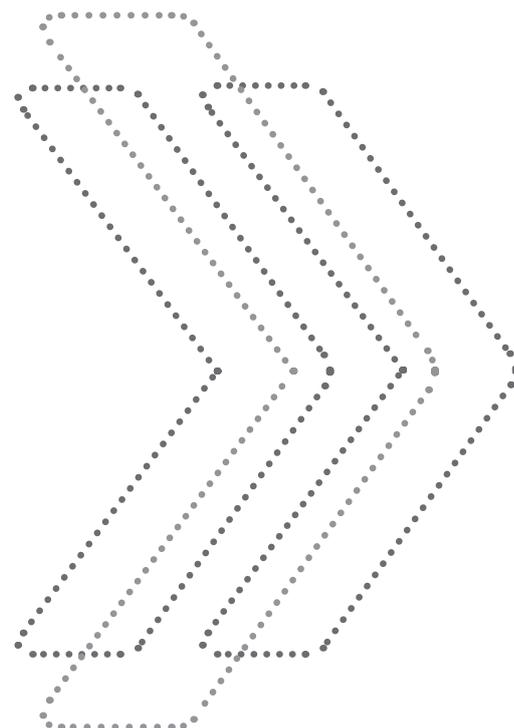

Managing health services through devolved governance

A perspective from Victoria, Australia

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Preface

In 2014 The King's Fund was approached by the health department in the Australian state of Victoria to undertake an independent review of the model of the state's devolved governance of health services. This report presents the findings of our review, drawing on three visits to interview key stakeholders and analysis of relevant documents and data about performance.

In commissioning the review, the health department agreed to our stipulation that the Fund should retain full editorial control of the resulting report. In the pages that follow we highlight both achievements and areas for further development, reflecting what we heard from stakeholders as well as our own assessment of how Victoria's governance model and performance compare with those of other jurisdictions.

The picture that emerges is of a health system performing well. Available data shows that Victoria delivers good results in comparison with other parts of Australia, being at, close to and sometimes above the average on many indicators. Underpinning Victoria's performance is a well-understood governance model that gives the boards running health services at a local level considerable autonomy within a state-wide framework of priorities.

It is also important that there has been a high degree of organisational stability (unusual and enviable from an English perspective) and the pioneering use of case mix-funding that has contributed to the costs of care being lower than in other states.

Recognising these achievements, we conclude that there are several areas in which Victoria could make improvements. These include reviewing the number of boards – from our perspective there seem too many – and bringing greater independence into the appointment of board members to ensure they are selected on the basis of skills and experience.

There is also a compelling case for more collaboration between boards. This is particularly important in the case of boards responsible for regional and rural health services, where isolation from other health services creates risks in relation to the safety and quality of patient care, as illustrated by recent failures of care at Djerriwarrh Health Service.

The transparent reporting of data on performance is another area for improvement. Not only would this strengthen accountability to the public, but also it would support health care providers to compare their performance with others and identify areas in which they can improve.

The 'disinfectant of sunlight', as it has been dubbed, is being used increasingly in other health care systems, including within Australia, and it could be a powerful means of providing an early warning of performance problems. Increased transparency on safety and quality would also provide boards with the information they need to discharge their responsibilities.

A recurring theme in our review was the proper role of the health department in a model of devolved governance. We heard many different views on this and concluded that it ought to have greater involvement in the planning and oversight of clinical services. To do this, the health department would need to strengthen its own capabilities in clinical services planning and monitoring.

In advancing these suggestions, we are clear that the principles of devolved governance are fundamentally sound. The challenge for health care leaders in Victoria is to ensure that the practice of devolved governance is fit for purpose by making incremental improvements of the kind we have proposed and avoiding the destabilising and damaging lurches in policy seen in some other systems.

Chris Ham

Chief Executive, The King's Fund

Executive summary

The present position

Since 2003, health services in the Australian state of Victoria have been run through a system of 'devolved governance'. Boards appointed by the state's health minister are responsible for overseeing the delivery of health services in their areas, operating within a 'statement of priorities' set out by the minister and the health department.

The 'statement of priorities' includes a small number of key performance indicators (KPIs) which, if they are met, see boards subject to much less detailed surveillance of their performance than in the past – a system, in effect, of 'earned autonomy'.

When the KPIs, which chiefly relate to finance and access, are not being met, this prompts graded intervention from the health department. This performance management occurs within a system that is explicit and understood, and helps generate trust between leaders at different levels.

Victoria's approach has enabled the recruitment and retention of experienced chief executives, contributing to a culture of innovation and agility that has been underpinned by organisational stability.

Analysis of the easily available public data shows that Victoria delivers good results in comparison with other parts of the country, being at, close to and sometimes above the Australian average on many indicators. It has used case-mix funding since the mid-1990s, and that appears to be one factor that has allowed it consistently to deliver lower costs of care. Victoria can therefore make the case that it delivers the best value health care in Australia.

Where next?

In a system that in many respects is working well, there nonetheless remains a case for making incremental changes and improvements that would avoid the destabilising and often damaging lurches in governance and reform seen in some other jurisdictions, both within Australia and outside it. Our discussions with leaders in Victoria and informed observers outside the state generated many ideas for how that might be done.

There are choices to be made over the balance of centralised control and devolved decision-making, over how far to use competition and collaboration to stimulate innovations in care, over how far to publish performance data as a stimulus for improvement, and over whether the department, even within a model of devolved governance, should play a greater role in the planning of clinical services and in supporting the development of leadership and improvement capabilities within the state's health services.

Ideas for consideration outlined in this report include:

- publishing performance data and establishing an agency independent of the health department to take on this role

- reviewing how decisions on the use of capital are made to ensure greater transparency and consistency in these decisions
- giving responsibility for board appointments to an independent appointments commission to avoid perceptions that these are not always based on skills and experience; or at the least creating an independent commission to advise the minister on appointments
- balancing an understandable focus on hospital care with greater attention to services provided outside hospital – building on the success of Hospital in the Home and a wide range of out-of-hospital developments
- deciding on the priority to give to integrated care in light of the many barriers to its development, not least the split between Commonwealth and state responsibilities, and how best to do this – for example, through innovations in payment systems that go beyond case-mix funding
- reviewing the number of boards and encouraging greater collaboration between them, especially among regional and rural health services
- exploring how the health department, in partnership with the health services, can become a more active planner and monitor of clinical services both within Melbourne and outside it
- assessing how boards can be encouraged to do more to share innovations in care and to support each other when they encounter performance challenges, including strengthening their leadership and improvement capabilities.

