarlunga Health Services
- **Upton, Ms Pamela,** Principal, Nosco
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Metropolitan Emergency Department Liaison Group
Metropolitan Women’s Health Services Coordinators
Mid North Primary Health Care Committee
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Northern Metropolitan Community Health Service
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Public Service Association
Quorn Health Services Inc Board of Management
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RAH Medical Staff Society
RAH Cardiovascular Investigation Unit
RAH Palliative Care Unit
RAH Post Graduate Education Office
RAH, Radiation Oncology
RAH, Radiation Oncology Department
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South Australian Branch of the Faculty of Rehabilitation Medicine
South Australian Cardiac Rehabilitation Association
South Australian Centre for Rural and Remote Health
South Australian College of Pharmacy
South Australian Community Health Association Inc
South Australian Community Health Research Unit
South Australian Council of Social Services (SACOSS)
South Australian Dental Service (SADS)
South Australian Divisions Of General Practice Inc
South Australian Human Services Libraries Consortium
South Australian Medical Scientists Association
South Australian Salaried Medical Officers Association
South Australian Task force on Multiple Chemical Sensitivity
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South East Regional Health Service
Southern District War Memorial Hospital
Southern Services Reform Group
SouthPath
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Adelaide Central Mission
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Australian College of Midwives (South Australian Branch)
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Australian Liquor, Hotel and Miscellaneous Workers Union
Australian Medical Association (South Australian Branch)
Australian Nursing Federation (SA)
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Pope, Dr David, Emergency Registrar, LMHS
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* Membership was subject to change. This list reflects those attending the February 2003 meeting.
Bissett, Mr John Hospital Activity Modelling Project

Eagar, Professor Kathy and Eckstein, Professor Gary, Consultants in Health Service Development, *Toward Population Based Funding and Governance of the South Australian Health System*

Griffith, Ms Kate, contribution to GHR’s Media Strategy

Harrison Health Research, market research focus groups

Herbertt, Mr Mark, Director, Lizard Drinking Pty Ltd *Modelling a Primary Health Care Focused System in Utopia (A Southern Metropolitan Region)*

Paul Laris and Associates *Community Health Centres in South Australia: A Brief History and Literature Review*
## APPENDIX 4: Recommended regional configurations

Regions by ABS Statistical Local Area

### NORTHERN ADELAIDE
- Playford (C) — East Central
- Playford (C) — Elizabeth
- Playford (C) — Hills
- Playford (C) — West
- Playford (C) — West Central
- Port Adel. Enfield (C) — East
- Port Adel. Enfield (C) — Inner
- Salisbury (C) — Central
- Salisbury (C) — Inner North
- Salisbury (C) — North-East
- Salisbury (C) Bal
- Tea Tree Gully (C) — Central
- Tea Tree Gully (C) — Hills
- Tea Tree Gully (C) — North
- Tea Tree Gully (C) — South

### CENTRAL ADELAIDE
- Adelaide (C)
- Adelaide Hills (DC) — Central
- Adelaide Hills (DC) — Ranges
- Burnside (C) — North-East
- Campbelltown (C) — East
- Campbelltown (C) — West
- Charles Sturt (C) — Coastal
- Charles Sturt (C) — Inner East
- Charles Sturt (C) — Inner West
- Charles Sturt (C) — North-East
- Norw. P’ham St Ptrs (C) — East
- Norw. P’ham St Ptrs (C) — West
- Port Adel. Enfield (C) — Coast
- Port Adel. Enfield (C) — Port
- Prospect (C)
- Unincorporated Western
- Unley (C) — East
- Unley (C) — West
- Walkerville (M)
- West Torrens (C) — East
- West Torrens (C) — West

