REVIEW OF NON-HOSPITAL BASED SERVICES

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ACRONYMS

Acronym	Definition
ASO	Administrative Services Officer
ATSI	Aboriginal and Torres Strait Islander
CaFHS	Child and Family Health Services
CALHN	Central Adelaide Local Health Network
CEO	Chief Executive Officer
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
DECD	Department of Education and Child Development
DHA	Department of Health and Ageing
EACH	Extended Aged Care at Home
EPC	Enhanced Primary Care
GP	General Practice
GPS	GP Plus Services
HIV	Human Immunodeficiency Virus
ICCOP	Integrated Complex Care of Older People
LHN	Local Health Network
LMH	Lyell McEwin Hospital
MAST	Mobile Assessment and Support Team
MBS	Medicare Benefits Schedule
NALHN	Northern Adelaide Local Health Network
OPAL	Obesity Prevention and Lifestyle
PBS	Pharmaceutical Benefits Scheme
SAHP	South Australian Health Care Plan
RDNS	Royal District Nursing Service
SALHN	Southern Adelaide Local Health Network
TEQH	The Queen Elizabeth Hospital
WCHN	Women's and Children's Health Network

CHAPTER 1

BACKGROUND

On 27 August 2012 Cabinet commissioned an independent review of non-hospital based services.

The key priority outcomes for the review are to:

1. Gain an understanding of the range of metropolitan non-hospital programs currently in place.
2. Identify the scope and cost of delivery for each specific services.
3. Establish an evaluation framework against which the non-hospital services can be assessed for effectiveness and efficiency, including an assessment of the productivity of each program.
4. Identify the services that have a direct impact on hospital services in accordance with the Independent Hospital Pricing Authority definition of non-admitted patient services.
5. Develop recommendations to assist in achieving sustainable, effective and efficient services into the future identifying any services that have reached the end of their effectiveness.
6. Identify those services that can no longer be justified given the financial situation of the State Budget.
7. Identify the risks and potential community response with ceasing any services.

SA Health currently has two non-hospital based funding allocations:

- primary/Community Health services, which are provided across a range of disciplines and a variety of settings, including the traditional community health centre services established about 30 years ago. These services have not been reviewed for many years with services provided from a range of facilities, including office based or shop front type facilities.
- GP Plus services, which have been developed over the past four years to proactively manage patients in the community with the objective of reducing the demand for hospital admissions or to enable early discharge from hospital. There are six GP Health Care Centres and Super Clinics located across the metropolitan area.

CHAPTER 2

OPERATING ENVIRONMENT

There are many factors which influence the operating environment in which non-hospital based services are provided. The most significant for the purposes of this review are discussed below:

BUDGETARY CONSTRAINTS

SA Health has been set a very challenging savings target over the forward estimates. Considerable progress towards the achievement of the target has been made but if it is to be met it is essential that every aspect of Health SA's operations is reviewed – including head office and regional corporate structures – and this review is part of that overall objective.

In this general context it is worth noting that it has been many years since a comprehensive review of non-hospital based services has been undertaken. Although the terms of reference discussed above make it clear that this review is as much about program efficiency and effectiveness as it is about savings, the requirement to identify savings is nevertheless an inescapable component of the exercise. The significance of this is that some difficult choices will have to be made; if they are not a greater burden will fall on other areas of the department or on other departments in the South Australian public sector. A robust, transparent and consistently applied evaluation framework is therefore critical to the achievement of the review's objectives. This is discussed further in the following sections.

COMMONWEALTH/STATE RESPONSIBILITY FOR PRIMARY HEALTH CARE

An important contextual factor for this review is the role of the Commonwealth Government in the primary health care space and, more to the point, how that role might evolve in the medium term.

Historically, the Commonwealth has been responsible for supporting general practice services and the States have been responsible for supporting allied health services and a wide range of community health services including child and maternal health, parenting support, early childhood programs and disease prevention programs.

Today, all levels of government continue to make significant contributions to primary health care services. The Commonwealth does this through the MBS and the PBS and through funding medicare locals, through specific program funding to non-government organisations and private providers of health services, as well as through payments to the States.

A contemporary expression of the Commonwealth's role is provided in the 2011 National Health Reform Agreement. Under that Agreement, the main elements of the role are described as follows:

- the Commonwealth will take lead responsibility for system management, funding and policy development of GP and primary health care with the objective of delivering a GP and primary health care system that meets health care needs, keeps people healthy, prevents disease and reduces demand for hospital services;
- the primary instrument for achieving this is medicare locals. The role of medicare locals is to develop integrated and coordinated services; support clinicians and service providers to improve patient care; identify the health needs of local areas and facilitate the implementation of primary care initiatives and services; and
- the Commonwealth is to develop by the end of this year [2012] a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care. In the meantime the State is to refrain from establishing any further duplicate GP or primary health care planning and integration organisations.

Thus on a literal and preliminary reading it would be reasonable to conclude that in terms of both direct service provision and funding and policy and planning, the Commonwealth's role will progressively increase over time – or, at least that is the way it is trending. An equally valid interpretation, however, is that while medicare locals will focus on population health and integrated planning, they will not be providing services and especially not to the particularly disadvantaged groups that attend State-funded primary health care services. Under this (and, possibly, more likely) scenario the State will continue to be responsible for both the funding and provision of a significant part of the primary care service spectrum for the foreseeable future.

Some more light on how the division of responsibility might look in the future is provided in a draft consultation paper recently released by the Commonwealth as foreshadowed in the National Health Reform Agreement. The paper acknowledges the evolving role of the Commonwealth through the medicare locals but asserts that the States will continue to be responsible for providing "a range of community health services that provide primary health care including health promotion services and services that help maintain community health and wellbeing"[1]. The process by which the detail of who does what is to be developed in a bilateral agreement that is due for completion by the end of the 2013 calendar year.

[1] National Primary Health Care Strategic Framework Consultation Draft 2012 – Commonwealth Department of Health and Ageing.

Although the trend is towards increased Commonwealth involvement in both the funding and provision of primary health care services (in addition to its more widely accepted role of service planning and integration), it is clear that the State will continue to have a significant role for the foreseeable future. Nevertheless, in preparing for the coming negotiations with the Commonwealth, it is entirely appropriate for the State to review its current suite of primary health care services and to reach a position on its priorities and on how it wishes to allocate its scarce State dollars. Part of that process will involve a State view on what primary healthcare services should be provided by the Commonwealth within the framework of the relevant National Partnership Agreements.

In this context it is instructive to note that the Queensland Minister for Health announced on 24 September 2012 that the Queensland Government looked to the Commonwealth for a greater contribution to primary promotion measures and to allied health. The Minister announced a range of cuts to State programs including chronic disease prevention which he said now fell within the domain of the Commonwealth Government.

RELEVANT STATE BASED INSTRUMENTS AND DOCUMENTS

In addition to the changing nature of the relationship between the Commonwealth and the State, the operating environment is also shaped, as would be expected, by a number of State based policy instruments, documents, strategic plans and the like that have been promulgated over the years. Because health is such a rapidly changing environment and because many of these plans have extended time frames (Palliative Care Services Plan 2009 – 2016 for example), some of the originally stated objectives have been overtaken by more recent shifts in strategic policy and direction. Nevertheless, much of the content remains relevant and therefore to assist in an understanding of the operating environment in which non-hospital based services are delivered, following is a brief summary of the broad policy intent of the relevant documents:

SOUTH AUSTRALIA'S HEALTH CARE PLAN 2007–16

South Australia's Health Care Plan 2007–2016 outlines among its objectives reducing the demand on hospital and emergency departments and the improved management of chronic disease through the development of GP Plus Health Care Centres and out of hospital services. The focus of these services is to provide chronic disease management services to keep people well and out of hospital and provide more in-home care and health support packages to enable people to be cared for at home instead of in hospital.

GP PLUS HEALTH CARE STRATEGY 2007

This theme is further developed in the GP Plus Health Care Strategy 2007. The emphasis is on an accessible health system which relieves the demand on hospitals and complements the work of General Practice to prevent and manage common chronic conditions and to increase prevention and early intervention services to promote good health. The strategy aims to improve the coordination and integration of services through partnerships with services across government, with the private sector, non-government organizations and Commonwealth government.

CHRONIC DISEASE ACTION PLAN FOR SOUTH AUSTRALIA 2009–18

This whole of system approach is supported in the Chronic Disease Action Plan for South Australia 2009–2018. The focus for this plan is on services and strategies for those with or at risk of chronic disease. The priority is those diseases which cause the greatest burden of disease, are preventable and share common risk factors. These diseases are identified as: cardiovascular disease, diabetes, chronic respiratory disease and musculoskeletal disease. The plan has an emphasis on vulnerable populations at greater risk of chronic disease with the aim of reducing the health inequalities between the most and least advantaged.

PRIMARY PREVENTION PLAN 2011–16

The Primary Prevention Plan 2011–2016 aims to improve the health and well-being of South Australians and reduce inequalities in health outcomes through a combination of healthy public policy approaches such as the Safe Drinking Water Act and targeted service delivery responses that focus on vulnerable populations. These targeted responses address inequalities in health by prioritizing high need communities. Using effective health promotion strategies to support good health and reduce the conditions that contribute to poor health such as smoking; risky alcohol use; under nutrition; obesity; poor oral health; and lack of physical activity is a key component of this plan.

PUBLIC HEALTH PLAN

The new *South Australian Public Health Act 2011* provides that a State Public Health Plan be developed to provide for an effective system for ongoing and coordinated public health planning across this State linked to public health planning to be undertaken by Local Councils. The focus of the State Plan will be on prevention, on the underlying causes and determinants of communicable and non communicable disease, and on taking coordinated action to address them. It is also focussed on building capacity to respond to public health challenges in partnership between State and local government and other public health partners potentially including NGOs and medicare locals. The First State Public Health Plan is due for release early in 2013.

OTHER PLANS

There are a number of other plans that include the key themes of chronic disease management, hospital avoidance and health promotion services for specific population groups such as older people, people with palliative care needs and people who have had or are at risk of Stroke. Common to all these plans is the need to deliver the right service, at the right time and in the right place.