These potential improvements to the way Victoria's health services are managed were set out ahead of the recent revelation that seven out of ten perinatal deaths at the Djerriwarrh Health Service in 2013 and 2014 may have been avoidable – the result of clinical and governance failures, according to the independent investigation into these events (Department of Health and Human Services 2015). That investigation makes recommendations about better reporting of clinical data and closer working relations between the Djerriwarrh Health Service and the larger Western Health Service, recommendations that underline the points made above about transparency, board appointments and greater collaboration between larger and smaller health services.

Underpinning many of the ideas outlined above is the question 'what is and should be the future role of the health department?'. By this we mean not only the role of politicians and the leadership they provide, but also that of officials in a system where – as 'devolved governance' implies – the underlying principle is that the main responsibility for service provision rests with boards.

In many jurisdictions there is a temptation to respond to performance failures and concerns about variations in the delivery of care by seeking to strengthen central controls and oversight. While this is often understandable in an era of 24/7 media and public scrutiny of health services, it carries the risk of micromanagement and of demotivating leaders and staff at a local level. Exploring other means of intervening and of building capabilities to deal with performance issues is one way of avoiding this.

1 Introduction: Australia and its health system

Australia likes to believe that it has a 'world class' health system. Up to a point, that is true. Within Australia, the state of Victoria likes to believe that it is at the forefront of that. Up to a point, that too is true. Victoria likes to believe that this achievement is essentially due to three things:

- first, what Victorians call '**devolved governance**', by which they mean that hospitals and health services are run by minister-appointed boards, operating at arm's length from the health department, rather than being line-managed from the centre
- second, Victoria's longstanding use of **case-mix funding**, or a diagnostic-related group means of funding a significant proportion of hospital activity
- third, **performance monitoring**, which sees health services – their boards and chief executives – held to account through a relatively small number of KPIs.

The purpose of this short report is to examine the case for Victoria's approach to health care management, to seek to identify its strengths and weaknesses, and to ask what might be done to improve it.

It also asks how well placed it is to cope with the problem facing health systems in all developed countries – the impact of an ageing population and with that a change in the burden of disease. It is a problem that has seen a steady rise in the number of patients with multiple chronic conditions that are not susceptible to one-off 'cures'. For such conditions, as is widely acknowledged the world over, patients too often experience unnecessary, costly and distressing hospital admissions. In other words, the challenge is to provide better integrated care, or better co-ordinated care.

Within the time and resources available, this cannot be a comprehensive study. Rather it applies outside eyes, which we acknowledge may not always be sensitive to all the nuances of national and local politics.

Australia from an international perspective

Ranking health care systems is a young art – even though it is supported by a welter of statistics. As yet it remains at least as much an art as a science, given that the selection of indicators, their reliability and comparability, and the weight given to them, crucially define the results.

Nonetheless, on the data available Australia performs well. It spends 9.3 per cent of its gross domestic product on health care – pretty much right on the Organisation for Economic Co-operation and Development (OECD) average, appreciably less than some European countries and far less than the United States, for example. In the highly contested World Health Organization (WHO) report of 2000, which attempted to rank the performance of some 190 countries by health attainment, responsiveness and fairness of financing, it ranked 32nd (WHO 2000). In a much more recent study that examined deaths amenable to health care, it scored better. This involved a much narrower definition than the WHO study, focusing more precisely on the impact of health care

on health (as opposed to, for example, income distribution, lifestyle or vehicle and workplace safety). Out of 19 OECD countries, Australia ranked third. That study too has its limitations, however, illustrated by the authors' own debate about whether to include ischaemic heart disease as an indicator and what weight to give it. Once it was included, Australia's ranking was reduced to eighth position (Nolte and McKee 2003).

The Commonwealth Fund produces a ranking of 11 developed countries' health care systems taking in a wider range of factors, including some limited measures of quality, access, efficiency, equity, expenditure and healthy lives. In the most recent update of that report, Australia ranked fourth (Davis *et al* 2014). The United Kingdom ranked first. But it should equally be noted that the United Kingdom scores much more poorly in other attempts to rank health systems that give differing weights to the various criteria chosen: for example, its responsiveness, or its record for five-year survival for a number of cancers. At the higher tech end of medicine – high-level secondary and tertiary care – Australia (and indeed Victoria itself) has hospitals that quite rightly seek to compare themselves with other leading teaching and research institutions in the United States and Europe.