### SOUTHERN ADELAIDE
- Holdfast Bay (O) — North
- Holdfast Bay (O) — South
- Marion (C) — Central
- Marion (C) — North
- Marion (C) — South
- Mitcham (C) — North-East
- Mitcham (C) — West
- Onkaparinga (O) — Hackham
- Onkaparinga (O) — Hills
- Onkaparinga (O) — Morphett
- Onkaparinga (O) — North Coast
- Onkaparinga (O) — Reservoir
- Onkaparinga (O) — South Coast
- Onkaparinga (O) — Woodcroft

### WAKEFIELD
- Barossa (DC) — Angaston
- Barossa (DC) — Barossa
- Barossa (DC) — Tanunda
- Clare and Gilbert Valleys (DC)
- Gawler (M)
- Goyder (DC)
- Light (DC)
- Mallala (DC)
- Wakefield (DC)

### HILLS SOUTHERN
- Adelaide Hills (DC) — North
- Adelaide Hills (DC) Bal
- Alexandrina (DC) — Coastal
- Alexandrina (DC) — Strathalbyn
- Kangaroo Island (DC)
- Mount Barker (DC) — Central
- Mount Barker (DC) Bal
- Victor Harbor (DC)
- Yankalilla (DC)
### MID NORTH
- Barunga West (DC)
- Copper Coast (DC)
- Mount Remarkable (DC)
- Northern Areas (DC)
- Orroroo–Carrieton (DC)
- Peterborough (DC)
- Port Pirie (C and DMC) — City
- Port Pirie (C and DMC) — Balance
- Unincorporated Yorke
- Yorke Peninsula (DC) — North
- Yorke Peninsula (DC) — South

### RIVERLAND
- Berri & Barmera (DC) — Barmera
- Berri & Barmera (DC) — Berri
- Karoonda East Murray (DC)
- Loxton Waikerie (DC) — East
- Loxton Waikerie (DC) — West
- Mid Murray (DC)
- Murray Bridge (RC)
- Renmark Paringa (DC) — Paringa
- Renmark Paringa (DC) — Renmark
- Southern Mallee (DC)
- The Coorong (DC)
- Unincorporated Riverland

### SOUTH EAST
- Grant (DC)
- Lacepede (DC)
- Mount Gambier (C)
- Naracoorte and Lucindale (DC)
- Robe (DC)
- Tatiara (DC)
- Wattle Range (DC) — East
- Wattle Range (DC) — West

### NORTHERN & WESTERN
- Ceduna (DC)
- Cleve (DC)
- Coober Pedy (DC)
- Elliston (DC)
- Flinders Ranges (DC)
- Franklin Harbor (DC)
- Kimba (DC)
- Le Hunte (DC)
- Lower Eyre Peninsula (DC)
- Port Augusta (C)
- Port Lincoln (C)
- Roxby Downs (M)
- Streaky Bay (DC)
- Tumby Bay (DC)
- Unincorporated Far North
- Unincorporated Flinders Ranges
- Unincorporated Lincoln
- Unincorporated West Coast
- Unincorporated Whyalla
- Whyalla (C)

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C: council
DC: district council
M: municipal
C and DMC: city and districts municipal council
How the health care system will address the needs of older South Australians — an example

Introduction
The proposed health system reforms would allow regions to provide more appropriate responses to meet the needs of older people by:

- maintaining health and wellbeing in their locality through a primary health care approach based on local partnerships between providers
- providing an integrated health system that ensures needs are addressed in a seamless way without gaps in services, such as being discharged without appropriate local care planning
- providing appropriate facilities and service responses required to meet special needs.

These responses should reduce the number of people requiring acute hospital care for avoidable issues, enhance the capacity of people to manage their wellbeing successfully within their local community and support the provision of services to address particular needs. In relation to death and dying this may mean resourcing options to assist those who wish to die at home to do so, as well as providing capacity within appropriate facilities for those who do not want to die at home.

