

Ministerial Review of  
Health Care Networks  
**Government Response**

May 2000

## Introduction

The Bracks Labor Government's election commitment was to replace the large and expensive public hospital network structure with a system of governance more responsive to the community.

Within weeks of being elected a Ministerial Review Panel was appointed, chaired by Professor Stephen Duckett, to determine what should replace the network structure. Following initial consultation, an Interim Report was released in February 2000 foreshadowing the configuration being contemplated by the Review Panel. Over 18,000 people visited the web site for the Review and 8,000 copies of the Interim Report were downloaded. Two hundred and fifteen submissions were received.

## Financial Viability of Public Hospitals

The urgency of creating a new structure for public hospitals is clear in the Review's Final Report. It shows a progressive decline in the financial viability of public hospitals under the previous Government. The need for immediate action is clear in the financial situation presented by the Review. Health Care Networks have gone from a position from making a \$26 million surplus in 1994/95, to a deficit at February this year of \$9 million.

Net current assets have dropped from \$76 million in 1992/93 to negative \$12.5 million in December 1999. This trend has been consistent over the last seven years, with a one-off improvement in the year leading up to the election. The Review states that:

'concurrently with this decline in net current assets, the relatively 'poor' Health Care Networks were forced to sell investment assets to provide operating funds and fund capital expenditure ... the North Western Health Care Network and the Austin & Repatriation Medical Centre ... are technically insolvent by normal commercial criteria despite selling available assets and spending reserves which ought to be available to support research commitments, medical staff benefits and employee entitlements. Financial performance across three of the other four Health Care Networks is patchy, with the richer hospitals supporting the poorer through various systems of cross-subsidisation.' (p. 1)

As part of its \$176 million boost to public hospitals, this year's Bracks Government Budget provides \$53 million in extra funding to the base operating budgets of public hospitals to address their medium-term viability.

Further work is being done on addressing the short-term liquidity problem arising from years of neglect. The Government is currently conducting a review to determine the level and type of one-off equity injection that will be needed to make the public hospitals solvent.

In addition to these injections of funds to address the short and medium term problems the Bracks Government inherited, a new approach to managing public hospitals is necessary to achieve long-term responsible financial management.

## Need for Change

The former Network system had become:

- Too large and remote from the communities they served, with Inner and Eastern Health Care Network stretching from the city to the Dandenongs, and North-Western from Williamstown to Epping.
- Unmanageable because of the number and complexity of agencies, leading to an inability to address the financial challenges and creation of expensive layers of bureaucratic overheads.

and

- Characterised by conflict and competition, instead of the necessary collaboration needed to tackle the difficult problems arising from changes in technology and health practices.

## New Approach to Managing Public Hospitals

The existing seven Networks will be replaced with twelve Metropolitan Health Services. The new configurations are based on three policy principles:

1. The larger Networks have been broken down to cover more reasonably sized geographic communities bringing them closer to the people they serve.
2. The new structures are designed to integrate across acute health, aged care, and mental health to achieve continuity of care and promote the most appropriate level of care depending on needs. These linkages will ensure people are properly supported after their acute hospital stay.
3. Capacity to meet the financial challenges faced by each hospital. Economies of scale are maintained where these have been effective.

Underlying the configurations is the beginning of a new era of cooperation and collaboration between Metropolitan Health Services and in their relationship with Government. We believe the public expects the Government to ensure their public hospitals are meeting their needs for quality and accessible care when they need it. This can only happen through partnership and a close working relationship between the elected Government and the Metropolitan Health Services charged with day-to-day management responsibility.

A series of measures will be implemented to ensure the new Metropolitan Health Services are actively pursuing the Government's public hospital agenda. These include requirements to present Annual Strategic Plans to the Minister, review of progress against Government objectives, and joint Board/Department involvement in selecting and evaluating the performance of the Metropolitan Health Service CEOs.

## New Configurations

The Government supports the Review Panel's proposed configuration with the seven Networks being replaced with twelve Metropolitan Health Services:

Bayside Health  
Eastern Health  
Southern Health

Northern Health  
Western Health  
Austin & Repatriation Medical Centre  
Peninsula Health  
Royal Melbourne Hospital  
Women's & Children's Health  
Peter MacCallum Cancer Institute  
Royal Victorian Eye & Ear Institute  
Dental Health Services Victoria

Subject to further detailed analysis and consultation, St Georges Hospital will be managed by the Sisters of Charity Health Service, to achieve integration of acute, aged, and mental health across the two sites, and recognising their longstanding referral relationship.

The key changes are the break up of the Inner & Eastern Health Care Network into four Metropolitan Health Services and the North Western Health Care Network into three.