How Australia's health system is organised

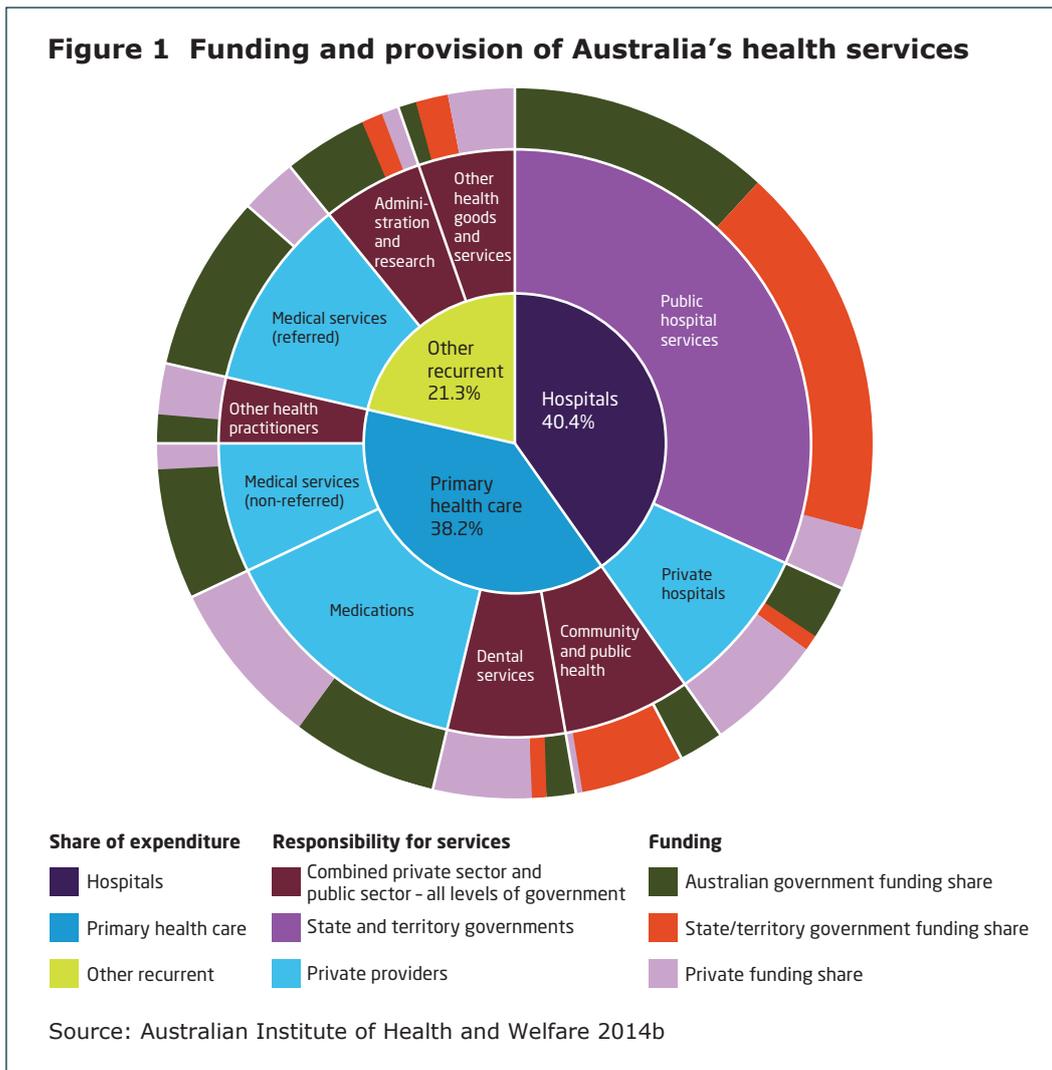
Any examination of the way health care is organised and managed in Victoria must start with some background on how it is organised in Australia as a whole. Any federal country that splits the public funding and responsibility for health care between its states, territories or provinces and the federal government – in Australia's case the Commonwealth – is bound to produce a degree of complexity. In Australia's case that is peculiarly so. Add in a significant private sector, in terms of both funding and provision, and the picture in Australia becomes highly complex. To the outside eye, the country at times seems to achieve its results despite its health care system as much as because of it.

Figure 1 below illustrates both the funding and provision of Australia's health services. Older people's residential care facilities, which are Commonwealth-funded but provided by a range of public, private and not-for-profit providers, are not included.

The inner segments of the ring indicate the relative size of expenditure in each of the three main sectors of the health system – namely hospitals, primary health care and other recurrent spending. The middle ring indicates the relative expenditure on each service in the sector, shown by the size of each segment, and who is responsible for delivering the service, shown by the colour code. The outer ring indicates the relative size of the funding, shown by the size of each segment, and the funding source for the different services, shown by the colour code.

Very crudely summarised, in a system that does provide universal access to health care, the Commonwealth is responsible for general practitioner (GP) services while the states run hospitals. This division hampers the integration of care. Were such a division to be insisted on, it would make marginally more sense – though still very little sense – if

Figure 1 Funding and provision of Australia's health services



it operated the other way around, given that GP services are more local than hospitals.

Through tax-funded Medicare, the Commonwealth pays the bills for GP consultations, although GPs, who operate as private businesses paid for almost entirely by fee-for-service, can charge above the set fee. Nationally, 83 per cent of consultations, and a similar percentage in Victoria, are 'bulk billed' – that is, the GP charges the Commonwealth without asking the patient for a higher or top-up fee. The Commonwealth, through Medicare, also funds out-of-hospital pharmaceuticals and diagnostics, a range of community programmes and aged residential care facilities (the equivalent of care homes and nursing homes in the United Kingdom).

These funding arrangements hamper rather than help the provision of integrated care for the growing number of patients who need ongoing attention, rather than one-off interventions. These are mainly, but not exclusively, older patients.

In Australia, the six states and two territories (hereafter referred to collectively as 'the states') have limited, and non-dynamic, taxation powers – in other words, the taxes they levy have only a limited ability to rise in line with the economy. The main ones that do – income tax and Australia's equivalent of VAT, the goods and services tax (GST) –

are raised by the Commonwealth, with GST returned to the states. As a result, to make public hospital provision viable, a significant amount of its funding comes from the Commonwealth, even though the states are responsible for its provision (Duckett and Willcox 2015).² The funding formula under which GST is returned to the states is a constant bone of contention.

The nature of general practice in Australia also lacks what are often seen as strengths in other countries. Single-handed GPs are becoming a rarity, and practices are 'corporatising' – being taken over by commercial companies, some of them with significant interests in diagnostics which are also Commonwealth-funded through Medicare. But there are no registered lists of patients as in the United Kingdom or New Zealand, for example, and, comparatively speaking, there is little of the aggregation of GP support and ongoing professional development that is provided by New Zealand's Independent Practitioner Associations. The nature of this support for GPs has been subject to repeated reform in recent years, moving from divisions of general practice in 2011 to short-lived Medicare locals which are now being replaced, in 2015, by primary health networks.

These arrangements, taken as a whole, bring widely acknowledged problems – ones that have been regularly revisited over the years, but which have to date proved politically insoluble.

As a paper by Judith Dwyer and Kathy Eagar for the National Health and Hospitals Reform Commission put it in 2008, 'everyone seems to agree that the split of responsibilities between the Commonwealth and the states is dysfunctional', but agreement over what to do about it 'breaks down at that point' (Dwyer and Eagar 2008, pp 3–5).

Nothing of any great substance has changed since. Problems include 'a bewildering array of funding programs, each with its own eligibility criteria, accountability requirements, timeliness and access barriers. Even experienced managers and clinicians find it hard to be sure their services are getting the funding they are eligible for.'