Context for older people
Bureaucracies and agencies tend to identify older people as a homogenous population group, but older people are as diverse as every other population group. They come from all sorts of backgrounds, walks of life, cultures and language groups. They have walked different paths of life experience, education, values and beliefs. They even differ in age — an Aboriginal Australian may be thought ‘old’ who is younger chronologically than non-Aboriginal Australians considered to be older people. It is not uncommon to hear people talk about young 80 year olds and old 65 year olds. These differences are important to understand if the system is to respond effectively to the diverse health needs of ‘older’ people. Services that use age as a criterion for inclusion or exclusion may not deliver the most appropriate health care response.

Even on the spectrum of natural distinctions such as gender, ethnicity and physical strength, ageing would rank last in terms of its distinguishing capacity.

Perceptions of ageing are entwined with societies’ cultural and social values. Australian society values people for their ‘doing’, their ability to be used as productive labour. Some recent papers paint a gloom and doom picture of the unsustainable demands the growing population of older, non-doing people will place on the community, even though there are many countries where older people are valued as an integral part of the community fabric.

It is easy to be alarmist about the demographic changes headed Australia’s way, dwelling on the negative aspects of an ageing population over the first half of the 21st century. Many pages of various reports have been filled with the impending decrease in the ratio of workers to non-workers, rising pension and health care costs and declining tax revenues.

Non-doing can make retirement confronting. Who are you when you retire? What is your identity, value, purpose or reason for being? Fundamentally spiritual questions confront people as their life track changes. Reflecting on past choices, opportunities and disappointments, and confronting the question...
of what that means can move sharply to a new point of viewing, linked to one's mortality. Other, pragmatic issues linked to retirement include financial security, housing and accommodation alternatives such as nursing homes, transport, health care, relationships, friendships and community linkages. These can also cause stress with resultant impacts on health and wellbeing.

Physical ageing often results in less energy, reduced capacity of concentration, forgetfulness, hearing loss, sight loss, reduced flexibility, need for longer recovery and loss of strength. These expressions of ‘normal biology’ impact on health and wellbeing. The development of more severe health conditions such as osteoporosis, arthritis, heart disease, blood pressure problems, diabetes, cancer, stroke, can create crisis points in people’s lives.

Who identifies these things? Who responds to the needs of individuals undergoing such life changes? We all do.

Not all of these issues require a medical response. Some require a community level response, either informal or formal, or a social health response. For example, an older person who can no longer maintain her garden or home but is otherwise able to stay in her own home can be easily supported to do so. The support might come through the assistance of neighbours, friends or families; the person might afford to pay some one to take care of these needs, or she might receive a more formal service response, possibly coordinated by local government.

Those broader social health issues are primary in ensuring the capacity, engagement and wellbeing of older people within communities. They will have limited impact if points of access are unknown to the person seeking help or are complicated, unclear, confusing or unavailable in their community. These issues need to be dealt with at the community level where potential navigators do exist to help older people find the right place to address their social health needs, at the right time.

Local government officers, it appears, are invoked frequently as community navigators, guiding people about what you can get and where to ask for it. Some have remarkable networks of volunteers for whom active ageing involves looking out for others. Staff in regional and community health services, and the range of people in various non-government, charitable and other service organisations also provide navigation roles. In local communities, not least in rural districts, individual members of various social, sporting and other clubs are also nurses or ambulance workers who have local knowledge and credibility and provide the same helpful navigating capacity. This kind of activity sits on top of a widespread willingness in South Australia to regard health services as common goods, not private commodities.

Failure to address the social or primary health needs and issues can result in premature, unnecessary contact with more medically intensive, more expensive levels of the health system. An older person unable to maintain her home may find herself, as time goes by, living with inadequate water and heating, or perhaps a hole in the roof. Winter comes, accompanied by pneumonia, an ambulance trip and a stay in hospital. Discharge from hospital may be to an environment that does not provide adequate social supports. The only option, then, may be referral to a nursing home or other aged care facility. This person’s needs could be addressed with connected arrangements focused on primary care.