The series of measures to improve community involvement are supported by the Government, consistent with its aims of making the new structure more responsive to the community, including establishment of Community Advisory Committees for each Metropolitan Health Service.

## **Implementation**

The target date for establishing the new Metropolitan Health Services is July 1, 2000. This will encompass creation of the legal entities, appointment of Boards, selection of interim CEOs, and assignment of the large majority of staff from existing Networks to the Metropolitan Health Services. The timeline depends on the passage of the enabling legislation through the Parliament in this Session.

The transfer of assets will occur from 1 July, with some assets being designated on 1 July to the new entities and others progressively being shifted after that date. The new Boards and Acting CEOs will have the authority to manage the services included in their new Metropolitan Health Service under transitional guidelines developed by the Department of Human Services in consultation with the new Boards and management.

It is recognised that the transfer of some assets and staff will not be straightforward. To enable an orderly resolution of these issues over time, the existing Networks will be maintained as legal entities and administrators appointed to replace the existing Boards.

The Government recognises that implementation of the new structure is essential to eliminate uncertainty in the State's public hospital system. The new management must be in place as quickly as possible to focus on achieving the Government's objectives of improving access to emergency care, addressing concerns about quality, responsible financial management, and controlling waiting lists.

It will not be possible to resolve all the issues surrounding the transfer of St Georges Hospital to the Sisters of Charity Health Service by July 1, so an interim management arrangement will be established, with an Administrator being appointed to perform the functions of the Inner & Eastern Health Care Network Board.

New Boards will be appointed across all Metropolitan Health Services. Public advertisement for Board members has occurred. The Government recognises the

experience and contribution of the existing Boards and this will be taken into account in selecting the new Boards.

The Boards will comprise six to nine members to ensure efficient decision-making. Government will be seeking a balanced membership, covering people with business, medical and community backgrounds, consumer orientation, and males and females.

Acting CEOs will be appointed by the Governor-in-Council. An executive search process has been initiated to assist in the selection of permanent CEOs after the Boards have been established.

## **Savings**

In breaking down the large Network bureaucracy, the Government sought to re-direct savings from administration to patient care.

The Review identifies \$18 million in savings derived from:

- Direct savings from abolition of Networks (\$9.2 million).
- Centralisation and rationalisation of the relationship between DHS and the new Metropolitan Health Services (\$3 million).

and

- Establishment of a new system to achieve economies of scale through joint purchasing across public hospitals (\$5-6 million).

## **Other Changes**

A series of other changes should be noted:

- The way the Department of Human Service deals with Networks will be streamlined. Instead of dealing with multiple parts of the Department at both regional and head office, the Metropolitan Health Services will deal directly with head office. The need for departmental regional involvement is diminished through breaking down of the size of the Networks and creation of their own community consultative structures. Regional Offices of the Department will re-focus on direct service delivery and promoting primary care services.
- The proposal to create a statewide purchasing system for public hospitals to achieve economies of scale from bulk purchasing. This was not possible under the previous system of competition between the Networks. In New South Wales this has led to major cost savings for the public health system.

## **Conclusion**

The Government has responded comprehensively to the 84 recommendations of the Ministerial Review of Health Care Networks. Implementation of the new structure of Metropolitan Health Services provides the organisational base for the Bracks Government's new approach to managing the public hospital system.

The new governance structure will bring public hospitals closer to the communities they serve. Acute care, aged care, and mental health will be integrated to improve continuity of care across the system.

There will be a closer relationship between Government and public hospitals, with streamlining of dealings with the Department and more attention to the public hospitals achieving Government's health policy objectives.

Responsible management of financial resources will be achieved through reducing bureaucracy and promoting cooperation across public hospitals rather than competition.

## Attachment 1: Detailed Government Response to Recommendations of Ministerial Review of Health Care Networks

Recommendations	Government Response
<p>1. That Government address the liquidity problem, including asset backing for Specific Purpose Funds, as a matter of urgency and before the establishment of the new Metropolitan Health Services.</p>	<p>Level and method to be addressed following the due diligence review commissioned by Department of Treasury and Finance, with Department of Human Services consulted.</p>
<p>2. That funding arrangements for 2000/2001 should equalise the proportion of activity funded at marginal rates. The proportion of activity funded at marginal rates should be restored to the pre-Health Care Network level of 5 percent.</p>	<p>Addressed in the 2000/2001 Budget.</p>
<p>3. That the transfer of assets from trust funds and specific purpose funding is taken into account in the establishment of the initial balance sheets for the new Metropolitan Health Services by reviewing decisions taken over prior years.</p>	<p>Agreed. To be clarified in due diligence (see Rec 1.)</p>
<p>4. That the following Metropolitan Health Services be established:</p> <p><b>Royal Melbourne Hospital</b> Royal Melbourne Hospital, Melbourne Extended Care &amp; Rehabilitation Service</p> <p><b>Women's and Children's Health</b> Royal Children's Hospital, Royal Women's Hospital</p> <p><b>Austin &amp; Repatriation Medical Centre</b> Austin Campus, Repatriation Campus, Royal Talbot Rehabilitation</p> <p><b>Bayside Health</b> Alfred Hospital, Caulfield General Medical Centre, Sandringham Hospital</p> <p><b>Dental Health Services Victoria</b></p> <p><b>Eastern Health</b> Angliss Health Service, Box Hill Hospital, Maroondah Hospital, Peter James Centre, Yarra Ranges Health Service</p>	<p>Agreed.</p>