CHANGING MODELS OF CARE

Inherent in the various plans and strategies discussed above is a recognition that traditional service models may no longer provide the optimal form of patient care. There is an extensive literature on how models of care are being adapted to meet modern circumstances. Described here (with some modification) is a model of care developed for the new Royal Adelaide Hospital[2]. Although hospital centric, its principles apply equally to the primary health care sector. It is included because it provides useful additional context against which to assess the current suite of non-hospital based services.

The SA vision is to create an integrated Health Care System in SA that will be recognised nationally and internationally as an example of best practice in terms of:

- patient-centred care;
- access;
- integration;
- safety and quality;
- innovation; and
- value for money.

Guiding Principles of the new vision:

- it encompasses a whole system redesign;
- care is integrated across disciplines, sectors and organisations;
- patients are at the centre of the system;
- evidence informs decisions and practices [underline mine];
- the workforce is supported to become more flexible and involved in shaping the future; and
- partnerships with other providers, industry, universities and other key stakeholders will be actively promoted.

Modern models of care are about striving for clinical excellence through a patient-centred model within a creative organisation that has the ability to incorporate clinical and technological change.

The model relies on maximising the use of leading edge, evidence based, information systems to support patient centred care.

[2] Models of Care for System Transformation: a Background Paper, SA Health, 2011, p2.

CHAPTER 3

METHODOLOGY INCLUDING REVIEW SCOPE

NON-HOSPITAL BASED SERVICES DEFINED

Non-hospital based services, or primary health care services to use a more traditional term, are defined by the World Health Organisation in its Alma-Ata declaration of 1978 as:

- *Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*[3]

In the Australian context, a commonly used definition from the Australian Primary Health Care Research Institute is:

- *Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.*[4]

[3] World Health Organization, 1978. Declaration of Alma Ata, International conference on PHC, *Alma-Ata*, USSR, 6–12 September, available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

[4] Definition developed by the Australian Primary Health Care Research Institute for ADGP Primary Health Care Position Statement 2005, also included in the Australian Medical Association Primary Health Care position paper, 2006.

NON-HOSPITAL BASED SERVICES BY CATEGORY

It is not proposed to list each of the 235 individual services that fall within the definition of non-hospital based services. Instead the services are grouped into the following service categories which, taken together, provide an overview of the services which come within the scope of the review:

Table 1 Non-hospital based services by category

SERVICE CATEGORY
health promotion activities including information sessions, training for staff in childcare settings and general community education and lifestyle advice to support increased activity and improved nutrition
health promotion activities including brochures, websites and information sessions to support parenting skills such as breastfeeding
health promotion activities for Aboriginal people including smoking cessation, healthy diet and activity and support to undertake chronic disease management services
Health Promotion activities such as community education and staff training to improve identification of health issues for youth
general counselling services including for people with anxiety and depression
counselling services for vulnerable populations including women and youth
diabetes education and symptom management
cardiac disease education and symptom management
respiratory conditions, education and symptom management eg asthma and emphysema
hepatitis C education and symptom management
other chronic disease education and symptom management
clinical services for children's health issues such as asthma, speech issues and nutrition
clinical services for women's health issues such as continence and cervical screening
clinical services for youth
clinical services for people newly arrived in Australia – including screening and connection to ongoing services
clinical medical and nursing services for Aboriginal people including chronic disease screening and management
in home services to support discharge from hospital eg. nursing care and equipment
clinical services and education to minimise falls and decline in function in older people
case management programs that provide more individualised support for people with complex conditions related to age, chronic disease, homelessness or other factors, to prevent frequent use of hospital
sexual assault support and clinical services
palliative care in home support to manage symptoms to avoid hospital
rehabilitation services
child protection services – clinical assessment, support and counselling
hospital flow programs to support flow of patients to alternative services avoiding admission or minimising length of stay in Emergency
programs to support General Practice with a focus on chronic disease management
clinical support and education to support people who live in residential care facilities

SCOPE AND FUNDING

The 2012–13 preliminary funding allocation for non-hospital based services is approximately $216m. However, a number of services have been excluded from this review on the basis that they have already been reviewed or will be subject to an internal review. These services include the SA Dental Service, Breast Screen SA, Drug and Alcohol Services, Royal District Nursing Service, SHine SA and country services. A full list of exclusions is itemised in Table 2. Once these programs have been excluded, 235 programs fall within scope attracting funding of $78.76m in 2012–13.

It should also be noted that as part of its normal business as usual work, SA Health has already identified some of the recommendations made in this report and is proceeding with implementation. That work has been included here so that a full picture of proposed changes to in scope non-hospital based services can be presented.

Table 2 Total funding allocation for non-hospital based services 2012–13

Base Allocation Primary Health Block and GPS Funding	**$'000**	**$333,0934**
Less Stage 1 Exemptions		
By Project Definition	$'000	$'000
Drug and Alcohol Services SA	31,384	
RDNS – Shine	19,124	
SA Dental Service	64,725	
Drug and Alcohol Services SA	1,921	
SA Dental Service	248	117,401
Sub Total		**$215,693**
Less Stage 2 Exemptions		
By Project Definition	$	
DHA Primary Prevention Branch	7,348	
DHA Mental Health Prevention	1,280	
Country Health SA Local Health Network	11,452	
CALHN – BreastScreen SA	14,458	
CALHN – Prison Health	16,414	
Transition Care Program	21,906	
Aged Care Assessment Teams	8,680	
Police Drug Diversion	286	
WCHN – CAFHS	40,623	
DHA central funding– Sub Acute strategies	636	
DHA central funding – GP Plus Programs	13,847	136,931
Total In Scope Services		**$78,762**

CHAPTER 4

EVALUATION FRAMEWORK

In order to achieve a high degree of equity and transparency it was regarded as essential that each of the services in scope was assessed against a robust and uniformly applicable evaluation framework. Although there are many existing evaluation methodologies in the primary health care field these, in the main, have been designed for quite specific services, rather than having application to the totality of services that make up the primary health care sector.

Thus it was necessary to construct a unique evaluation framework that would meet the purposes of the review to give effect to both the principles of equity and transparency and at the same time to accommodate the specific tasks set out in the terms of reference.

Of equal weight was the need to find a methodology that would ensure that, as far as practicable, those services which are contributing to the achievement of headline objectives in the health system are retained. For example, the SAHCP set a target of limiting growth of inpatient separations to 2% per annum. In 2006–07 growth of all separations across South Australia was 3.3%; in 2010–11, growth was 1.9%. In metropolitan Adelaide, a more significant result is seen, whereby growth in inpatient activity fell from 4.6% in 2006–07 to 1.1% in 2010–11. These results are set out in Table 3.

Table 3 All inpatient separations in South Australian Public Hospitals

Financial Year	Metro Hospitals	Country Hospitals	Total Hospitals	Metro Growth	Annual Growth
2005/06	259,648	85,501	345,149	–	–
2006/07	271,717	84,934	356,651	4.6%	3.3%
2007/08	280,659	86,885	367,544	3.3%	3.1%
2008/09	286,629	87,111	373,740	2.1%	1.7%
2009/10	292,116	90,939	383,055	1.9%	2.5%
2010/11	295,599	94,555	390,154	1.1%	1.9%

Date excludes chemo and scopes

More recent data for 2011–12 show a sharp increase to 4.1% for metro growth. It is too early to tell whether this is a spike or a return to longer term averages. Nevertheless, the results achieved between 2007 and 2011 are impressive. There is strong evidence that these separation outcomes are a direct result of increased investment in the primary health care sector in recent times and it would be self defeating at best to disinvest in those programs which are contributing to this result. Thus the focus in the evaluation framework on avoiding hospitalisation, improving management of chronic disease and positive and measurable impacts on population health has meant that some services that may have benefits beyond the health setting, or for which there is no evidence of a productive outcome, have been recommended for funding cuts.

With this background in mind the evaluation framework adopted for this review is as follows:

1. FIRST TEST

The first test is to screen each service according to the following criteria:

- is it consistent with current primary health care policy and strategy (and in particular avoiding hospitalisation, improving management of chronic disease, resulting in positive and measurable impacts on population health) set out in various high level policy documents including South Australia's Healthcare Plan 2007–16 and the GP Plus Health Care Strategy 2007 modified as necessary by contemporary developments in models of care and the future role of medicare locals? and
- should the program continue to be undertaken by the State now or into the future having regard to the division of responsibility for primary health care between the Commonwealth and the States as defined in the National Health Reform Agreement 2011?

Services that satisfy these criteria will then be evaluated against the second test i.e. whether there are opportunities for service modification or reconfiguration and value for money criteria.

Services that do not satisfy the first test will be risk rated (see section 3).

2. SECOND TEST

2.1 Reconfiguration opportunities

Factors for consideration under this criteria include:

- does the service overlap or duplicate other activities within either the health or other government sectors?
- are productivity improvements or cost reductions achievable through the centralisation, consolidation or similar modification of service delivery?
- are there opportunities to absorb the service within other existing services (or to combine two or more services at less cost)? and
- do eligibility and priority of access criteria fit with contemporary practices?

2.2 Value for money

Unlike the acute sector, there is no agreed standard approach to evaluating value for money effectiveness of primary healthcare services. This is due largely to the complexity and range of interventions in primary health care; the variety of objectives identified for individual services; the shortage of research evidence demonstrating intervention effectiveness; and the limited availability of validated utilisation data. Thus, the methodology will be as follows:

- first, is there any measurable evidence of service performance or outcomes? If no such evidence exists or there is no credible methodology for determining whether service objectives are being met, what other basis exists for justifying the continued funding of the service? and
- for those services for which evidence based evaluations exist, what do the data show in relation to service performance and productivity?

Services that do not satisfy the second test will be risk rated.

3. RISKS

Almost without exception, services and activities within the health sector are inter-related or connected in some form or another with other services or activities. Changes in the primary health care sector may impact on the acute sector for example or on other primary care services or on specific population groups, for example homeless people with very complex needs or Aboriginal communities with no access to local services. Thus, for those services for which the recommendation is to discontinue or modify funding in some substantial way, it is important, as part of the evaluation framework, to identify, and take account of, the impact of such decisions for other health services and community groups.