People come under notice at numerous points of entry into the health and welfare system, ranging from a visit to the general practitioner for flu vaccine, request for the pension, an inquiry to a council help service, midnight admission after a stroke or an Aged Care Assessment Team authorisation for a changed grade of accommodation or support. The current and future needs of people will vary and
may not necessarily be appropriately identified or responded to. The response is more likely to be based on where and why they enter the system rather than enabling a whole-of-system primary care response. This is partly due to health and welfare services being organised along categorical lines.

There are certified professions, designated institutions, criteria of eligibility and so on. The Commonwealth has age-based formulae for the provision of varying grades of accommodation. The state has formal arrangements about who is responsible for service to specified regions of a long, thin city in the south-east corner of a very long, wide territory. This categorical, formulaic approach is clearly rational but less clearly helpful. Greater flexibility and linkages are needed to avoid squeezing people, and needs, of varied shapes and sizes into systematic square holes. It is a fact that the population is living longer and as a result people are ‘older’ longer. The life path over these ‘older’ years cannot be assumed to be one of linear decline.

A railroad through ageing is not appropriate, but the current system does not offer enough interchanges for the different pathways. People will need to change trains as their needs move from being a valuable volunteer, to locked-in caring for a partner, to hostel care to medical intervention, back to hostel care for themselves, to medical intervention, back to hostel, on to one or another level of nursing dependency. When the tracks are too rigid, people will not be able to rejoin the system if they get off the first train they boarded. If support is not to create dependency, it must be responsive and flexible, whether it involves a single item of service, an extended period of support or a major change of location. For example, the ‘up-front fee’ for sheltered accommodation makes sense in the discourse of markets and secure titles, but gives little chance for people at a watershed in their life to test the water before selling their major asset.

If the problems are medical, a good general practitioner who remains accessible at further stages will be a help but good general practitioners, themselves, find it hard to keep up with the doors and handles. Where general practitioners are pressed between community care needs and the problems of older patients that are more clearly medical, there is some risk that the resort to hospital will happen too early.

There was literature in the 1990s that made assertions that older people will consume great amounts of medical and hospital care in the last year of life. Most of these assertions originated outside of Australia where medical and hospital settings are more privatised and less supportive of people with limited means. In these international settings, the lack of accessible services, appropriately staged and funded over the last ten years of life, inevitably led to crowded, more intractable and more costly needs into the last year. This also brought the last year on earlier.

**The future**

Appropriate care for older people sits comfortably within the GHR system reforms, that set out from where need appears, rather than from where services are supplied.

*Policy which is driven by the needs of the state, uninformed by the population it affects, is likely to be categorical, bureaucratised, professionalised and inflexible in the face of the rapidly changing age and health patterns of older populations.*

*Trust is more likely if the service is regionalised to a scale where people have a fair chance of knowing a neighbour for whom it is working or being able to talk to a ‘governor’ or advisory board member whose plaudits and complaints will reach the ear of a responsible officer.*
**Case Study A**
Mrs A lives in a small semi-urban community an hour from the central business district. Mrs A is a widow and has recently joined the bowls club. The president of the ladies bowls team who was previously a district nurse is a known ‘system navigator’. Over the years Mrs A begins to reduce her attendances at bowls and the president notes this and mentions it when they next meet. Mrs A says that failing eyesight forced her to give up her driver’s licence, so the president arranges for Mrs A to be given a lift to bowls on a regular basis but enquires about the impact of her diminishing eyesight on other aspects of her wellbeing. She tells Mrs A that a visiting social worker, who attends the local general practice once a week as part of the new regional primary care network can link her into various services to help her cope with managing the house. Mrs A, already more confident, rings her general practitioner’s office to ask for an appointment with the social worker.

**Case Study B**
Mr B has cancer. He lives in a rural township where he first met the specialist at the integrated community care service. The specialist was a visiting provider who had been making regular visits to the town during the past few months, after the primary care network identified a number of cancer patients in the area and the clinical planning network on cancer developed a planned approach to services for them.