There is 'blame and cost-shifting between levels of government... where one level can "win" financially through measures that cause the other level to "lose" financially. The impact on patients and care providers is significant in the form of unnecessarily fragmented and complex referral and care pathways... services are fragmented for those who require ongoing care for complex and chronic conditions.

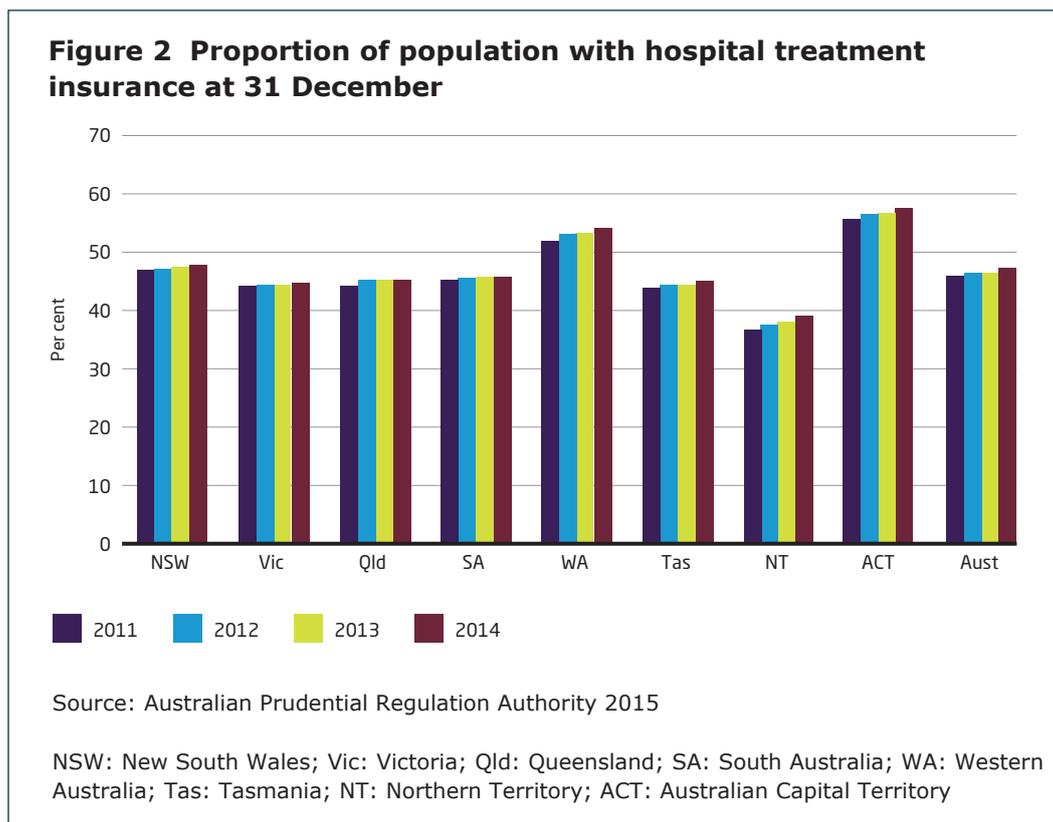
'While the current arrangements work reasonably well for those of us who have only occasional or episodic health problems, they are not well designed to respond to the needs that some of us have for coordinated, ongoing care.'

In addition, Australia has a hybrid public–private funding system. That too has its strengths and weaknesses.

Access to care is universal through Medicare. But the Commonwealth also pays a 30 per cent rebate on private medical insurance and there are strong tax incentives not only to take out such cover but to keep it

² For a more detailed description of Australia's health system see Duckett and Willcox 2015.

going. Approaching 50 per cent of the population has private medical cover – the percentage is marginally lower in Victoria – although its comprehensiveness and the level of co-payment vary by policy. That means, nonetheless, that the private sector plays a highly significant role. For example, some 60 per cent of all elective surgery is performed in the private sector – including 60 per cent of surgery for bowel, breast and lung cancer. Dwyer and Eagar judge, however, that ‘coordinated planning of the government, non-government and private sectors is the exception rather than the norm’ – although in Victoria and indeed elsewhere in Australia, there are some limited initiatives to start to tackle that.



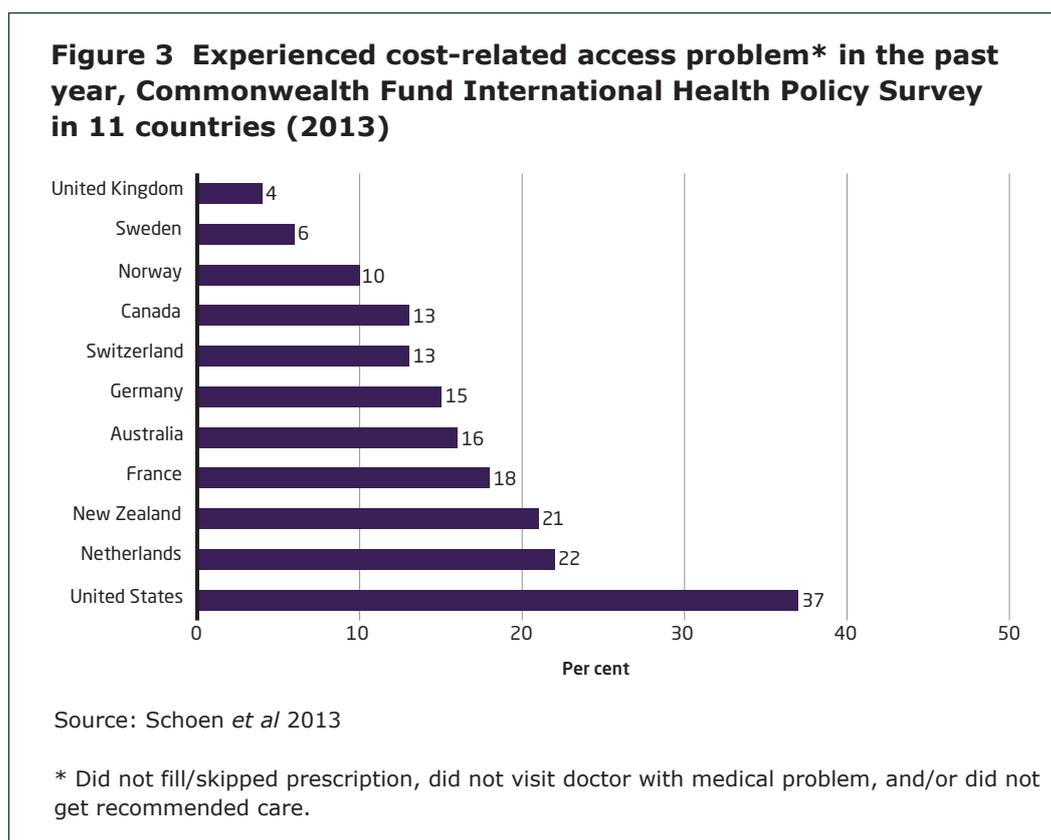
The complexity that all this produces is acknowledged in Victoria, as elsewhere in the country. The Victorian Health Priorities Framework for 2012–22 states that the Victorian health system is ‘a complex web of types and providers of services that are managed and funded by the Commonwealth, state and local governments, and by private and not-for-profit organisations.