CHAPTER 5

OUTCOME OF EVALUATIONS INCLUDING RECOMMENDATIONS

Each of the 235 in scope services was assessed against the evaluation framework. This process resulted in the following services/service categories being further considered for funding modification in some form:

- Practice Nurse Initiative
- Youth Primary Health Services
- Health Promotion Services
- Children's Primary Health Services
- Women's Primary Health Services
- Residential Care Health Service Support
- General Practice Spirometry Lung Function Service
- Integrated Complex Care for Older People
- Aboriginal Workforce Initiative
- Hospital Based Services

Each of these services is now examined in some detail. A note of caution here. Each of the service categories examined is in itself a complex service system involving an array of clinical interactions and linkages across the entire health system (and beyond) built on long experience over many years. It has not been possible within the time allocated for the review (eight weeks) to reach the depth of understanding required to map out pathways in any kind of detail. We are confident that the broad directions are right. Nevertheless, it would be prudent to allow, for those recommendations that are adopted, a degree of flexibility in implementation to take advantage of the more intimate knowledge of those working in the field to whom the responsibility for implementation will fall.

PRACTICE NURSE INITIATIVE

Background

There are three practice nurse initiative programs in metropolitan Adelaide:

- Central western;
- Northern; and
- Southern

delivered via service agreements with the relevant medicare locals.

The total budget of these services is $ 2.250m.

The GP Plus Practice Nurse Initiative was an election commitment in 2007 based on a recommendation from the AMA. It was designed to enhance the provision of chronic disease care in general practice through increased access to practice nurses. It has now achieved that goal with a marked increase in practice nurse use within general practice in metropolitan Adelaide.

Assessment against the evaluation framework

Relationship with current policy

Only some of the services delivered via this initiative contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

The services do not contribute at all to the hospital avoidance objective. However, they do have a strong focus on workforce models and processes such as data collection and pathways to support chronic disease management.

Relationship with Commonwealth Policy

The Practice Nurse Initiative has achieved an increase in practice nurse uptake across metropolitan Adelaide. Since its introduction, new Medicare items and subsequent new funding incentives, such as the Practice Nurse Incentive Payment, have improved the business model for practice nurses within General Practice.

The focus of the practice nurse initiative is to support General Practice and in particular in:

- uptake of evidence based practice supporting chronic disease management and referral pathways to appropriate services; and
- delivering health promotion and illness prevention services such as vaccination and bowel cancer screening.

As such, the initiative fits squarely in the role articulated by the Commonwealth that medicare locals are intended to play.

Value for money

There are no measurable outputs specified for these services. There have been regular program reports with some evaluation of individual projects where this has been possible. However, there has been no evaluation of the overall service impact. The varying nature of the practice nurse initiative strategies, including practice visits through to development of tools and processes, means that no clear or comparable activity data is available.

Financial details

	CALHN	NALHN	SALHN	Total
	$m	$m	$m	$m
Contracted Services	0.750	0.750	0.750	**2.25**
	0.750	0.750	0.750	**$2.250**

Risk profile

There is little risk with ceasing funding for this program. As discussed above, the program was designed to enhance the provision of chronic disease care in general practice through increased access to practice nurses and was never intended to be a permanent program. It has now achieved its goal with a marked increase in practice nurse use within general practice in metropolitan Adelaide. Funding for this program should cease on 31 December 2012 and discussions to this end are already underway.

Recommendation

Funding to the Practice Nurse Initiative cease on 31 December 2012 in line with the terms of the current agreements with medicare locals and in recognition of the primary policy responsibility of the Commonwealth in this area.

YOUTH PRIMARY HEALTH SERVICES

Background

There are three youth primary health services delivered out of five sites in metropolitan Adelaide:

- the Second Story Youth Health Service (WCHN) with sites at Christies Beach, Elizabeth, City and in Youth Training facilities;
- Shopfront Youth Health and Information Service (NALHN) with a site at Salisbury; and
- Southern Primary Health, Marion Youth (SALHN) sited in the GP Plus at Marion.

The total budget of these services is $5.450m.

The total FTE of these services is 52.7.

Services provided include:

- health promotion and primary prevention activities such as information provision, drop in counselling, sexual health screening, clean needle programs, immunisation and groups for same sex attracted and gender questioning young people;
- secondary prevention, early intervention services including counselling, group programs, medical and nursing services; and
- case management with tailored responses to vulnerable populations including those living in youth training centres, community residential care and under the Guardianship of the Minister. These populations include a high proportion of Aboriginal young people.

In addition, Uniting Communities offers a metropolitan based primary health care service in the city, Streetlink Youth Health Service, with a focus on young people experiencing or at risk of homelessness and SHine provides a service to youth with a focus on sexual health (these programs are not in scope for the review).

Assessment against the evaluation framework

Relationship with current policy

Only some of the services contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Many of the services do not contribute at all to these objectives having a stronger focus on social support, community engagement and health promotion. These include programs such as Homework and youth support club, Chefs on the move, Healthy eating and lifestyle program (HELP), Amigos, World United and a number of informal community engagement and health promotion strategies.

Value for money

There are no measurable outputs specified for these services. There have been some recent process evaluations that have recommended improvements in how the services are delivered. However, there have been no evaluations of overall service impact. Some activity data exist as follows:

	Marion Youth	Shopfront	The Second Story
Activity in occasions of service	4652	6992	8078
Full time equivalent staff	5.2	11.4	36.1

A Review of SA Health Metropolitan Youth Primary Health Care Services in September 2010 found a need for:

- increased collaboration between the metropolitan youth services;
- integration of youth services with specialist and generalist services; and
- an increased focus on vulnerability in terms of risk and protective factors with Aboriginal young people and those under the guardianship of the Minister acknowledged as populations with the overall highest health needs.

The recommendations of this review have been partially implemented in some sites and remain under active consideration by SA Health and LHNs.

Reconfiguration opportunities

Differing models of care and service eligibility criteria exist across the service sites and integration with generalist and specialist services varies across the services. Changing demographics has meant that some service locations are no longer matched with the location of the target youth population. A number of the services have relatively small staff numbers, each with its own management and reception structure. There are limitations with a small staff group working in a specialised field to provide appropriate clinical governance.

Currently, a significant number of services are provided to people in the 18–25 year age group. The Health services Framework for Children and Young People 2012–22 indicates that the transition to adult services needs to commence around the age of 16 and should be well established by the age of 19 years.

As discussed above, some components of the current service profile do not meet the key policy objectives of chronic disease management, hospital avoidance and population health. These include programs such as Homework and youth support club, Chefs on the move, Healthy eating and lifestyle program (HELP), Amigos, World United and a number of informal community engagement and health promotion strategies.

The development of GP Plus and GP Plus Super Clinics in recent years provides alternate venues for some of these services and an opportunity to integrate them with generalist and specialist services.

In the light of the above, it is proposed that the three existing youth services be replaced by a single fully integrated metropolitan youth service that operates out of two service hubs: one northern and one southern.

The hubs could provide outreach services to the local area:

- a southern hub at Noarlunga could provide outreach to Aldinga and Marion; and
- a northern hub at Elizabeth could provide outreach to Salisbury.

This proposal would allow for service sites to be aligned with areas of growing need, such as in the South where the need is in the outer Southern suburb of Aldinga. Under present arrangements services are located at Marion and Noarlunga.

A hub and spoke model where the outreach is to a variety of sites rather than one fixed location provides greater flexibility for future population changes.

A single integrated youth service would have a focus on providing health services in line with the key policy objectives for vulnerable youth including Guardians of the Minister, Aboriginal Youth and those within Youth training facilities. Pathways to other appropriate health service options would be provided to those who do not meet the criteria of vulnerable. Those seeking more social and education support would be directed to other providers of this type of service.

The target population would be aged 12–19 years providing 12 months to support transition to adult services.

The hubs could be located within or close to the GP Plus and Super Clinic sites to build on the generalist and specialist integration model proposed in the 2010 review. The convergence from five hubs to two would reduce the management and reception structures and may result in efficiencies in service delivery areas as well. Further efficiencies could be gained from having one LHN managing the two hubs, enabling easier sharing of resources and staff and would provide more robust clinical governance structures.

It is estimated that, if the recommended changes in focus and eligibility are adopted, demand for youth services would fall by 30%.

It is proposed that a steering committee be established to manage the implementation of the new youth service. Representation from all metropolitan LHNs on the committee would facilitate alignment of planning and strategic issues as well as the management of any operational issues.

It is proposed that the integrated youth service be given a new name to emphasise that a new service is being developed. The restructure should be considered as a whole of service change rather than undertaken in a piecemeal approach. This would enable the new service to be developed and promoted across the metropolitan area minimising confusion and service gaps.

Financial details

	Marion Youth	Shop Front	Second Story	Total
	$'000	$'000	$'000	$'000
Revenue & Grants	-99	-3	-199	-301
Salaries & Wages				
Administrative	181	418	842	1,441
Allied Health & Professional	151	379	851	1,381
Medical	23		577	600
Nursing	68		924	992
Employee Entitlements	37	72	313	422
Non Salaries				
Medical & Pharmaceutical	5	1	10	16
Occupancy Leasing		164	227	391
Utilities		10	31	41
Motor Vehicles			102	102
Grants & Contracted Services		10		10
Computing		2	62	64
Other Supplies & Services	30	67	194	291
	396	**1,120**	**3,934**	**5,450**

Risk profile

The community may be concerned about the lack of access to some of the more social support programs previously offered by the youth service sites. The new service will identify pathways to other options where they exist.

The change in eligibility may result in some older youth (20 year +) finding it difficult to access appropriate services. The new service will need to develop clear pathways and links with generalist and specialist services for adults to mitigate this.

The change of governance carries the risk that some local needs and plans may not be addressed and integrated into a centralised service and ongoing communication will be required to mitigate this.