Mr B is having a planned admission to a metropolitan hospital to undergo some interventions. The general practice in the primary care network is managing the pre- and post-admission planning together with the local physiotherapist. The general practice is linking directly with the specialist. Mr B regularly visits his general practitioner and the physiotherapist in the primary care network has coordinated his needs for transport to hospital and the care of his house and dependent wife during his hospital stay.

**Case Study C**
Mrs C has been caring for her husband full time for the past two years. In recent months he has become bedridden. About 3 years ago, he lodged a living will with his general practitioner and it was recorded on his electronic health record. A palliative care nurse visits once a week to see how Mr and Mrs C are doing. The nurse’s notes on these visits are added to Mr C’s electronic health record so that all members of the primary care network are informed of changes in his health status. Mrs C is worried about his impending death and feels quite stressed. The palliative nurse takes some extra time to discuss these issues with her and agrees to visit twice a week to enable them to talk more. The nurse also asks her about her religious beliefs and if there is anyone else she can speak with. As a consequence of these conversations one of the town’s chaplains drops in to visit.

The palliative care nurse soon discovers that Mrs C is worried about being alone when Mr C dies, not knowing what to do and being frightened. They discuss her fears and talk through different options available to her. Mrs C decides to call her sister in Adelaide to see if she will come and stay with her later on — and that gives her some comfort and a sense of security. She is worried how she will cope and what she will do in future but feels guilty thinking of herself when her husband is so ill. Talking with the chaplain and nurse — and more frequent conversations with her sister — sustains her and helps her to explore ideas rather than feeling alone and guilty about her thoughts of a future without Mr C.

**Case Study D**
Mrs D is 84 years old and lives alone. Her family is concerned that she is becoming increasingly frail and forgetful. She is on a number of medications and they worry about her safety.

Mrs D’s general practitioner has had several discussions with her about her living arrangements but she is adamant that she wishes to stay home and not go to a nursing home.
One day, Mrs D trips on her back step and falls, fracturing her hip. She is admitted to the nearest acute hospital and her general practitioner is notified by email. While the fall affects her confidence, she remains keen to return to her unit. Her family is keen for the doctors at the hospital to have her admitted to a nursing home.

Mrs D is transferred after only a few days to her nearest integrated community care centre, for a comprehensive rehabilitation and strengthening program. The care plan is managed by her general practitioner in partnership with an aged care and rehabilitation specialist. RDNS and Domiciliary Care liaison nurses at the centre participate in a case conference, along with Mrs D's community pharmacist, prior to her discharge and a comprehensive discharge plan is made. Mrs D and her family are also involved in these discussions. Mrs D's medications are reviewed, a visit is made to her home to assess for falls prevention and a range of improvements are made. A number of other support mechanisms are put in place, including companion volunteer visitors to monitor her progress and assist her daily activities.

Mrs D returns home on half the medications she was on previously, feeling much stronger and more confident than she had been prior to the fall. Her general practitioner is keeping a careful eye on her wellbeing as she is concerned that Mrs D may have the early stages of dementia.

The following issues may require further consideration:

- high need consumers
- rehabilitation and restorative care
- palliative care.

If private providers in aged care exclude high need consumers because they are ‘too costly’ and ‘too hard’ for services to manage, it falls on the state to provide an appropriate response. To address these issues with greater civic decency, it may be necessary to have a statewide population network to examine and address needs across the state in order to provide appropriate service responses. The same applies to rehabilitation and palliative care. Both would fall within a clinical planning framework and would need to be addressed on a statewide level. The emphasis of the proposed system is to link acute and speciality services across the state to enable appropriate linkages and services at the regional level. If the needs of older people are to be adequately addressed it is essential that both rehabilitation and palliative care are given appropriate attention.

Rehabilitation and restorative care is essential to aid older people moving in and out of acute care to re-establish themselves at the highest possible level. There will be a direct link to and role for primary care networks in providing support and assistance. Failure to address this issue will result in the avoidable use of acute hospitals and potentially unnecessary or early admissions to nursing home facilities.