‘These organisations and governments vary in their approaches, and operate in an uncoordinated and fragmented way. This complexity makes the system extremely difficult for patients and clinicians to navigate. It is not easy for people to work out where they should go to for information and get the right care to meet their needs’ (State Government of Victoria 2011, p 5).

Of Australia’s total funding for health care, some 70 per cent is government-funded. Of that, roughly 43 per cent comes from the federal government and 26 per cent from the states, with health costs

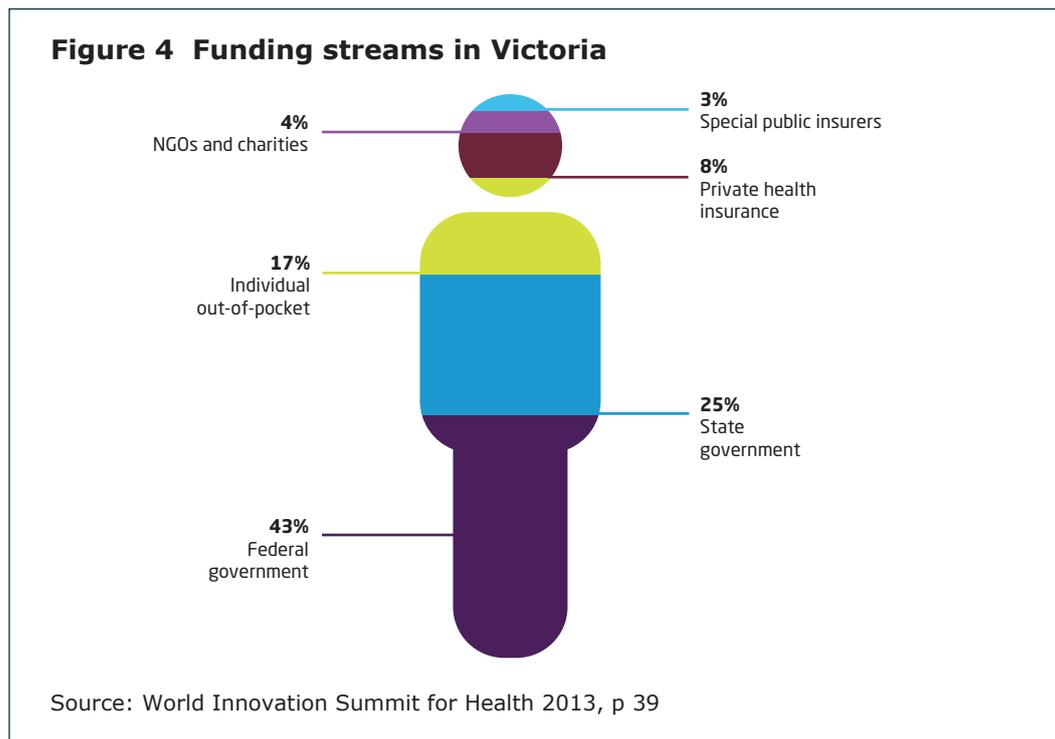
at present rising faster than state revenues. At around 17 per cent of all health care costs, Australia's reliance on out-of-pocket expenditure – including additional fees for GPs and diagnostics, and co-payments on private insurance – is high relative to most OECD countries. 'This exposure of consumers to health costs may have helped to restrain health inflation,' Stephen Duckett, the leading analyst of Australia's health care system judges, 'albeit with negative equity consequences'.

The Commonwealth Fund's 2013 survey found that around 16 per cent of Australians said that they had not filled a prescription, visited a doctor and/or accessed recommended care because of cost.



Less recent but more localised data from the National Health Performance Authority (NHPA) shows that in 2011–12 between 4 and 12 per cent of the population in various parts of Victoria did not see, or delayed seeing, a GP or specialist because of the cost, while broadly similar proportions delayed filling, or did not fulfil, a prescription because of cost. The figures for access to dental care were worse (National Health Performance Authority 2013a, pp 61–8).

In Victoria, the split of total health spending is as follows:



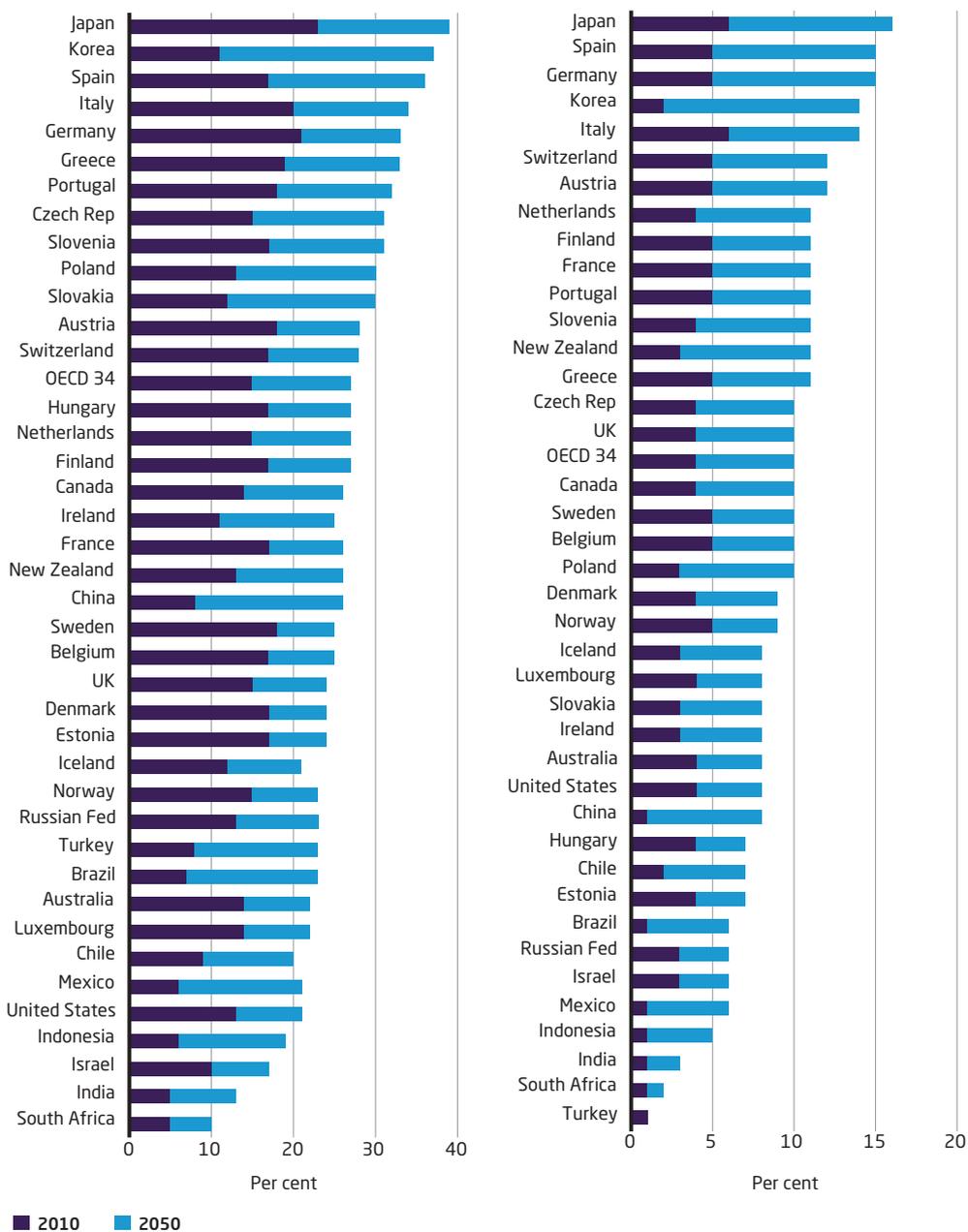
Two more points of broad background are worth noting before turning to the state of Victoria itself.

First, while Australia like all developed countries has an ageing population, it remains, in comparison to those others, a relatively 'young' country, with a slower projected increase in the numbers aged over 65 and 80 (see Figure 5). That provides an opportunity to move to better integrated care ahead of the full force of the rising tide.

Second, Australia escaped the worst consequences of the 2008 global financial crisis which in some countries led to significant cuts, or highly constrained growth in health and social care expenditure. Nonetheless, growth in such spending is currently appreciably slower than in the past and is forecast to remain so for the foreseeable future. Figure 6 below sets out the position in Victoria, where limited growth is also being accompanied by a rapidly growing population.

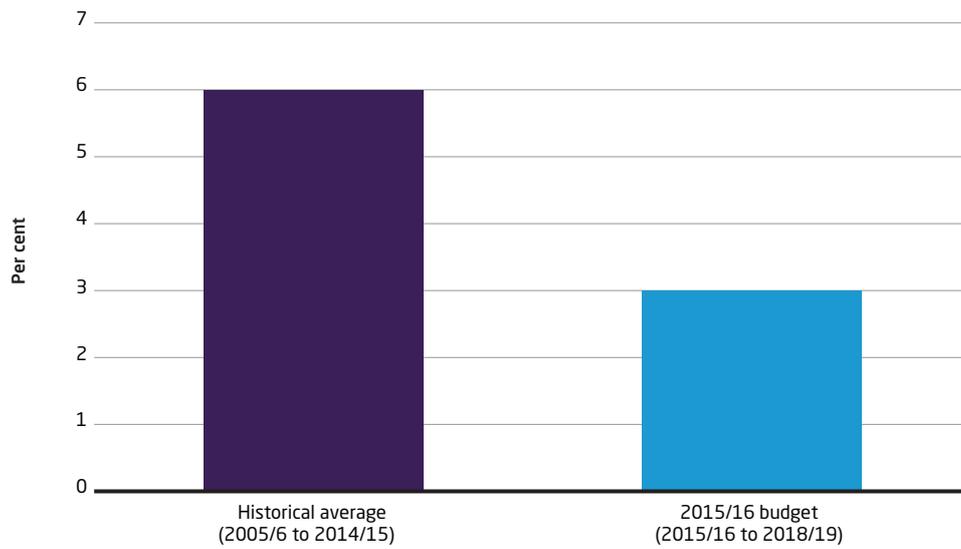
This underlines the need for health spending not just to be technically as efficient as possible but also to be directed at areas of spend that will produce the best results for patients – allocative efficiency.

Figure 5 Percentage of population aged over 65 and 80 years, 2010 and 2050



Source: Organisation for Economic Co-operation and Development 2015

Figure 6 Growth in government spending in Victoria 2005/6 to 2014/15 compared with 2015/16 budget and forward budget estimates to 2018/19*



Source: data supplied by Department of Treasury and Finance, Australia

* Growth in expenses in the period 2014/15 excludes the impact of the revised AASB 119 Employee Benefits. The figure for 2014/15 used in the calculation of the historical average is an estimate.

2 The origins of Victoria's 'devolved governance'

Back in 2002, Victoria's public hospitals and health services were broke. As so often, out of financial crisis came reform.

Victoria had been the first state in Australia – and one of the first places outside the United States – to adopt case-mix funding; that is, using diagnostic-related groups to establish an average price for treating patients with similar conditions.

Introduced in 1993, it had started to drive technical efficiency through the hospital system. It encouraged those with high costs to lower them and those with low costs to do more. But it also helped create a financial problem in what came to be seen as an under-funded health system.