Recommendation	■ The three existing youth services be replaced by a single fully integrated metropolitan youth service operating out of two service hubs: northern and southern; ■ The new youth service have a focus on providing services that are consistent with the policy objectives specified in the evaluation framework with a particular focus on vulnerable youth including Guardians of the Minister, Aboriginal youth and those within Youth training facilities; ■ The integrated service be given a new name to emphasise that a new integrated service is being developed; ■ The restructure be implemented as a whole of service change rather than undertaken in a piecemeal approach with the objective of minimising confusion and service gaps; and ■ Funding to youth services be maintained at the current levels for the remainder of FY 2012–13 (unless proposed changes can be achieved earlier). Funding should be reduced by $1.0m in FY 2013–14 and by a further $1.0m in FY 2014–15 (making a total ongoing reduction of $2.0m) in the light of reduced eligibility and more targeted focus of services (as per policy objectives) and reduced overhead costs from the reconfiguration of the service.

HEALTH PROMOTION SERVICES

Background

Health promotion services are delivered out of each Local Health Network across metropolitan Adelaide:

- Health Promotion service and initiatives, Women's and Children's Health Network;
- Do it For Life, Eat Well Be Active and Health Promotion Officer to support the Healthy Weight Initiative – Central Adelaide Local Health Network, Northern Adelaide Local Health Network and Southern Adelaide Local Health Network;
- Community Foodies, Healthy Youth project and Start Right Eat Right – Southern Adelaide Local Health Network; and
- other health promotion activities undertaken within chronic disease primary health teams eg cooking classes and meditation (NALHN, CALHN and SALHN).

The total budget of these services is $4.03m.

The total FTE of these services is 40.7.

Services are designed to promote healthy eating and activity messages to support health promotion and illness prevention. Strategies include:

- provision of information about quality parenting practices including safe sleeping strategies and breastfeeding;
- training and accreditation in healthy food policies and choices in childcare and early childhood settings;
- education and health promotion activities which increase the skills and knowledge of children in schools;
- healthy lifestyle advice for adults at risk of chronic disease; and
- training and support to volunteers to deliver healthy eating messages in their local community.

There are a number of other health promotion services such as the Health Promotion Branch of SA Health and OPAL that work closely with some of the programs in the LHNs. There are also a number of non-government organisations delivering health promotion services such as the Breastfeeding Association. Although these services are not in scope for this review, they nevertheless need to be considered in terms of their interface with the LHN health promotion services.

Assessment against the evaluation framework

Relationship with current policy

These services do not contribute to two of the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Many of the services contribute to the objective of improved population health through health promotion and illness prevention.

Relationship with Commonwealth policy

The provision of primary prevention services such as health promotion and illness prevention are identified by the Commonwealth as areas for medicare locals to address.

Value for money

There are no measurable outputs specified for these services. There have been some regular process evaluations and client feedback that have indicated improvements in delivery for individual services. There have been no evaluations, however, of overall service impact. There is no activity data available due to the nature of the initiatives eg awareness campaigns, community activities and pamphlet development which cannot be collected as occasions of service.

Reconfiguration opportunities

As discussed, the current service profile does not contribute significantly to the key policy objectives of chronic disease management, hospital avoidance and population health. Even in population health, where it could be argued that the case for continued funding is strongest, there is insufficient specific program evidence to demonstrate that these programs are having a positive impact.

Some of the services provided through the OPAL program in partnership with Local Government have a close relationship with State programs and there may be opportunities for synergies in this area. The State Public Health plan may provide a framework for better coordination and partnership across government and NGOs.

There is a strong argument that programs that seek to change the behaviour of large segments of the population will not succeed without a significant commitment from the Commonwealth. The emergence on medicare locals offers the opportunity to explore with the Commonwealth its plans and the extent of its proposed investment in the health promotion/illness prevention area.

It may be difficult to realise savings for some activities such as exercise groups and Healthy Eating and Lifestyle programs that are not part of the formal statewide health promotion initiatives. These other activities are run in the chronic disease management teams of primary health services and the staffing component is quite piecemeal and may be part of other services that are to be retained. Nevertheless, there is an opportunity to reorient these other health promotion type activities to more chronic disease management services. Such a reorientation would provide an opportunity to reduce waiting times for existing services and/or to develop service responses where gaps currently exist.

Financial details

Budget Allocation	Health Promotion WCHN & SALHN*	Eat Well Be Active	Health Weight Coordinators	Do It For Life	Total
	$'000	$'000	$'000	$'000	$'000
Revenue	**-36**				**-36**
Salaries	**1,557**	**584**	**364**	**833**	**3,308**
Administration & Clerical	932	144	77	590	1,743
Allied Health Professional	440	392	257	79	1,168
Health Ancillary					
Medical Officers					
Nursing				96	96
Operational					
Professional					
Superannuation	155	48	30	68	301
Goods & Services	**526**	**153**	**21**	**62**	**762**
Total Budget	**2,017**	**737**	**385**	**895**	**4,034**

FTE					
Administration & Clerical	12.7	2.0	1.0	7.8	23.5
Allied Health Professional	3.2	5.6	3.6	1.0	13.4
Health Ancillary	2.8				2.8
Medical Officers					
Nursing				1.0	1.0
Total FTE	**18.7**	**7.6**	**4.6**	**9.8**	**40.7**

*includes Start Right Eat Right, Community Foodies SALHN

Risk profile

The community and referring General Practitioners may be concerned about the lack of access to healthy lifestyle counselling. If medicare locals are not able to financially support these services communication will need to be prepared to address this concern and a transition out strategy developed.

Childcare and early childhood settings may be concerned about the future of the Start Right Eat Right accreditation scheme. Communication will need to be prepared to address this concern and a transition strategy developed.

Community members involved in the Community Foodies program may be concerned about future support for the education sessions they have been running and how they will continue to use these skills. Opportunities with the council led OPAL services and medicare locals which have a primary prevention role, should be explored to support the transition.

In the event that local councils and medicare locals do not choose to deliver similar primary prevention services a transition out strategy will need to be developed for the relevant services.

Community and staff may be concerned that SA Health is significantly reducing its investment in primary prevention services. Communication about the role of SA Health and medicare locals will be important including an understanding of the plans from medicare locals for initiatives in this area.

Disinvestment by the State in these primary prevention services may lead claims that there will be an increase in childhood obesity and chronic disease prevalence. The answer to any such claims is that the State continues to support investment in health promotion programs that can be demonstrated to be effective. There is no evidence that the current programs provided by the State, at the modest level of funding that the State can afford, are having significant impact on population health outcomes. The State will explore with the Commonwealth Government its plans for investment in health promotion through the medicare locals.

Recommendation

- **Funding to health promotion services cease at the end of FY 2012–13 (unless proposed changes can be achieved earlier);**
- **There are discussions with Local Government and the Commonwealth Government about their future plans in this area; and**
- **Other health promotion type activities within chronic disease primary health teams be reoriented to chronic disease management services to reduce waiting times for existing services and/or to develop service responses where gaps currently exist.**

CHILDREN'S PRIMARY HEALTH SERVICES

Background

There are three children's primary health services across metropolitan Adelaide:

- Parks and Pt Adelaide Primary Health centres for Central Adelaide Local Health Network;
- GP Plus Super Clinic Modbury, Gilles Crescent campus, Salisbury and Playford Primary Health centres for Northern Local Health Network; and
- GP Plus Super Clinic Noarlunga, GP Plus Marion, GP Plus Aldinga, Southern Primary Health Seaford and Morphett Vale

There is a Community Paediatrician in SALHN.

The total budget of these services is $3.815m.

The total FTE of these services is 42.7.

Primary health services are targeted at children 0–4 years with, or at high risk of, developmental delays.

Services address the complex health needs of vulnerable (socially and/or financially disadvantaged) children and include:

- individual comprehensive assessment and management of delays in development including:
  - speech and language;
  - fine and gross motor skills;
  - social, emotional and behavioural skills; and
  - nutrition; and
- group therapy services to support management of developmental delays and enhance parental capacity to meet their child's special needs.

Some primary health services for children are also provided via outreach by Women's and Children's Local Health Network. Lyell McEwin Hospital also provides a primary health level allied health service to specific postcodes within the North.

The Community Paediatrician role improves access to specialist services by delivering care to children with general medical, developmental, learning or behavioural issues in a range of community settings such as GP Plus centres. The target group for the service are children and youth 0-18 years, particularly vulnerable infants and young children (ATSI children, children at risk of or who have experienced abuse and neglect).

There are a range of other service providers who deliver services to children and families including Novita, Department of Education and Childhood Development as well as private Allied Health and non-government providers. These programs are not in scope for this review. The primary health services target children who are not eligible for, cannot afford or experience other barriers to accessing these other services.

Assessment against the evaluation framework

Relationship with current policy

Only some of the services contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Most of the services do not contribute to these objectives, having a stronger focus on development goals and improving the parenting capacity to support social and emotional wellbeing with the aim of preventing chronic disease and disadvantage in future years.

Value for money

There are limited measurable outputs specified for these services. There have been regular evaluations in some sites measuring the improvement in attainment development goals; however, there have been no evaluations of overall service impact. Some activity data exist as follows:

	CALHN	SALHN	NALHN
Activity in occasions of service 2011–12	2085 (primary health team)	4,310 (primary health team) 2903 (community paediatrician)	2,903 (primary health team) (activity from some group services was not available)
Full time equivalent staff	4.5	19.1	19.1

Reconfiguration opportunities

As discussed above, most of the services do not contribute to the objectives of chronic disease management, hospital avoidance and population health, having a stronger focus on childhood development and improving parenting capacity to support social and emotional wellbeing of children with the aim of preventing chronic disease and disadvantage in future years.

There is consistency across the metropolitan area in the eligibility criteria and the service model with some local variation to meet the needs of the local population. For example, CALHN has a focus on migrant populations. There is evidence that the model of service delivery is regularly reviewed to align with contemporary practice and changes in surrounding services. Good networks and communication channels exist between the early childhood services in LHNs.