Palliative care is another essential service because it empowers people and helps to maintain quality of life in extremis. Palliative care is often associated, inappropriately, only with institutionalisation and death but is a required health service and, for some people, an option chosen over medical intervention. It can allow them to make choices about their health care and can sustain quality of life up until the moment they die. It is said that some older people die in hospitals because it is not possible for them to have an alternative, but there are some developments in the provision of palliative care outside teaching hospitals already underway. Extension of that option will require financial support but may be balanced by the reduction of pressure on more costly acute settings.
Two palliative care projects of interest are the Australian Palliative Aged Care Project and the Caring Community Palliative Care grants. The Australian Palliative Aged Care Project is looking at the development of guidelines for palliative care in residential aged care and staff education. To date, no guidelines for implementation of palliative care in aged care facilities exist and there are no specifications for how staff should be trained in palliative care. There is a need to develop a systematic approach to palliative care education for this workforce.

RDNS has been awarded a Caring Community Palliative Care grant to train caseworkers in palliative care in an effort to keep people in the community longer as their needs increase. This project is due to start soon.

Proposals for workforce and research are particularly relevant to the wellbeing of older people. Workforce explores development of new types of workers to enhance a multidisciplinary approach to care and seeks to reduce levels of professional separation. Research and the development based on social enquiry endorses the potential of consumers as active participants in research, in a fashion that outcomes research obscures.

A focus on the social determinants of health and a whole-of-government response to them will encourage the development of research that explores policies in areas other than health and how they affect healthy ageing. This includes the impact of physical environmental factors related to the independence of people as they grow older, macro-sociological studies of retirement, gender, class and ageing, and explorations of how people manage and spend their time post-retirement. Exploration of these broader issues and the development of knowledge about the variable trajectories through ageing and desirably flexible responses will foster services that sustain successful ageing until ‘the least worst death’.

The GHR has recommended the formation of a joint Commonwealth–state body to provide a shared approach to health issues. This will be particularly important for the development of services for older people and designing flexibility into structures and programs to ensure they work on the ground. The complexity of aged care services, funding sources, bodies and various accountability frameworks and guidelines is a major barrier to the development of seamless services for older people.

State and Commonwealth relations is one aspect of these, and services for older people should be a priority issue for such a body. Local government and the range of non-government and charitable providers will be best included at the local level through primary care or other appropriate networks and planning processes. At the statewide level these bodies will also need to be included in the development of future plans which impact on older people.
### APPENDIX 6: Sorting and prioritising of key recommendations

**Category 1**

<table>
<thead>
<tr>
<th>Recommendations without predecessor/within budget</th>
<th>Implementation</th>
<th>System reform need</th>
<th>Change indicator</th>
<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12 months</td>
</tr>
<tr>
<td>2.10 DHS commit to a multi-year health program budget cycle for Aboriginal health services as a priority.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP – long term</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>4 – 10 years</td>
</tr>
<tr>
<td>3.4 DHS establish a public and environmental health division to enhance capacity to lead and coordinate public and environmental health across the state.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>6 months</td>
</tr>
<tr>
<td>3.7 DHS ensure that the proposed primary health care policy underpins and drives the recommended health system reform agenda.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>6 – 12 months</td>
</tr>
<tr>
<td>3.12 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>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP – ongoing</td>
</tr>
<tr>
<td>3.13 DHS establish networked clinical service groups, as appropriate, including a networked group for pathology services.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP – ongoing</td>
</tr>
<tr>
<td>3.14 DHS continue with the development of the service delineation guidelines on advice from the clinical senate and the state community council.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP</td>
</tr>
</tbody>
</table>
### Recommendations without predecessor/within budget