<b>Recommendations</b>	<b>Government Response</b>
<p><b><i>Northern Health</i></b> Broadmeadows Health Service, Bundoora Extended Care Centre, Northern Hospital</p> <p><b><i>Peninsula Health</i></b> Frankston Hospital, Mt Eliza Aged Care &amp; Rehabilitation Service, Rosebud Hospital</p> <p><b><i>Peter MacCallum Cancer Institute</i></b> <b><i>Royal Victorian Eye and Ear Hospital</i></b></p> <p><b><i>Southern Health</i></b> Dandenong Hospital, Hampton Rehabilitation Hospital, Kingston Centre, Monash Medical Centre-Clayton, Monash Medical Centre-Moorabbin, Cranbourne Integrated Care Centre</p> <p><b><i>Western Health</i></b> Sunshine Hospital, Western Hospital, Williamstown Hospital</p>	
<p>5. That aged care and mental health services units, not specified in recommendation 4, within the Inner and Eastern Health Care Network and aged care services within the North Western Health Care Network should be assigned to the Metropolitan Health Service which has responsibility for the proposed catchment area in which they are located. Aged care and mental health services in other Health Care Networks should remain with the successor Metropolitan Health Service pending the realignment of the catchment areas.</p>	<p>Agreed.</p>
<p>6. That MonashLink be established as a separate community health centre.</p>	<p>Agreed.</p>
<p>7. That an independent reviewer evaluate the impact of Metropolitan Health Service management on community health service provision in the Southern Health Care Network, and develop a strategy to ensure that community health principles are protected and promoted.</p>	<p>Agreed with the additional brief that the review address the strengths and weaknesses of the MonashLink model of consolidating community health centres alongside those that remain separate from each other but within the Network structure.</p>

<b>Recommendations</b>	<b>Government Response</b>
<p>8. That the North Western Health Care Network Mental Health Program (with the exception of Central East Mental Health Service which should become part of Eastern Health) should continue to operate in its current form. Operational responsibility for the service should be located within Western Health. The Program should be reviewed after twelve months to ensure there is appropriate coordination of services.</p>	<p>Agree with the recommended configuration. Do not support auspice at Western at this stage. Recommend management auspice at Royal Melbourne to be reviewed in twelve months consistent with the program review.</p>
<p>9. That the North Western Health Mental Health Program (Western Health) should auspice MH-Sky in liaison with Women's and Children's Health. These joint arrangements should be reviewed after twelve months.</p>	<p>Agreed.</p>
<p>10. That the North West Regional Dialysis Service should continue to operate in its current form. Operational responsibility for the service should be located at Royal Melbourne Hospital. The Program should be reviewed after twelve months to ensure there is appropriate coordination of services.</p>	<p>Agreed.</p>
<p>11. That the services of St George's Health Service should be auspiced by the Sisters of Charity Health Service.</p>	<p>Agreed, subject to resolution of a range of transition issues, including staffing and equipment. Assets (land and building) to be maintained in public ownership.</p>
<p>12. That formal linkages between Metropolitan Health Services and denominational or privately operated (public) hospitals should be established where there is a common community of interest or close geographic proximity between providers.</p>	<p>Agreed.</p>
<p>13. That, where services have defined geographic catchments (aged care and mental health), the boundaries of the catchment should, as far as possible, be aligned. In relation to Aged Care Assessment Services, the Department of Human Services should consult with the Commonwealth as soon as possible.</p>	<p>Agreed.</p>
<p>14. That the boundaries of the catchments of the Primary Care Partnerships should also align, as far as possible, with the aged care and mental health catchments.</p>	<p>Agreed.</p>