The Commonwealth Government has a number of schemes/initiatives focussed on children and families and supporting their access to services. Primary Health services actively support families to use these services whenever possible, including:

- National Disability Insurance scheme trial. This trial will commence in the middle of 2013 and will provide opportunities for some children to find alternatives to current services; however, the impact of this will be dependent on eligibility. This scheme will have only limited impact on primary health through shortening the waiting period for disability services in which time gap fill services are provided by Primary health (approx. 64 per year);
- Enhanced Primary Care (EPC) program supports families to access a limited number of Allied Health services (5 per year). The majority of children seen by Primary Health services require a multidisciplinary intervention beyond the number of sessions funded; and
- Autism funding. Primary health services assist families through diagnosis and referral to this service.

All of the primary health services experience demand which outweighs resources (average 27 week wait in SALHN) and have in place demand management processes such as prioritisation, eligibility criteria and referral on wherever possible. The time critical nature of these services which rely on working with children during a critical period of brain development means long waits for services can have a significant impact. Any further tightening of eligibility criteria, with limited other services available will result in some children not being able to access any service.

It is acknowledged that the boundary between education and health in the area of childhood development is an area of unfinished business. Transition of some early childhood services to DECD is underway, namely Child and Family Health Services (CaFHS); however, Primary Health services currently sit outside the new Department.

In areas such as the North where primary health services are delivered jointly by primary health staff and hospital staff, the reconfiguration of governance and location of staff delivering primary health services may lead to some efficiencies and a less siloed service.

The draft Health Service Framework for Children and Young People 2012–22 outlines a model for health services that is based on child health teams situated within each LHN. This model supports the development of more community based roles including Community Paediatricians and clinical nurse consultant specialists in community and primary health. The increased presence of services in the primary health setting supports a stronger interface between other community services for children and provides a more conducive environment for the delivery of non-acute services for children.

The Community Paediatrician role is identified as a part of the future child health team model. Its funding stream and governance are currently at odds and discussion needs to be undertaken to determine whether this is a primary health service that reaches in to hospital or a hospital service that reaches out to the community.

Financial details

Allocation	SALHN	SALHN Comm Paed	NALHN	CALHN	Total
	$'000	$'000	$'000	$'000	
Revenue & Grants					
Salaries & Wages	**1,647**	**95**	**1,546**	**383**	**3,671**
Administrative	2		313	20	335
Allied Health & Professional	1,395		1,017	332	2,744
Health Ancillary			23		23
Nursing	39		65		104
Medical		87			87
Operational	78				78
Employee Entitlements	133	8	128	31	300
Agency Staff			**14**		**14**
Non Salaries	**12**		**95**	**23**	**130**
Total	**1,659**	**95**	**1,655**	**406**	**3,815**
FTE					
Administration & Clerical			4.8	0.4	**5.2**
Allied Health Professional	16.9		12.9	4.1	**33.9**
Health Ancillary			0.6		**0.6**
Medical Officers		0.4			**0.4**
Nursing	0.5		0.8		**1.3**
Operational	1.3				**1.3**
Total	**18.7**	**0.4**	**19.1**	**4.5**	**42.7**

Risk profile

Any reduction of staff will have impact on waiting times which are already extensive. In this time critical area of childhood development extended delays in accessing services may lead to a reduction in possible outcomes for children.

Any further tightening of eligibility criteria, with limitations on other services available will result in some children not being able to access any public service. Those most likely to be effected will be those most vulnerable and in need.

The reconfiguration of governance of Primary health service delivery for children in NALHN may be difficult as some staff may work across acute services as well as the primary service areas. Careful mapping of the different service elements will need to be undertaken to support the process.

Recommendation	
	■ **Although many of the services provided in this area do not meet the primary policy objectives in the evaluation framework, it is not proposed that the funding be reduced at this time. This recommendation recognises the priority that the government attaches to early childhood development and also recognises that the transition of many of these services from SA Health to DECD is not yet complete. This remains a challenging task and it would not make sense to complicate it further through funding cuts at this time;** ■ **The shared service currently provided within NALHN by LMH and primary health sites be reconfigured to develop a less siloed primary health service; and** ■ **The Community Paediatrician role be discussed between relevant parties in SALHN in terms of future funding and governance to determine whether this role is a primary health service that reaches in to the hospital or a hospital service that reaches out to the community.**

WOMEN'S PRIMARY HEALTH SERVICES

Background

There are three women's health services across metropolitan Adelaide:

- Women's Health Statewide (WCHN) at Pennington Tce, North Adelaide serving women across SA (i.e. non postcode restricted);
- Dale Street Women's Centre (CALHN) at Pt Adelaide and with outreach to GP Plus Elizabeth and GP Plus Super Clinic Modbury; and
- Southern Primary Health, Women's Health (SALHN) at GP Plus Super Clinic Noarlunga.

The total budget of these services is $3.538m.

The total FTE of these services is 39.8.

Services are designed to address the complex health needs of vulnerable (socially and/or financially disadvantaged) women and include:

- therapeutic counselling and group work that focuses on the intersections between mental health, violence and wellbeing. There is a particular emphasis on depression (including perinatal depression), anxiety and complex trauma;
- health screening services such as cervical screening for vulnerable women and those at high risk including Aboriginal Women, same sex attracted women and women newly arrived to Australia who to date, have not been engaged or catered for by mainstream General Practice services;
- statewide programs that support specific health issues related to gender vulnerability including HIV, Female Genital Mutilation and Rural women's health; and
- education and health promotion activities which increase the skills and knowledge of main stream health services in responding to the needs of women who have experienced violence. For example, training of GPs around the impacts of child sexual abuse and how this influences women's health as adults.

There are also some discrete antenatal services offered within the GP Plus super Clinic Noarlunga by Primary Health staff.

Assessment against the performance framework

Relationship with current policy

Only some of the services contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Many of the services do not contribute to these objectives at all having a stronger focus on social support, community engagement and health promotion.

These include programs such as Keys to the Closet, Strengthening Community Connections, cooking demonstrations and a number of community engagement and health promotion strategies.

Relationship with Commonwealth policy

The provision of screening services currently undertaken by women's health services to those not catered for in the General Practice environment is an issue for the medicare locals to address. Women's health will work on the transition out of these services with the improvement of General Practice capability, skill and knowledge of the particular needs in this area.

Value for money

There are no measurable outputs specified for these services. There have been some recent process evaluations that have indicated service improvement; however, there have been no evaluations of overall services. Some activity data exists as follows:

	Dale Street and outreach sites	Southern Primary Health Women's services	Women's Health Statewide
Activity in occasions of service	6869 (excludes some group activity)	6816	2,900
Full time equivalent staff	19.5	6	14.3

Reconfiguration opportunities

Differing models of care and service eligibility criteria exist across the service sites and integration with generalist and specialist services varies across the services. Changing demographics has meant that some service locations are no longer matched with the location of the target population and not all currently offer an outreach service.

A number of the services have relatively small staff numbers, each with its own management and reception structure. There are limitations with a small staff group working in a specialised field to provide appropriate clinical governance.

As observed above, some components of the current service profile do not meet the key policy objectives of chronic disease management, hospital avoidance and population health. These include programs such as Keys to the Closet, Strengthening Community Connections, cooking demonstrations and a number of community engagement and health promotion strategies.

The development of GP Plus and GP Plus Super Clinics in recent years provides alternate venues for some of these services and an opportunity to integrate with generalist and specialist services.

In light of the above, it is proposed that the three existing women's services be replaced by a single fully integrated metropolitan women's health service that operates in areas of most need across the metropolitan area. Further investigation into the most appropriate locations and size of service response required would need to be undertaken; however, a hub and spoke model is proposed. The spokes would, where possible, be located within the GP Plus and Super Clinic sites to build on the generalist and specialist integration model that these sites offer.

The new Women's health service would have a focus on providing health services for vulnerable (socially and/or financially disadvantaged) women who are not catered for by mainstream services, with pathways to appropriate services for those not meeting this criteria.

If this recommendation is adopted it is estimated that demand on current services would fall by 30%.

The new service will be able to provide a consolidated mental health counselling service and by using a mix of therapeutic groups and individual services to provide episodic rather than longer term care, should result in greater operational efficiency. Further, the consolidation of salaried GP's and nurses into one team that can provide services at the different sites will provide efficiencies and more robust clinical governance. The application of the current Medicare exemption to this service will enable better use of the Medicare items to support the service. Further investigation should be undertaken of more cost effective models of care including the use of Nurse Practitioners where appropriate.

The convergence of operational governance from three management structures to one, overseeing the new service, should deliver additional savings.

Financial details

Budget Allocation	SALHN Women's Health	CALHN Dale St	WCHN Women's Health	Total
	$'000	$'000	$'000	$'000
Salaries & wages	**478**	**1,637**	**1,178**	**3,293**
Administration & Clerical	327	565	635	1,527
Allied Health Professional		345	223	568
Health Ancillary		8		8
Medical Officers		238		238
Nursing	112	348	215	675
Operational				
Professional				
Superannuation	39	133	105	277
Goods & Services	**46**	**98**	**100**	**245**
Total Budget	**524**	**1,735**	**1,278**	**3,538**
Administration & Clerical	4.52	9.20	9.10	22.82
Allied Health Professional		4.50	2.71	7.21
Health Ancillary		0.20		0.20
Medical Officers		1.50		1.50
Nursing	1.44	4.10	2.54	8.08
FTE	**5.96**	**19.50**	**14.35**	**39.81**

Risk profile

The community may be concerned about the lack of access to some of the more social support programs previously offered by the women's health service sites. The new service will identify pathways to other options where they exist.

The community may be concerned about the lack of access to the women's health services sites for those not identified as vulnerable. The new service will need to develop clear pathways and links with generalist and specialist services for women to mitigate this.

The change of operational governance from three management structures to one carries the risk that some local needs and plans (including service partnerships) may not be addressed and integrated into a centralised service and ongoing communication will be required to mitigate this.

The sector has developed specialist skills and expertise in health interventions specific to women and the associated trauma of violence. Services reliant on this support may need to investigate alternative mechanisms to inform best practice.

The combination of reduced funding for both women's health and Shine SA will mean that services will have very limited sexual health referral pathways in the short term and long term should GPs not pick this up. This will be most pronounced in the financially disadvantaged groups as a fee-for service medical system applies with most GP practices.