Shortly after the introduction of case-mix funding, Melbourne's hospitals, which cover about two-thirds of the state's population, underwent a major reorganisation. In 1995 no fewer than 35 independent public hospitals existed within the city and its immediate environs, all run by their own boards with their own support structures. As the review that led to their amalgamation put it, each was 'independently pursuing its own vision... with limited collaboration and responsiveness to the needs of the community'. In 1995, these 35 organisations were corralled into first seven and then five 'health care networks' – competing groups of hospitals, organised largely by geography but partly by specialism. These were overseen by regional offices that sat between them and the health department (at the time, the department of human services). A key aim of the networks was to transfer services from inner to outer Melbourne in order to locate more of them in the growing parts of the city (Metropolitan Hospitals Planning Board 1995). Intended to achieve economies of scale, these arrangements came to be seen as unwieldy and excessively bureaucratic.

A review conducted for the health minister in 2000 – the Duckett review – cited complaints that the administration of the networks was too remote from the front line. There was duplication of effort and cumbersome processes. Split responsibilities between the regional offices and the department compounded these problems. The review supported the view that the additional administrative costs 'have not made any demonstrable contribution to improving the level and quality of health services within the networks' (Duckett *et al* 2000).

It recommended that the networks be disbanded. They were duly replaced by the dozen health services and boards which exist today. These acquired a direct relationship with the department rather than one mediated through regional offices, although for services outside the city regional offices were retained.

The 1990s had also, however, been characterised by cuts to health spending. As a result, payments to hospitals reduced. That compounded the effects of the introduction of case-mix funding as a driver for technical efficiency. The Duckett review concluded in 2000 that the level of funding per patient had fallen 'too low'. Two of the large hospital groups in and around Melbourne were technically insolvent by normal

commercial criteria, the review stated, and others were under serious financial pressure (Duckett *et al* 2000).

These financial problems stimulated a debate among health care leaders in Victoria about how to solve them, including within that discussion of whether the governance arrangements for health services were robust. Shane Solomon is currently chair of Australia's Independent Hospital Pricing Authority. In 2002, he was the head of metro at Victoria's department of health: in other words, he was responsible for the oversight and funding of the largest hospitals and health services in the state capital. He says that the result of budget cuts and case-mix funding had been to eat away at the reserves held by the public hospitals.

In a state that spent some A\$4.8 billion on all forms of health care in 2003, the big Melbourne hospitals and the larger regional ones had an accumulated deficit of some A\$300 million to \$400 million, according to Shane Solomon in an interview for this report.

'We took the view that if one or two services were doing badly, then it was poor performance. But if across the system everyone was losing money, then that was a system problem.'

Interactions with the Treasury, Shane Solomon says, consisted of 'the department repeatedly going back and asking for more money and the Treasury telling us we weren't managing the situation properly'.

The problem, however, he says, was not just financial. It lay in part in the pretty much complete independence of the dozen boards which ran the metro health services. They were not, he says, 'in any real sense' accountable.

'The department's relationship was chiefly with chief executives, with hardly any contact with the boards. The board members saw their work as being charitable, and we felt the chief executives were hiding behind the boards – their reward came from giving us in the department a hard time and getting money out of us, rather than being rewarded for managing their services well.'

Kath Cook, now Chief Executive of MidCentral Health Board in New Zealand, was Shane Solomon's number two. She had come from New Zealand, where she had helped set up the district health boards that replaced its short-lived but spectacular experiment with a purchaser/provider split in health care. She recalls relationships with the metropolitan chief executives in Victoria as being 'pretty terrible'. She says: 'I remember one of my very early meetings with the metropolitan chief executives that I went to with Shane. They kept us sitting around outside for ages. When they let us in they just harangued us, and I thought "well, there's something rather wrong here". It felt, to use an Australian word, a bit feral.'

'There was no relationship management,' she explains. 'So you had this flawed relationship with the chief executives, but also a huge department in which every man and his dog, if they treasured a particular bit of policy, would be on the phone to their counterpart, often quite low down in the health service, instructing them to get on with it. I think staff out in the metropolitan health service probably felt overwhelmed by the constant phone calls and requests for data and

information about what they were doing and how were they doing it, and where were they going. There was a need to bring some sense of order to all that, to rebalance it.'

Much else was wrong. The department, the funder, did have health service agreements with the boards about what they should deliver. 'But these ran to 1,000 pages,' Shane Solomon says. 'They were never agreed, rarely signed, and were completely ineffective accountability tools.' Hospitals often didn't know their budgets until four to six months into the financial year. Monitoring data ran to hundreds of pages, mainly listing inputs in grinding detail – staff numbers, pay rates, acute bed days and much else – but precious little to actually illustrate performance.

The Duckett review in 2000 dismissed these health service agreements as 'unworkable'. It went on: 'Neither agencies nor the department of human services can use the health service agreement as a management tool because of the sheer volume of indicators and paper' (Duckett *et al* 2000, p 6).

'What we had was autonomy without accountability,' Shane Solomon says. 'We [the department and minister] had the capacity to sack a board chair. But that, by definition, was difficult. And we had no power over chief executives. We didn't even have a say in their appointment.'

This analysis was taken by the health minister of the day, Bronwyn Pike, to John Brumby and John Lenders, the Treasury and finance ministers in Steve Bracks's Labour government. To cut a long story short, and after much negotiation, a deal was finally cut in the Cabinet to stabilise the finances, but in return a review of governance was launched. Three outside experts were called in, producing in 2003 the report of the Victorian Public Hospital Governance Reform Panel.

At the time, across the rest of Australia, the idea of independent boards running health services was fast falling out of favour. In the years immediately preceding and following the review of Victoria, all the other states moved, in one form or another, to much more centralised line management by the respective state's health departments. Queensland had already long been running a more centralised system without boards.

In 2003, Shane Solomon says, the Treasury's initial view was that it too wanted to abolish the boards. 'But we felt they were valuable and redeemable. If you abolish them you put line management into the department and it can't sensibly micro-manage every health service. You risk stifling innovation when people have good ideas about how to do things better, but then need permission to do them. If you've got your chief executives in the department two days every week to hold them accountable – and that happened in some states – they're not running their services. We felt there was merit in retaining boards.'

In summary, the outcome of the review was that the health service agreements were scrapped and replaced by a 'statement of priorities' – itself a health service agreement by another name, but of a very different nature.