<b>Recommendations</b>	<b>Government Response</b>
<p>15. That the Department of Human Services establish a process to achieve the alignment of these catchments. A proposed geographic grouping of local government areas to achieve full alignment is contained in this Report. Further discussions may be required with stakeholders in a small number of areas, in particular those relating to the City of Monash. The new boundaries should be implemented by June 2002.</p>	<p>Agreed.</p>
<p>16. That the legislation should enable the creation of new public statutory health care agencies known as Metropolitan Health Services. Metropolitan Health Services should be governed by Boards. The focus of Boards should be good governance in a manner appropriate for public statutory providers of health services.</p> <p>Metropolitan Health Services should be registered funded agencies and generally subject to the statutory controls which apply to such agencies.</p>	<p>Agreed. Additional administrative changes: selection of the CEO to be jointly by Board Chair, Secretary of DHS, and independent expert chosen by DHS; annual performance appraisal of the CEO jointly by Board Chair and Secretary of DHS; annual performance review and Strategic Plan meeting Board and Minister to ensure Government objectives met. Further details of roles and responsibility of Boards, CEOs and DHS will be developed.</p>
<p>17. That the core purpose of Metropolitan Health Services be to provide services to public patients in accordance with the Australian Health Care Agreement (Medicare) principles. This should be given a legislative base (with appropriate adjustments in terminology to reflect the special case of Dental Health Services Victoria). Boards should have the capacity to alter their objects, provided that the revised objects are not inconsistent with the core purpose.</p>	<p>Agreed.</p>

<b>Recommendations</b>	<b>Government Response</b>
<p>18. That the Health Services Act 1988 provide that the functions and duties of the Board of a Metropolitan Health Service expressed in legislation include to:</p> <ul style="list-style-type: none"> <li>• Establish the organisational structure of the Metropolitan Health Service.</li> <li>• Appoint the CEO and senior management team, in consultation with the CEO [Note: the legislation should enable the initial CEOs to be appointed by Government on an interim basis].</li> <li>• Oversee the management of the Metropolitan Health Service by the CEO.</li> <li>• Develop a strategic plan consistent with any guidelines produced by the Minister for Health from time to time.</li> <li>• Develop plans, strategies and budgets to ensure the accountable and efficient provision of health services by the Metropolitan Health Service.</li> <li>• Develop collaborative arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care.</li> <li>• Work with other Metropolitan Health Services and other agencies to facilitate sharing of common services to promote efficiency.</li> <li>• Ensure effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the Metropolitan Health Service.</li> <li>• Ensure that any problems identified with the quality or effectiveness of health services are addressed in a timely manner and that the Metropolitan Health Service strives to continuously improve quality and foster innovation.</li> <li>• Facilitate health research and teaching.</li> <li>• Monitor the performance of the Metropolitan Health Service and the CEO.</li> </ul>	<p>Agreed with some refinement to reflect governance principles (for example, Financial management) and avoid duplication, and reflect role of Department and Minister in ensuring accountability for performance.</p>

<b>Recommendations</b>	<b>Government Response</b>
<ul style="list-style-type: none"> <li>Establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served by the Metropolitan Health Service, and that the views of users of health services are taken into account.</li> </ul>	
<p>19. That Boards of Metropolitan Health Services should comprise between six and nine people appointed by the Governor in Council on the recommendation of the Minister Terms of appointment should be for a maximum of three years. Directors should be eligible for reappointment but should not be able to serve more than three consecutive terms.</p>	<p>Agreed.</p>
<p>20. That the Minister have discretion in recommending appointments to Metropolitan Health Service Boards. The Health Services Act should require the Minister, in making recommendations to the Governor in Council, to ensure that:</p> <ul style="list-style-type: none"> <li>Each Board includes at least one person who is able to reflect the perspectives of users of health services. Health service providers should be ineligible to fulfil this role. Accordingly, registered health practitioners and people currently or recently employed or engaged in the provision of health services should be ineligible for appointment under this particular criterion.</li> <li>Women and men are adequately represented.</li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>No more than 25 percent of Directors can be registered medical practitioners.</li> </ul> <p>Although this should not be in legislation, when making appointments to Boards, the Minister should take into account Victoria's culturally diverse community, the Metropolitan Health Service's role in teaching and research, the comprehensive nature of the Service, including aged and mental health services, and other relevant matters</p>	<p>Agreed in principle as a target but mechanisms needs further consideration. Legislation does not stipulate exact membership but talks about the need for balance.</p>