Recommendation

- **The three existing women's services be replaced by a single fully integrated metropolitan women's health service;**
- **Further consideration be given to where to locate the service hubs noting that the main population centres and therefore areas of greatest need are in the North and the South;**
- **The new women's health service have a focus on providing services that are consistent with the policy objectives specified in the evaluation framework with a particular focus on vulnerable women including those who are socially and/or financially disadvantaged;**
- **The integrated service be given a new name to emphasise that a new integrated service is being developed;**
- **The restructure be implemented as a whole of service change rather than undertaken in a piecemeal approach with the objective of minimising confusion and service gaps; and**
- **Funding for women's services be maintained at the current levels for the remainder of FY 2012–13 (unless the proposed changes can be achieved earlier). Funding in FY 2013–14 should be reduced by $0.5m and by a further $0.5m in FY 2014–15 (making a total ongoing reduction of $1.0m) in the light of the more targeted focus of services (as per policy objectives) and reduced overhead costs from the reconfiguration of the service.**

RESIDENTIAL CARE HEALTH SERVICE SUPPORT

Background

There are a range of residential care health support services delivered across metropolitan Adelaide.

The total budget of these services is $ $0.770m.

Services are delivered in residential aged care settings providing:

- primary care education and support to residential care staff in the health care needs of residents with the aim of preventing unnecessary presentations to emergency departments. Education includes the use of Extended Care Paramedics, management of continence devices and clinical assessment; and
- direct primary care services to residents of aged care facilities such as ordering blood tests or providing a GP service when the usual GP is unavailable.

There are a number of other services that support the needs of older people within Residential care including the Extended Care Paramedics in the South Australian Ambulance Service and hospital avoidance support programs. These programs are not in scope for the review however need to be considered in terms of their interface with the LHN health services for older people that are the focus of this analysis.

General Practice provides primary care support to the residents of residential care facilities. Some residential care facilities have informal relationships with General Practices in their local area who provide primary care support to many of their residents.

Assessment against the evaluation framework

Relationship with current policy

Some of these services contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Many of the services contribute to improved access for residents to primary care.

Relationship with Commonwealth policy

Access to primary care services is part of the newly developed role for medicare locals. Medicare locals in metropolitan Adelaide have identified Aged Care services as a focus for their service.

Value for money

There have been outputs specified in some services with a 14% reduction in hospital ambulance transfers in the involved facilities in the central western and northern part of Adelaide. In other areas there have been some recent process evaluations; however there have been no evaluations of the overall service impact. Some activity data exists as follows:

	REACH – SALHN	Ambulance avoidance strategy
Activity in occasions of service	3785	No activity data available This program was run jointly between CALHN and NALHN until June 30 2012

Reconfiguration opportunities

As discussed, these services provide access to primary care – and have been identified as part of the role of medicare locals. The Southern medicare local has already allocated funding to support residential facilities in the primary care area. There may be opportunities for medicare locals to generate further efficiencies in this area.

Financial details:

- CALHN $0.259m
- NALHN $0.261m
- SALHN $0.250m

Payments are made to external contracted providers.

Risk profile

Residential care facilities staff and residents may be concerned about the lack of access to primary care. Communication will need to be prepared to address this concern and a transition out strategy developed with medicare locals.

There may be concern that ceasing this service may result in an increase in ambulance transfers to hospital from residential aged care facilities. The hospital avoidance support utilised by these services including Extended Care Paramedics and hospital avoidance services will remain in place. The transition out plan will need to include added communication about access to these services.

Recommendation	
	■ **Funding to residential aged care health support services cease by the end of FY 2012–13 (unless the proposed changes can be achieved earlier);** ■ **The possibility of the programs fitting with other primary care providers such as medicare locals be investigated; and** ■ **The plans of medicare locals and SA Health for access to primary care be discussed to develop a clear understanding of the work being undertaken in this area.**

GENERAL PRACTICE SPIROMETRY AND LUNG FUNCTION SERVICE

Background

There is one General Practice Spirometry and Lung Function service in metropolitan Adelaide located within Noarlunga Hospital.

The total budget for this service is $0.100m.

The General Practice spirometry and lung function service provides support and education to GPs to improve the quality of lung function assessment and clinical interpretation and consequently the management of patients with Chronic Obstructive Pulmonary Disease (COPD) and Asthma.

The program includes:

- provision of lung function tests for people referred by their GP; and
- Education and General Practice support in testing and interpretation of results.

Assessment against the evaluation framework

Relationship with current policy

The service delivered via the program contributes to only one of the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

The services do not contribute to the hospital avoidance or population health objective; however do contribute to chronic disease management.

Relationship with Commonwealth policy

The provision of support for General Practice in uptake of evidence based practice supporting chronic disease management, including the delivery and interpretation of lung function tests, is part of the newly developed role of medicare locals.

Value for money

There are no measurable outputs specified for this program area with the exception of estimated outpatient visits saved. Some activity data exists as follows:

	General Practice Spirometry and Lung Function unit
Activity in occasions of service (2011–12)	5270

Financial details

- $0.081m Medical Scientist salary
- $0.019m Superannuation
- 1.0 FTE

Risk profile

The removal of funding to support and educate General Practice to improve the quality of lung function assessment and clinical interpretation and consequently the management of patients with Chronic Obstructive Pulmonary Disease (COPD) and Asthma has some risk that the improvements that have been achieved to date may progress more slowly. However, support of General Practice in the management of chronic disease is part of the role of medicare locals and it is appropriate that future funding for these services is determined by these bodies.

Recommendation	**Funding for the General Practice Spirometry and Lung Function unit cease at end of FY 2012–13 (unless the proposed changes can be achieved earlier), consistent with the Commonwealth policy responsibility for these services.**

INTEGRATED COMPLEX CARE OF OLDER PEOPLE

Background

There are two Integrated Complex Care of Older people (ICCOP) services in metropolitan Adelaide:

- Central western; and
- Northern

delivered via service agreements with a shared service provider.

The total budget for these services is $ 0.858m.

The ICCOP service provides care coordination and direct clinical support such as nursing for older people with complex health care needs living in the community. The program has focussed on older people who have multiple chronic conditions and have been identified as frequent presenters to hospital.

Assessment against the evaluation framework

Relationship with current policy

The service has contributed to the management of chronic disease and hospital avoidance in response to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

Value for money

There are no measurable outputs specified for this program area. There have been program reports with counts of nominated activities which were said to result in hospital avoidance. However, there have been no evaluations of the overall service impact. Some activity data exists as follows:

	ICCOP – CALHN	ICCOP – NALHN
Activity in occasions of service (2011–12)	584	1302

Reconfiguration opportunities

There is significant overlap between the function of ICCOP services and the function of the Mobile Assessment and Support Team (MAST) service with the exception of the longer term case management provided by ICCOP.

The Mobile Assessment and Support Team was developed in Central and Northern Adelaide in late 2010 as part of the Community Geriatric service supporting the health needs of older community dwelling people with complex health and care needs. This interdisciplinary team has a focus on short term interventions and case management to avoid preventable presentations to hospital.

A service approach that combines these functions would prevent duplication with hospitals and General Practice and avoid confusion about the differing roles of each service.

Longer term case management of older community dwelling people is a service provided by Domiciliary Care and via the Commonwealth Government Aged Care packages eg Extended Aged Care at Home packages (EACH) as part of their responsibilities in the area of care for older people.

Consolidation of ICCOP with the MAST program would deliver efficiencies in terms of reduced administration and corporate overheads and the withdrawal from long term case management and is estimated to result in savings of 45%.

Financial details

- CALHN $0.487m
- NALHN $0.371m

Risk profile

The community and referring General Practices may be concerned about the withdrawal of longer term case management. The consolidated service will identify pathways to other options such as Domiciliary Care and Commonwealth Government Aged Care packages which are designed to provide this care.

The consolidation of service functions may cause some concern that access to this case management service for older people will be reduced. The changes to the programs will need to be well communicated to key stakeholders to mitigate this risk.

Recommendation

- **Funding to ICCOP be maintained in FY 2012–13 (unless the proposed changes can be achieved earlier), with a transition plan developed to support the integration with the functions of the MAST program; and**
- **Funding in FY 2013–14 be decreased by $0.370m in line with the reduced administration and corporate overheads and the withdrawal from long term case management.**

ABORIGINAL WORKFORCE INITIATIVE

Background

The Aboriginal Workforce initiative is based in southern metropolitan Adelaide as a program of Southern Adelaide Local Health Network.

The total budget of these services is $0.415m.

Total FTE is 3.9.

The initiative has included:

- an Aboriginal pre-employment program to develop work ready applicants for potential employment to SALHN in administration and patient service assistant roles;
- enrolled nursing cadetships at Flinders Medical Centre;
- Bonded Aboriginal Medical scheme – scholarship in partnership with Flinders University to increase the number of Aboriginal and Torres Strait Islander doctors in Southern Adelaide Local Health Network;
- Hands on health – in partnership with DECD provide activities to introduce year 9/10/11 Aboriginal students in southern public schools to different jobs and career pathways into SA Health;
- Learning Centre – health training programs for staff and community in a culturally appropriate setting, with close links to health services for the Aboriginal community;
- job matching – a database of potential Aboriginal employees to feed into vacancies within the LHN; and
- retention strategies – including professional development and other workforce development activities such as advocating cultural competency training for new Aboriginal Health workers across the LHN; working with SA Health Aboriginal health Workforce division.

Assessment against the evaluation framework

Consistent with current policy

Only some of the services delivered via the program contribute to the three basic policy objectives of:

- chronic disease management;
- hospital avoidance; and
- population health.

The services do not contribute to the hospital avoidance objective; however the strong focus on models and processes to support increased involvement of Aboriginal people in the health workforce and their access to training in the health area contribute to chronic disease management and population health objectives.

Value for money

There are no measurable outputs specified for this program area. There have been regular program reports with some evaluation of individual projects where possible. However, no evaluation of the overall service impact has been undertaken. The varying nature of the Aboriginal workforce initiative strategies means that no clear or comparable activity data are available.