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Implementation</th>
<th>System reform need</th>
<th>Change indicator</th>
<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>3 months</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>2 years</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>3 months</td>
</tr>
<tr>
<td>6.2 The State Government provide regular and public reporting on progress against whole-of-government benchmarks.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>3 months</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>ASAP</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>2 months</td>
</tr>
</tbody>
</table>
### Recommendations without predecessor/within budget

<table>
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<tr>
<th>Category 1 (continued)</th>
<th>Implementation</th>
<th>System reform need</th>
<th>Change indicator</th>
<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.6</strong> DHS in partnership with Aboriginal health advisory committees:</td>
<td>Easy</td>
<td>Diff</td>
<td>High</td>
<td>Low</td>
<td>Yes</td>
</tr>
<tr>
<td>- ensure there are no changes to rural and remote Aboriginal health advisory committees unless requested by relevant communities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- establish Aboriginal health advisory committees aligned with metropolitan regions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- ensure the recommended legislation incorporates the protection and validation of Aboriginal health advisory committees.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>6.8</strong> Regional health services work in partnership with Aboriginal communities to ensure effective representation of the communities and their interests on regional health boards.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>6.10</strong> 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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>6.14</strong> 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.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
## Category 2

<table>
<thead>
<tr>
<th>Recommendations with predecessor/within budget</th>
<th>Implementation</th>
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<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Easy</td>
<td>Diff</td>
<td>High</td>
<td>Low</td>
<td>Yes</td>
</tr>
<tr>
<td>2.1 DHS establish a regional configuration of six rural and remote regions and three metropolitan regions as defined in Appendix 4.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2.12 DHS develop the governance arrangements outlined in the Chapter 2 of the report (see full recommendation)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3.11 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>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4.3 DHS develop a comprehensive performance management approach to ensure achievement of key performance targets by regional health services.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5.2 DHS establish a statewide health workforce planning group (see full recommendation).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Recommendations without predecessor/ budget implications

<table>
<thead>
<tr>
<th>Recommendation</th>
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<th>Change indicator</th>
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<th>Duration of implementation</th>
</tr>
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<tbody>
<tr>
<td><strong>Category 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 DHS develop and implement a population health funding model to inform</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1 – 5 years</td>
</tr>
<tr>
<td>funding at the regional level, commencing with acute inpatient services and</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>progressing to a comprehensive approach in line with the key output classes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the health system.</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.13 DHS provide drafting instructions for new legislation to replace the</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>6 months</td>
</tr>
<tr>
<td>SAHC Act and incorporate provision for the establishment of the new</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>governance structures and processes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 DHS implement the Strategy for managing metropolitan hospital workload.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>ASAP – ongoing</td>
</tr>
<tr>
<td>3.2 DHS establish an out of hours statewide health call centre, providing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>6 – 12 months</td>
</tr>
<tr>
<td>telephone triage and referral services, supplemented by advice on self-care</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and information about service availability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 The State Government, through DHS, work with the Divisions of General</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>3 years</td>
</tr>
<tr>
<td>Practice and the Commonwealth Government to develop strategies that enable</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>general practitioners to be partners in networked primary care services,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>including primary care centres.</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9 DHS initiate discussions with the SA Department of Treasury and Finance</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>3 – 6 months</td>
</tr>
<tr>
<td>to secure adequate parallel funding to maintain existing acute care services</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at current levels and to enable transition to the proposed primary health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>care focused system.</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.15 DHS review the existing statewide information technology plan and</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>3 months – 6 years</td>
</tr>
<tr>
<td>prioritise the resources required for statewide connectivity within five</td>
<td>Diff</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>years.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Recommendations without predecessor/within budget

<table>
<thead>
<tr>
<th>Recommendation</th>
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<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.17</strong> DHS implement a statewide capital investment plan to deliver the proposed health system reforms.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>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.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td><strong>4.1</strong> 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.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td><strong>4.6</strong> 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.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td><strong>4.12</strong> DHS develop a strategy for coordinating ongoing public information and education across the health system.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td><strong>5.5</strong> DHS provide a focus on the development of the Aboriginal health workforce (see full recommendation)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td><strong>6.15</strong> 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.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>
### Category 4