<b>Recommendations</b>	<b>Government Response</b>
<p>21. That legislation should require the Board to establish a Community Advisory Committee and a Primary Care and Population Health Advisory Committee.</p> <p>To assist in creating effective linkages between Metropolitan Health Services and Primary Care Partnerships, the Primary Care and Population Health Advisory Committee should include nominated representatives from the relevant Primary Care Partnerships, including Divisions of General Practice, community health, local government and consumers. A representative of the relevant Department of Human Services region should also be included.</p> <p>The Board should have the capacity to establish such other committees as it determines.</p> <p>The Department of Human Services be responsible for ensuring that an independent evaluation of the effectiveness of Primary Care and Population Health Advisory Committees be conducted and reported within three years of establishment.</p>	<p>Agreed. The legislation should also require Boards to establish Finance/Audit and Quality/Patient Review Committees.</p>
<p>22. That Directors of Boards of Metropolitan Health Services be entitled to remuneration of \$5,000 and Chairpersons be entitled to \$10,000 per annum. The Government should review the remuneration currently paid to regional Public Hospital Boards in light of this recommendation.</p>	<p>Not supported. Board remuneration will be regulated by Government. Remuneration levels will be subject to the outcome of the broader Government review of Board arrangements and negotiation with prospective members to ensure high calibre Board members are attracted recognising the public service aspect of public hospital Board positions. As an initial guide, it is proposed that Board remuneration be at least comparable with Board members in major rural hospitals. Board members in the larger organisations have responsibilities for the financial performance and clinical quality of large organisations and will need to assign the necessary time to perform their duties.</p>

<b>Recommendations</b>	<b>Government Response</b>
23. That legislative immunity, consistent with that provided to public hospitals and Health Care Networks, be provided to Boards of Metropolitan Health Services.	Agreed.
24. That the Commissioner for Public Employment be responsible for determining the bands for CEO and executive officer remuneration consistent with Joint Advisory Panel Guidelines. The maximum total remuneration package available to CEOs of Metropolitan Health Services should be capped at that of the Secretary of the Department of Human Services.	Agreed.
<p>25. That the Health Services Act 1988 provide guidance to Directors of Metropolitan Health Service Boards on how to manage conflicts of interest.</p> <p>Where a Director has a direct or indirect pecuniary interest in a matter being considered or about to be considered by a Board, the Health Service Act 1988 should require the director to:</p> <ul style="list-style-type: none"> <li>• Declare the interest at a meeting of the Board as soon as practicable after the relevant facts come to the director's knowledge.</li> <li>• Absent him or herself during any deliberations of the Board in relation to the matter.</li> </ul> <p style="text-align: center;">and</p> <ul style="list-style-type: none"> <li>• Not take part in any decision of the Board in relation to the matter.</li> </ul>	Agreed.
26. That a range of shared support services should be established to ensure continued provision of services to the successor Metropolitan Health Services of the North Western Health Care Network. The precise range of shared support services should be determined by the Chief Executive Officers of the successor Metropolitan Health Services and should be the subject of consultation with unions and affected staff.	Agreed.

<b>Recommendations</b>	<b>Government Response</b>
27. That the Chief Executive Officers of the successor Metropolitan Health Services of the Inner and Eastern Health Care Network should review the need to establish a shared support service for the maintenance of information technology infrastructure services.	Agreed.
28. That section 42 of the Health Services Act 1988 should be amended to authorise the making of statutory directions with respect to the creation of shared support service agencies.	Agreed. Additional action may be required to encourage proposals to be brought forward for the establishment of such agencies for suitably experienced organisations.
29. That the Government should mandate that all hospitals will purchase a specified range of pharmaceuticals and general medical supplies according to approved contracts from 1 July 2001. This should be predicated on the establishment of mechanisms to ensure that the purchasing contracts reflect the needs of the field and that the purchasing agency/agencies meet agreed performance standards with respect to price and responsiveness.	Agreed. In addition, medical equipment should be included in the scope for the new agency/agencies.
30. That the Department of Human Services should establish a Task Force with the industry to examine the best possible model for establishing centralised purchasing for the health sector and to make implementation recommendations to achieve the 1 July 2001 start-up date.	Agreed.
31. That the Department of Human Services should review the opportunities available to build on existing structures and centres of proven performance in developing the Victorian centralised purchasing framework.	Agreed.
32. That section 42 of the Health Services Act 1988 should be amended to authorise the making of statutory directions with respect to centralised purchasing arrangements.	Agreed.