Reconfiguration opportunities

- some of the positions within the Aboriginal workforce team will cease at the end of FY 2012–13 with the end of the COAG funding that has supported some of these initiatives;
- with the ending of the enrolled nurse cadetships and the support required for this program there is a reduction in demand of 25%;
- the consolidation of the management of this small team into the Aboriginal Health Manager's role would also result in savings; and
- the reconfiguration of the program and team will lead to a 50% reduction in FTE and saving of $0.200m.

Financial details

	2012/2013	
	Budget $'000	Annual FTE
Salaries	**378**	**3.9**
Administration & Clerical	344	3.9
Superannuation	34	
Goods and services	**37**	
Food Supplies	1	
Minor Equipment	1	
Communications Exp	6	
Printing & Stationery Exp	3	
Staff Training & Development	12	
Staff Travel	10	
Other Supplies & Services	4	
Total	**415**	**3.9**

Risk profile

The reduction of funding to support Aboriginal Health Workforce initiatives will be of concern to the Aboriginal community who have seen these programs as a positive investment in the health of the Aboriginal population. The reconfiguration of the roles within the program will enable programs that are in place and valued by the community and LHN to be supported in a more efficient structure.

Recommendation	Funding for the Aboriginal workforce Initiative be maintained in FY 2012–13 (unless the proposed changes can be achieved earlier) and reduced by $0.200m in 2013–14 through the development of a more consolidated service in line with the evaluation framework;

HOSPITAL BASED SERVICES

Background

There are 6 hospital based services delivered out of 3 sites in metropolitan Adelaide:

- Allied Health in the Emergency Department at Flinders Medical Centre;
- allergy service at FMC;
- chest pain clinics at The Queen Elizabeth Hospital (TQEH), Royal Adelaide Hospital and Lyell McEwin;
- chronic disease – Respiratory (RAH);
- rapid access clinics – Ambulatory & outpatient clinic RAH; Hospital at Home Rapid Medical Assessment Clinic LMH; Transient Ischaemic Attack Rapid Assessment clinic at TQEH and FMC; and
- peri-operative management clinics at RAH and TQEH.

The total budget of these services is $2.435m.

Services provided include:

- rapid assessment of people presenting to Emergency departments with specific conditions with the aim of facilitating streamlined access to relevant testing and referral on to appropriate follow on services in the community to prevent readmission;
- improved patient access to highly specialised investigations and treatment to improve hospital flow such as cardiac stress tests; and
- enhanced and targeted management of patients presenting to Emergency departments or admitted on the Hospital @ Home program at risk of presentation to Emergency via appropriate OPD based or inpatient Physician, Nursing and Allied Health led interventions and referral to General Practice and community based services.

Assessment against the performance framework

Consistent with current policy

Many of these services support the management of chronic disease; however, the internal process programs do not contribute to the policy objectives of hospital avoidance or improved population health outcomes.

The services that support improved referral processes for hospital staff contribute to hospital avoidance through the reduction of readmissions to hospital.

Hospital based services which are delivered in hospital by hospital staff, with governance through the hospital structures do not meet the definition of non-hospital services and should not be in scope for Primary health funding.

Value for money

There are no measurable outputs specified for this service area. There have been some recent evaluations of some of the services that have indicated positive program impact. Some activity data exists as follows:

Service	11/12 Activity – 2011–12
Allied Health in ED	6793
Allergy Nurse Program	6628
Cardiac support to the ED, RAH	1846
Regional Chest Pain TQEH,	1312
Regional Chest Pain LMH	868
Chronic Disease – Respiratory (RAH)	*No data available*
Rapid Assessment Ambulatory Care & Outpatients Services RAH	4091
Rapid Assessment – TIA TQEH,	100
Rapid Assessment TIA FMC	962
Hospital at Home Rapid Medical Assessment Clinic (LMH)	730
Perioperative High Risk Clinic (POHR) RAH	804
Peri-Operative Management of High Risk Elective Surgical patients (QEH)	531

These services whilst delivering positive outcomes appear to be more hospital services than Primary Health or Non-Hospital services – delivered in hospital by hospital staff, with governance through the hospital structures.

Without a change in program form, function and governance, the Primary Health and non-hospital service funding source is not appropriate for these programs.

Financial details

Summary	Allied Health in ED	Allergy	Chest Pain Clinics	Chronic Respiratory RAH	Rapid Access Clinics – TIA & HMAC	Peri-op clinics	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Salaries & Wages	**343**	**129**	**484**	**372**	**737**	**136**	**2,201**
Administrative			30		133	34	**197**
Allied Health & Professional	315						**315**
Health Ancillary					44		**44**
Medical			254	342	168	62	**826**
Nursing		118	163		354	29	**664**
Employee Entitlements	28	11	37	30	38	11	**155**
Non Salaries	**59**	**10**	**98**	**27**	**34**	**6**	**234**
Medical & Pharmaceutical					6		**6**
Occupancy							
Grants & Contracted Services							
Other Supplies & Services	59	10	98	27	28	6	**228**
Total Allocation	**402**	**139**	**582**	**399**	**771**	**142**	**2,435**
Central Adelaide Health Network			177	399	321	142	**1,039**
Northern Adelaide Health Network			405		170		**575**
Southern Adelaide Health Network	402	139			280		**821**
FTE							
Administrative			0.6		2.7	0.5	3.8
Allied Health & Professional	3.5						3.5
Health Ancillary					1.0		1.0
Medical			2.0	1.0	0.8	0.2	3.9
Nursing		1.4	1.8		3.8	0.6	7.6
Total FTE	**3.5**	**1.4**	**4.4**	**1.0**	**8.2**	**1.3**	**19.8**

Risk profile

- if the LHNs determine the program utility warrants their continuance they will need to identify more appropriate funding sources in an environment of savings;
- some of the services may be delivered as outpatient services increasing outpatient activity in an environment of Outpatient reform and savings;
- if the programs are not to be continued appropriate transition out plans and identification of alternate referral options will need to be developed;
- if the programs are not continued this may impact on patient flow within the hospital and have impact on hospital capacity; and
- the community may be concerned about any increased waits that may result from the cessation of these services.

Recommendation

- **Hospital based services which are delivered in hospital by hospital staff, with governance through the hospital structures do not meet the definition of non-hospital services and should not be in scope for primary health funding;**
- **The funding for identified hospital based services be maintained for FY 2012–13 and FY 2013–14 unless proposed changes can be achieved earlier, whilst a transition plan is developed by LHNs;**
- **A transition out plan be developed for all services where funding is ceased in FY 2014–15;**
- **The governance of other non-hospital services be reviewed to ensure they are aligned with primary health structures; and**
- **A steering committee be formed comprising of representation from all the metropolitan local health networks to manage the refocussing and reconfiguration of funded services.**

CHILD PROTECTION SERVICES

Child protection services are not being considered for savings initiatives as a result of this review. However, through the course of the evaluation process it has become evident that the current configuration of these services may benefit from further review.

There are two child protection services in metropolitan Adelaide located at Women's and Children's Hospital and Flinders Medical Centre. The total budget of these services is $4.670m.

Services provided include assessment and treatment of children from 0–18 years and their families where there are suspicions of child abuse or neglect.

It has been noted in the course of this review that the development of paediatric services at Lyell McEwen in recent years has not been matched by the development of a child protection service. This service is currently delivered to patients of LMH either on an outreach basis by WCHN or requiring transfer to WCHN to receive the relevant support. This complex service has many linkages with Country Health sites, SAPOL and Families SA. A more detailed examination of these services is beyond the scope of this review. Further work is therefore required to provide a clearer understanding of whether the current configuration of services remains appropriate.

Recommendation	**A more detailed examination of the state child protection services be undertaken to determine the optimal configuration of this service.**

EFFICIENCY DIVIDEND

Careful consideration was given to whether to recommend a broad based efficiency dividend for non-hospital based services. It has to be said that efficiency dividends are generally blunt instruments which fail to distinguish between efficient and non-efficient programs. On this argument, a targeted approach where the potential for efficiency gains has been identified is preferred. The problem with this approach, however, is that, as has been pointed out elsewhere in this report, very few of the programs which make up the non-hospital based sector have defined outputs or have been subject to a robust evaluation of performance – or any kind of evaluation at all in many cases. There are simply no data or reliable evidence that would enable judgments to be made about performance. Thus, in the absence of evidence to the contrary, an assumption has been made that there is room for improvement in efficiency across the non-hospital based spectrum and it is recommended that a dividend of 3% be applied.

Two factors will assist to make this conclusion more palatable. First, it is proposed that it be applied to only those programs that are not subject to detailed review in this report. Total funding for those programs is $23.665m. Thus if this number is deducted from total in scope funding of $78.762m the balance to be subject to an efficiency dividend is $55.096. At 3% this results in an efficiency dividend of $1.653m. The second factor is that although total residual program expenditure (after deducting those programs to which savings apply) is used as a basis of calculating the quantum of the efficiency dividend, it is proposed that LHN CEOs have the authority to determine how the dividend is applied to particular services. This will allow local knowledge to be brought into play and will re-introduce an element of precision to the process.

One final qualification here. There is evidence to suggest that the potential for recommended savings to be actually realised is more likely when savings are tied to a particular program or service rather than to an unspecified and broad class of expenditure. Historically, despite the best of intentions, agencies have often struggled to meet efficiency dividend targets. Thus the greater the proportion of efficiency dividends in overall savings targets, the greater the risk that the targets will not be met.

Although there is merit in this argument, it is not of sufficient weight to exclude an efficiency dividend from the suite of proposals altogether – for the reasons discussed above. However, to avoid any temptation to substitute further efficiency dividends for specific program based targets it is proposed that the efficiency dividend be capped at 3% of residual program expenditure.

Recommendation

- **An efficiency dividend of 3% be applied based on the total funding of those services which have not been subject to detailed review in this report;**
- **This dividend be capped at 3%; and**
- **LHN CEOs have the authority to determine how the dividend is applied to particular services.**

PERFORMANCE EVALUATION AND PRODUCTIVITY

The review disclosed what seems to the author to be a glowing omission in the management of the primary health care sector. As discussed in the previous section, very few non-hospital based services have specified outputs, outcomes or KPIs. It therefore follows, and certainly is the case, that equally few of the services have been evaluated for performance to enable judgments to be made about whether program objectives are being met or, where objectives are being met, this is being achieved with high levels of productivity.