<table>
<thead>
<tr>
<th>Recommendations with predecessor/ budget implications</th>
<th>Implementation</th>
<th>System reform need</th>
<th>Change indicator</th>
<th>Legislation</th>
<th>Duration of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8 DHS provide funding in the first year of reform to initiate the development of networked primary care services.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>1 year</td>
</tr>
<tr>
<td>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.</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>ASAP – ongoing</td>
</tr>
</tbody>
</table>
APPENDIX 7: Special thanks

Altamura, Ms Christine, DHS
Andrews, Dr Jane, Royal Adelaide Hospital
Baggoley, Dr Chris, RAH
Bastian, Mr John
Beltchev, Mr George, DHS
Cappo, Monsignor David, South Australian Social Inclusion Unit
Champion de Crespigny, Mr Robert
Diamond, Mr Mark, Wakefield Regional Health Service
DiSisto, Mr Nino, Riverland Regional Health Service
Eades, Mr Michael, Leigh Creek, Quorn, Hawker Health Services
Eglinton, Mr Kevin, Hills Mallee Southern Regional Health Service
Ellis, Ms Marj, Adelaide Central Community Health Service
Francis, Mr Bevan, Northern and Far Western Regional Health Service
Frith, Dr Peter, FMC
George, Archbishop Ian, Anglican Archbishop of Adelaide
Hicks, Dr Neville, The University of Adelaide
Hodgson, Ms Meredith, Mid North Regional Health Service
Kirchner, Mr Roger, Mid North Regional Health Service
Marshall, Prof Villis, RAH
Martin, Ms Kae, DHS
Menadue, Ms Maxine, DHS
Nikolof, Mr Atanas, DHS
Neilson, Mr Tom, South East Regional Health Service
Phillips, Dr Pat, TQEH
Richter, Ms Jenny, DHS
Roberton, Prof Don, WCH
Stewart, Mr Gary, Eyre Regional Health Service
Stubbs, Dr Tom, DHS
Taylor, Mr Bill, RDNS
Van Eyk, Ms Helen, DHS
Yates, Mr Ian, Council on the Ageing

GHR also wishes to acknowledge the significant contributions by DHS staff in relation to content and infrastructure support to the GHR secretariat.
FOOTNOTES

263 Hicks, Neville Ageing, well-being and research. A supplement to Australian Society, December 1991


266 It may be generational: the cohort of present older volunteers are of an age to remember Australian analogies to Titmuss, R.M.: The Gift Relationship who argued that the remarkable level of donations to the British blood bank was underpinned by people who saw it as ‘giving back’ for the benefit they had gained from the National Health Service 1973


268 Stacey A.F Enhancing the Health of Informal Carers: implications for general practice, policy and public health in the 21st century drawing on extensive enquiry among GPs in a metropolitan division of Adelaide, reports a frequent comment by them about the difficulty of staying abreast with options of potential help to their patients or the patients’ carers – notwithstanding recent initiatives such as Enhanced Primary Care or Carelink (MMSc) Adelaide 2001


270 op cit Ageing, well-being & research p10.

271 Response from a commentator on the GHR’s Ageing Roundtable.

272 For example consumers with multiple conditions, mental and/or physical disabilities requiring a range of service responses.

273 See Australian Palliative Aged Care Project website at www.apacproject.org

274 Dr Diane Gibson, head of the Aged Care Unit in the AIHW, provides in Aged Care: old policies, new problems (Cambridge Melbourne 1998), 151-165, a sharp critique of the logical and practical weakness of outcomes measures in aged care, compared with the methodological neatness for which it is espoused. We have preferred the term social enquiry to indicate an approach that seeks to report humanly the situation of the relevant individual and examine it critically, so as to reveal context, circumstance and process – as well as outcome.