<b>Recommendations</b>	<b>Government Response</b>
<p>33. That a Health Services Planning Council be established to develop a strategic vision for health service planning in the future and advise Government and the Department of Human Services on specific local, regional and statewide planning issues. The Council should comprise between nine and twelve people representing a range of interests and at least two-thirds of the membership should be external to the Department of Human Services. The Chair of the Council should be external to the Department of Human Services.</p>	<p>Not supported. Such a Council would require its own planning bureaucracy to be effective, and this would duplicate the Department of Human Services. The planning role proposed is the core function of the Department of Human Services and can only be performed with the resources and neutrality available to a Government Department. The Department's planning function has been strengthened with the recent establishment of the Policy Development and Planning Division. The Department's program areas (for example, Acute Health Division) has responsibility for both operations and planning. Instead of a standing Council, the Minister will draw on ad hoc Ministerial Committees to address specific issues.</p>
<p>34. That the Health Services Planning Council should be required to report at least three times a year to the Minister. These reports should be made available to the general public.</p>	<p>Not supported. See Rec 33 response.</p>
<p>35. That the Department of Human Services should review the international and Australian experiences with setting explicit waiting list criteria, and evaluate the effects of these initiatives on resource use and allocation.</p>	<p>Agreed and underway.</p>
<p>36. That the Department of Human Services should develop a program to introduce clear criteria and concise scoring systems for priority setting for elective surgery. The criteria and scoring systems should build on the international experience in this area.</p>	<p>Agreed and underway.</p>
<p>37. That, in developing the scoring system for elective surgery priority, the Department of Human Services should be assisted by a Task Force including surgeons from appropriate sub-specialties, physicians, epidemiologists/health service researchers, general practitioners and consumers.</p>	<p>Agreed.</p>

<b>Recommendations</b>	<b>Government Response</b>
38. That the Task Force should complete criteria and scoring systems for at least two sub-specialties by the end of 2001, and all relevant sub-specialties by the end of 2002.	Agreed.
39. That the Department of Human Services should evaluate the most appropriate way (from a consumer point of view) of presenting information on valid expected waiting times for 20 procedures by hospital and publish this information widely.	Agreed.
40. That Metropolitan Health Services should be required, as part of any planning guidelines issued by the Minister, to develop strategies to ensure equity in waiting times within their responsibility, between specialties and in comparison with metropolitan-wide benchmarks.	Agreed.
41. That Metropolitan Health Services should be required to establish a mechanism to assist consumers make an informed choice of the location for their surgery.	Agreed.
42. That each Metropolitan Health Service Board includes at least one person, appointed by the Governor in Council on the recommendation of the Minister for Health, who is able to reflect the perspectives of users of health services. Health service providers should be ineligible for this role.	Agreed.
43. That a provision in keeping with section 40L of the Health Services Act 1988, requiring the establishment of at least one Community Advisory Committee, be included in the amendments to the Act, and the provision strengthened with the inclusion of provisions governing timelines for the appointment of Advisory Committees, and the maintenance of such Committees.	Agreed.
44. That the legislative provision governing the appointment of Community Advisory Committees should also stipulate that membership should comprise between six and nine people appointed to the Committee by the Board of the Metropolitan Health Service.	Agreed as administrative guide.

<b>Recommendations</b>	<b>Government Response</b>
45. That Community Advisory Committees should comprise people who have the capacity to reflect the perspectives of the communities served by the Metropolitan Health Service. Registered health practitioners and people currently employed or engaged in the provision of health services should be ineligible for membership to such Committees.	Agreed.
46. That the Department of Human Services publish non-statutory guidelines, prior to the establishment of Metropolitan Health Services, and then from time to time, which will assist in the selection and appointment of members for Community Advisory Committees and provide guidance in relation to the role and conduct of such Committees.	Agreed.
47. That the legislative provision governing the appointment and conduct of Community Advisory Committees should also require the establishment of an arrangement for direct reporting and accountability between the Board and the Community Advisory Committee.	Agreed as administrative guide.
48. That a member of the Board, not being the Chief Executive Officer, who satisfies the selection criteria for appointment to a Community Advisory Committee, be appointed as a member of each Community Advisory Committee. This appointment would be in addition to the Chief Executive Officer's appointment to the Community Advisory Committee, if such an appointment is made.	Agreed.
49. That the Board of a Metropolitan Health Service be required to report to the Minister for Health, on an annual basis, on the activities of the Community Advisory Committee and the actions taken by the Board in relation to the recommendations made to it by such a Committee.	Agreed.
50. That the legislation require the Secretary of the Department of Human Services to incorporate a report on the activities of the Community Advisory Committees into the Annual Report of the Department of Human Services.	Agreed as administrative guide.

<b>Recommendations</b>	<b>Government Response</b>
51. That the Department of Human Services be responsible for ensuring that an independent evaluation of the effectiveness of Community Advisory Committees be conducted and reported within three years of their establishment.	Agreed.
52. That Boards negotiate key performance measures with their Community Advisory Committees and that information gained from assessments against these measures be used in an ongoing improvement process by the Committee.	Agreed.
53. That Boards of Metropolitan Health Services ensure that a range of mechanisms and opportunities are established and made available to the community to enable meaningful input into decision-making within Metropolitan Health Services. Community Advisory Committees should supplement the array of mechanisms by which Boards are able to ascertain community views and integrate these views into decision-making processes.	Agreed.
54. That the Department of Human Services fund an independent mechanism to assist Boards of Metropolitan Health Services in recruiting, training and resourcing consumer/community representatives thus strengthening community involvement in Metropolitan Health Services and participation in health care debates more generally.	Agreed.
55. That the Department of Human Services develop and publish, by 1 July 2001, a suite of performance indicators against which the quality of care provided by Metropolitan Health Services and public hospitals can be assessed.	Agreed.
56. That the Department of Human Services assist Metropolitan Health Services to establish processes to ensure that all data collected against performance indicators is reported in a manner that will enable the Board to monitor and review performance on an ongoing basis and enable a comparison with peer hospitals.	Agreed.