Even where evaluations have been undertaken the methodology has not been sufficiently robust, with some notable exceptions, to provide a reliable evidence base for future decision making. Moreover, as discussed earlier, unlike the acute sector, there is no agreed standard approach to evaluating primary health care sector services. This is due largely to the complexity and range of interventions in primary health care; the variety of objectives specified for individual services; the shortage of research evidence demonstrating intervention effectiveness and the limited availability of utilisation data.

These are very real challenges for the evaluator and they should not be underestimated. The alternative to finding a solution to these challenges, however, is that primary health care clinicians and administrators will continue to struggle to mount a case for retaining current levels of investment, to say nothing of attracting new investment, in primary health care. This is the reality of the fierce competition for resources that is part and parcel of modern government.

Performance measurement and evaluation is not a perfect science as everyone who works in the sector knows. The task therefore is one that requires an agility of imagination rather than the application of off-the-shelf methodologies. For example there are whole of population longitudinal data that irrevocably demonstrate a positive correlation between certain health promotion interventions and improved health outcomes. To overcome the lag issue, therefore, it could be a matter of taking this evidence as given and crafting a number of short term output (rather than outcome) indicators which demonstrate that best practice is being applied.

Related to evaluation of whether program objectives are being achieved is the notion of productivity. Significant variations in input/output ratios for the delivery of the same or similar services were noted throughout the review. No doubt there are legitimate explanations in many cases. Nevertheless, mechanisms should be put in place to measure program productivity either through internal benchmarking or through comparison with external best practice standards.

Recommendation

- **Each non-hospital based service be reviewed to ensure that productivity benchmarks and KPIs (in the most appropriate form) which will provide robust evidence of performance are specified; and**
- **There be a continuing program of evaluation against the KPIs and productivity benchmarks so that no service continues beyond two years without reliable evidence that service objectives and productivity standards are being met.**

SUMMARY OF RECOMMENDED SAVINGS

Table 4 Summary of recommended savings

Program	State funding	Proposed savings			
	2012/13	2012/13	2013/14	2014/15	ongoing
	$'000	$'000	$'000	$'000	$'000
Youth services	5,450		1,000	2,000	2,000
Women's Services	3,538		500	1,000	1,000
Health Promotion	4,034		4,034	4,034	4,034
Children's Services	3,815				
Hospital Services	2,435			2,435	2,435
Aboriginal Workforce Initiative	415	85	200	200	200
Integrated Complex Care of Older People	858		370	370	370
Practice Nurse Initiative	2,250	1,125	2,250	2,250	2,250
Residential Care Health service support	770		770	770	770
General Practice Spirometry and Lung Function	100		100	100	100
Total Program Specific	23,665	1,210	9,224	13,139	13,139
Efficiency dividend			1,653	1,653	1,653
Total Savings Target		1,210	10,877	14,792	14,792

Program	State funding FTE	Proposed savings FTE			
	2012/13	2012/13	2013/14	2014/15	ongoing
Youth services	52.7		15.0	30.0	30.0
Women's Services	39.8		6.0	12.0	12.0
Health Promotion	40.7		40.7	40.7	40.7
Children's Services	42.7				
Hospital Services	19.8			19.8	19.8
Aboriginal Workforce Initiative	3.9	1.0	2.0	2.0	2.0
Integrated Complex Care of Older People					
Practice Nurse Initiative					
Residential Care Health service support					
General Practice Spirometry and Lung Function	1.0		1.0	1.0	1.0
Total Program Specific	**200.6**	**1.0**	**64.7**	**105.5**	**105.5**

Table 5 – Calculation of the efficiency dividend by LHN

	State funding – 2012/13				Total
	SALHN	CAHLN	NALHN	WCHS	
	$'000	$'000	$'000	$'000	$'000
Youth services	396		1,120	3,934	**5,450**
Women's services	524	1,735		1,279	**3,538**
Health promotion	1,470	605	602	1,357	**4,034**
Children's services	1,754	406	1,655		**3,815**
Hospital services	821	1,039	575		**2,435**
Aboriginal Workforce initiative	415				**415**
Integrated Complex Care of Older People		487	371		**858**
Practice Nurse Initiative	750	750	750		**2,250**
Residential Care health Service support	250	259	261		**770**
General Practice Spirometry and Lung Function	100				**100**
Total	6,480	5,281	5,334	6,570	**23,665**
Efficiency dividend*	474	410	424	345	**1,653**

* The total efficiency dividend of $1.653m is calculated by deducting the total funding for those services subject to review in this report ($23.665m) from total in scope funding ($78.762m) and applying 3% to the balance ($55.096m)

CHAPTER 6

SUMMARY OF RECOMMENDATIONS

- Funding for the Practice Nurse Initiative cease on 31 December 2012 in line with the terms of the current agreements with medicare locals and in recognition of the primary policy responsibility of the Commonwealth in this area. (Page 18)

- The three existing youth services be replaced by a single fully integrated metropolitan youth service operating out of two service hubs: northern, southern;
- The new youth service have a focus on providing services that are consistent with the policy objectives specified in the evaluation framework with a particular focus on vulnerable youth including Guardians of the Minister, Aboriginal youth and those within Youth training facilities;
- The integrated service be given a new name to emphasise that a new integrated service is being developed;
- The restructure be implemented as a whole of service change rather than undertaken in a piecemeal approach with the objective of minimising confusion and service gaps; and
- Funding to youth services be maintained at the current levels for the remainder of FY 2012–13 (unless proposed changes can be achieved earlier). Funding should be reduced by $1.0m in FY 2013–14 and by a further $1.0m in FY 2014–15 (making a total ongoing reduction of $2.0m) in the light of reduced eligibility and more targeted focus of services (as per policy objectives) and reduced overhead costs from the reconfiguration of the service. (Page 23)

- Funding to health promotion services cease at the end of FY 2012–13 (unless proposed changes can be achieved earlier);
- There are discussions with Local Government and the Commonwealth Government about their future plans in this area; and
- Other health promotion type activities within chronic disease primary health teams be reoriented to chronic disease management services to reduce waiting times for existing services and/or to develop service responses where gaps currently exist. (Page 27)

- Although many of the services provided in this area do not meet the primary policy objectives in the evaluation framework, it is not proposed that the funding be reduced at this time. This recommendation recognises the priority that the government attaches to early childhood development and also recognises that the transition of many of these services from SA Health to DECD is not yet complete. This remains a challenging task and it would not make sense to complicate it further through funding cuts at this time;
- The shared service currently provided within NALHN by LMH and Primary Health sites be reconfigured to develop a less siloed primary health service; and
- The Community Paediatrician role be discussed between relevant parties in SALHN in terms of future funding and governance to determine whether this role is a primary health service that reaches in to the hospital or a hospital service that reaches out to the community. (Page 32)

- The three existing women's services be replaced by a single fully integrated metropolitan women's health service;
- Further consideration be given to where to locate the service hubs noting that the main population centres and therefore areas of greatest need are in the North and the South;
- The new women's health service have a focus on providing services that are consistent with the policy objectives specified in the evaluation framework with a particular focus on vulnerable women including those who are socially and/or financially disadvantaged;
- The integrated service be given a new name to emphasise that a new integrated service is being developed;
- The restructure be implemented as a whole of service change rather than undertaken in a piecemeal approach with the objective of minimising confusion and service gaps; and
- Funding for women's services be maintained at the current levels for the remainder of FY 2012–13 (unless the proposed changes can be achieved earlier). Funding in FY 2013–14 should be reduced by $0.5m and by a further $0.5m in FY 2014–15 (making a total ongoing reduction of $1.0m) in the light of the more targeted focus of services (as per policy objectives) and reduced overhead costs from the reconfiguration of the service. (Page 36)

- Funding for residential aged care health support services cease by the end of FY 2012–13 (unless the proposed changes can be achieved earlier);
- The possibility of the programs fitting with other primary care providers such as medicare locals be investigated; and
- The plans of medicare locals and SA Health for access to primary care be discussed to develop a clear understanding of the work being undertaken in this area. (Page 39)

- Funding to the General Practice Spirometry and Lung Function unit cease at end of FY 2012–13 (unless the proposed change can be achieved earlier), consistent with the Commonwealth policy responsibility for these services. (Page 40)

- Funding to ICCOP be maintained in FY2012–13 (unless the proposed changes can be achieved earlier), with a transition plan developed to support the integration with the functions of the MAST program; and
- Funding in FY 2013–14 be decreased by $0.370m in line with the reduced administration and corporate overheads and the withdrawal from long term case management. (Page 42)

- Funding to the Aboriginal workforce Initiative be maintained in FY 2012–13 (unless the proposed changes can be achieved earlier) and reduced by $0.200m in 2013–14 through the development of a more consolidated service in line with the evaluation framework. (Page 45)

- Hospital based services which are delivered in hospital by hospital staff, with governance through the hospital structures do not meet the definition of non-hospital services and should not be in scope for primary health funding;
- The funding for identified hospital based services be maintained for FY 2012–13 and FY 2013–14 unless proposed changes can be achieved earlier, whilst a transition plan is developed by LHNs;
- A transition out plan be developed for all services where funding is ceased in FY 2014–15;
- The governance of other Non-hospital services be reviewed to ensure they are aligned with primary health structures; and
- A steering committee be formed comprising of representation from all the metropolitan local health networks to manage the refocusing and reconfiguration of funded services. (Page 48)

- A more detailed examination of the state child protection services be undertaken to determine the optimal configuration of this service. (Page 49)

- An efficiency dividend of 3% be applied based on the total funding of those services which have not been subject to detailed review in this report;
- This dividend be capped at 3%; and
- LHN CEOs have the authority to determine how the dividend is applied to particular services. (Page 50)

- Each non-hospital based service be reviewed to ensure that productivity benchmarks and KPIs (in the most appropriate form) which will provide robust evidence of performance are specified; and
- There be a continuing program of evaluation against the KPIs and productivity benchmarks so that no service continues beyond two years without reliable evidence that service objectives and productivity standards are being met. (Page 51)