<b>Recommendations</b>	<b>Government Response</b>
57. That Boards ensure that processes are established to measure actual performance against benchmark standards and to facilitate ongoing improvement and innovation as well as addressing poor performance, in terms of delivery of care, at a unit level as well as at an individual provider level.	Agreed.
58. That Metropolitan Health Services report to the Department of Human Services on an agreed suite of indicators, derived from existing data collections, to enable the Department to provide feedback to Services on performance at a campus level, a Metropolitan Health Services level and also at a state-wide level thereby facilitating ongoing improvement in the delivery of care and to enable the Department to publish comparative data on an annual basis.	Agreed.
59. That Metropolitan Health Services should plan for entity-wide accreditation as soon as practicable. This does not preclude application for accreditation of separate programs.	Not supported. The method of gaining accreditation of the component parts of the Metropolitan Health Services should be determined by their Boards. It may be impractical and onerous for the accreditation process to be done simultaneously across all entities at the same time.
60. That Metropolitan Health Services should consult with relevant unions and staff about the implementation of Government policy relating to improving the cleanliness of hospitals and introducing better infection control.	Agreed.
61. That a Memorandum of Understanding be negotiated between major regional hospitals and at least one Metropolitan Health Service. The purpose of the Memorandum of Understanding should be to facilitate access for rural patients requiring specialist treatment and care, such as Coronary Care or Intensive Care, at the Metropolitan Health Service, and formalise such arrangements as staff secondments, dual appointments and teaching and support services.	Agreed.

<b>Recommendations</b>	<b>Government Response</b>
62. That the Health Services Planning Council should review the appropriateness and effectiveness of Memorandum of Understanding arrangements within two years.	Not supported. See Rec 33
63. That Boards of Metropolitan Health Services ensure written protocols are disseminated to all staff in relation to the accommodation of male and female patients within the same ward/unit/room.	Agreed.
64. That \$8.7 million identified as recurrent savings through the abolition of Health Care Networks and the reduction in Health Care Network bureaucracy be redirected into improved infection control and cleaning in hospitals, aged care and mental health facilities.	Agreed and included in the 2000/2001 Budget.
65. That all Metropolitan Health Services should contract directly with Department of Human Services Head Office, for both the Acute Health Program and the Aged, Community and Mental Health Program.	Agreed.
66. That the Department of Human Services should develop improved mechanisms to ensure coordination between the Acute and Aged, Community and Mental Health programs at the regional level.	Agreed. Further work will be undertaken in the Department to ensure no anomalies arise from this measure, such as whether ACMH program administration should be split between central (hospital based services) and regional offices (non-hospital based services). Mechanisms for ensuring linkages of related services at regional level will be important, including child and adolescent mental health services and child welfare functions.

<b>Recommendations</b>	<b>Government Response</b>
<p>67. That residual metropolitan regional Acute Health functions such as Ministerial correspondence should be undertaken in Head Office. In terms of Aged, Community and Mental Health functions, metropolitan regions should retain responsibility for the management of primary care services and all other functions should be managed centrally. The reallocation of Aged, Community and Mental Health functions may lead to redirection of funds currently provided for regional operations. Net savings of \$2 million from the previously recorded Acute and Aged, Community and Mental Health contributions have been identified. The remaining central office contribution to the metropolitan regional offices should reflect workload.</p>	<p>Agreed.</p>
<p>68. That the Department of Human Services should develop improved mechanisms to ensure ongoing coordination between the Acute and Aged, Community and Mental Health Programs, particularly in relation to funding policy development and payment systems operation.</p>	<p>Agreed.</p>
<p>69. That three year Health Service Agreements should be introduced. This will add greater stability and significantly reduce the administrative overlay associated with processing and reprocessing the Agreement.</p>	<p>To be considered, recognising that while the budget cycle operates on an annual basis a three year Health Service Agreements would have little meaning. Public hospitals operate in an environment of relative certainty already compared with other industries, with both revenue and expenditure varying by only a few percent each year. More certainty can be created through better health service planning which stipulates which areas are targeted for expansion and contraction. Development of a Metropolitan Health Services Plan which would provide this more certain planning environment is under consideration.</p>

<b>Recommendations</b>	<b>Government Response</b>
70. That the number of activities, performance measures and level of reporting detail required in the Health Service Agreement be reduced to a more appropriate level.	Agreed.
71. That a 'rolled up' purchasing framework for Aged, Community and Mental Health patient services should be developed. As a minimum, current 'unit of service' determined budgets can be weighted and aggregated to 'weighted units of Aged, Community and Mental Health services'. Services would then be interchangeable within the overall funding cap.	Agree that there should be a 'rolled up' purchasing framework for ACMH, but not that the purchasing framework should be 'weighted units of Aged, Community and Mental Health Services'. More work is required on the appropriate basis for purchasing.
72. That the Department of Human Services be required to adhere to a defined schedule of activity to ensure that the development and variation of Health Service Agreements is streamlined and concluded at an earlier stage. Draft Health Service Agreements should be available to agencies before the start of new three year funding agreements. These would then be open for discussion/refinement between the Department of Human Services and the agency for a fixed short period (for example, two months) rather than having the budget imposed with no scope for negotiation.	Agree to increased streamlining to finalise Agreement process earlier, but not to three year funding agreements.
73. That the Department of Human Services investigate adopting a policy where any necessary variations to Health Service Agreements are dealt with only at defined points of the year (for example, quarterly).	Agreed.
74. That the Aged, Community and Mental Health Division investigate utilising an efficient Health Service Agreement and payment systems for its services. The Acute Health Division provides a model in this regard.	Agreed, but casemix type systems are unlikely to be applicable across the whole of ACMH because of the diversity of service types.
75. That the Acute Health Division should review and minimise the list of specified grants requiring separate control/acquittal. This should be done immediately to minimise 1999/2000 acquittal requirements and funding adjustments.	Agreed.

<b>Recommendations</b>	<b>Government Response</b>
<p>76. That current arrangements for payments of Training &amp; Development Grants should be reviewed for 2001/2002 with the objective of maintaining the identity of these grants while reducing the acquittal and reporting burden on Metropolitan Health Services. In particular, it is recommended that the Acute Health Division investigate:</p> <ul style="list-style-type: none"> <li>• The possibility of folding research payments, payments for University medical staff and Hospital Medical Officers, other than interns, into a fixed payment which could be allocated on the proportion of tertiary DRGs or a similar model.</li> <li>• Transferring the reporting requirements for all clinical under-graduate education funding to Universities with whom hospitals contract for these programs.</li> </ul> <p style="padding-left: 40px;">and</p> <ul style="list-style-type: none"> <li>• Transferring the reporting requirements for post-graduate nursing funding to Universities with whom hospitals contract for these programs.</li> </ul> <p>For 2000/2001, the Metropolitan Health Services should be exempt from reporting staffing numbers pending the introduction of the new arrangements.</p>	<p>Agreed. These options along with others will be explored.</p>
<p>77. That the role and function of Department of Human Services Head Office Divisions (particularly Resources, Acute Health and Aged, Community and Mental Health) be considered in the light of the changed locus of service contracting, the proposed reduction in the complexity and administrative burden associated with management of the Health Service Agreements and the reduced emphasis on micro-management. It is estimated that \$1 million in recurrent savings through staffing or an equivalent financial contribution can be achieved by reducing the bureaucracy associated with these activities. It is likely that this would also result in estimated savings of \$0.5 million within the agencies due to reduced compliance costs.</p>	<p>Agreed.</p>

<b>Recommendations</b>	<b>Government Response</b>
78. That legislation be developed to facilitate the disaggregation of the Health Care Networks in a speedy, efficient and cost effective manner and the creation of new 'successor' health care agencies along the lines of the proposals outlined in this Report.	Agreed.
79. That the legislation should provide for the initial establishment of a new stand-alone Community Health Centre with an appointed Board as an interim measure.	Agreed.
80. That legislation should, as far as possible, facilitate the transfer of Health Care Network staff to new 'successor' health care agencies, on the same Terms and Conditions and with continuity of service.	Agreed.
81. That the successor organisations should consult with relevant unions and staff about the career structures in the successor organisations.	Agreed.
82. That legislation should enable Metropolitan Health Services to benefit from trusts in favour of the former (pre-Health Care Network era) public hospitals and require, so far as possible, that trust moneys be applied at the corresponding campus/premises.	Agreed.
83. That legislation should facilitate the creation of Health Service Support Agencies.	Agreed.
84. That legislation should ensure that existing approved mental health services automatically continue to be approved services for the purposes of section 94 of the Mental Health Act 1996.	Agreed.