In place of hundreds of pages, a typical statement of priorities now runs to a dozen or at most 20 pages, depending on the size and complexity of

the hospital or health service. The core of the document – strategic and performance priorities, and activity and funding – generally amounts to seven pages or fewer. The minister continues to appoint the board, and the statement of priorities sets out what the minister and health department expect the service to do within the department's overall strategic priorities. These are themselves set out in the department's 10-year plan, the Victorian Health Priorities Framework 2012–22. They include, purely by way of example, reducing unplanned re-admissions, expanding the use of nurse practitioners, completing a promised new facility, or in the case of a teaching hospital improving translational research. The agreement is between the board and the minister.

With that comes a smallish number of KPIs – typically 20 to 30 but sometimes a few more, depending on the size of the health service and the services it provides. Until recently, these were focused almost entirely around finance and access issues – balancing the books and limiting waits in emergency departments, or for elective surgery, for example. That, Shane Solomon says, came in part from feedback from the board chairs and the chief executives themselves. They had no more love for the hundreds of pages of the old health service agreements than did the review panel. 'Their message was "don't tell us everything. Tell us what is actually important. Tell us what we are going to get sacked over";' he says. Quarterly performance discussions were introduced on each health service's progress against their KPIs.

A new emphasis was placed on getting the right skills on boards, particularly finance and business skills, and a requirement was placed on boards to ensure that new members were trained.

In place of the single nuclear option of sacking the board chair, a more graded intervention process was introduced. This runs from more intensive monitoring where performance is going awry, to the requirement to produce a remedial plan, to the appointment of a 'delegate' or ministerial observer to a board, to the possibility of sacking the chair or the board.

In the early days after 2003, some chief executives were dismissed by their boards for failure to perform and the odd board chair was forcibly removed. It was, Kath Cook says, 'pretty challenging. Some people just didn't get the trade-off – that if you focused on doing the right thing, then you could run your own ship without interference. And that was the biggest gain – the freedom actually to govern.'

A council of board chairs was created to provide a relationship with the minister that had been lacking. 'One element of that idea was that they would focus on the big strategic issues, and I don't know whether it ever quite got there,' Kath Cook says. 'But it certainly served a purpose because it became a lot clearer what the government was focusing on and wanted, and it gave the boards and their chairs equally a chance to say what they were happy and unhappy with.' In addition, the department acquired a veto on the appointment of chief executives. These days, the department is involved in the interview process, alongside the board. The board decides, but with the department holding a right of veto. In other words, the department is able to block an appointment but not create it. The department also has input to

the annual performance appraisal of chief executives, chiefly around whether the statement of priorities is being achieved.

The net result, Shane Solomon says, is that 'we went from autonomy without accountability to autonomy with accountability, but for the things that really mattered'.

Thus it is worth noting that the 2003 reforms that produced the current version of what Victoria describes as 'devolved governance' in practice **reduced** the autonomy of boards. It hugely cut back on the day-to-day interaction between the department and the service – the attempted management and oversight of, or interference in, depending on your point of view, the micro level. But it raised accountability at the macro level. It created, in effect, a system of earned autonomy – and Kath Cook says 'when we were doing this, I at least was thinking in terms of "earned autonomy" rather than "devolved governance"'.

Health services were to be subject to much less detailed surveillance, provided they performed on the key measures. If they met the requirements in the statement of priorities, they were left free to innovate beyond that in the way services were delivered, and indeed, up to a point over what services they provided.

So on a scale between laissez-faire and centralised line management, Victoria sits towards the more laissez-faire end of the spectrum, but a long way short of it. Ministers and the department, as we shall see, still shape services. The issue is around the degree to which they seek to do that, and the balance between the freedom to manage one's own affairs as a health provider and accountability for performance.

Thus by 2003/4 the three-legged stool of the Victoria model was in place, one that its ministers have boasted produces the best results in Australia. The three elements are:

- devolved governance – that is, the retention of boards in place of more direct line management by the health department
- case-mix funding
- performance management.

3 Devolved governance in Victoria today – the positives

Victoria conceptualises its health system as consisting of three parts – metro, regional and rural. Metro covers the fast expanding city of Melbourne, which accounts for some 4 million of the state’s 6 million population. Regional covers the state’s more significant towns and cities, such as Geelong, Ballarat and Bendigo, although by international standards these are small. Geelong, the state’s second largest city, has a population of some 140,000. Ballarat and Bendigo are nearer to 80,000. Rural includes the outlying districts of the state.

This conceptualisation is used throughout Australia and thus allows some comparison of performance across it. There is a question, to which we will return, around how far the conceptualisation is helpful – particularly the formal distinction between rural and regional.

The state’s ‘health services’ are overseen by boards, typically of six to nine people in metro and regional, the aim being to assemble the right mix of skills, including business and financial skills. Chief executives report to the board, but are not members of it.

The term ‘health service’ for the care and the cure that the boards oversee is a useful, indeed potentially very powerful, rhetorical device, not least in a world where the need is to move towards more integrated care for patients with multiple chronic conditions. But to the outsider it can initially be confusing. The ‘health services’ that the boards oversee are extremely diverse. They range from running a single hospital, to situations where all hospital, community and non-GP primary care is run by one board. In other scenarios, boards have to collaborate with 28 quite separate community health centres run by their own independent boards. In rural areas a board’s ‘health service’ may be no more than literally two or three medical beds and an aged residential care facility – with the running costs for aged care coming from the Commonwealth. Some tiny rural hospitals still provide surgery through visiting medical officers who fly or drive in, and some still provide surgery of a seriousness that must raise questions around the safety of such procedures.

Table 1 Details of Victoria’s health services

Type	Number	Description
Health services		
Metropolitan and regional health services	21	Large organisations providing the full spectrum of tertiary services or state-wide specialty services, generally over a number of sites and often with integrated aged care and community services
Sub-regional and local health services	21	Smaller organisations located in rural areas, delivering a more limited range of hospital services, generally from one main location
Small rural health services	43	Very small services offering minimal to no hospital care, often with a significant residential aged care component
Total	85	
Registered community health services	28	Small, community-based services offering a mix of primary and community care, including nursing, allied health, dental, prevention and health promotion services

Thus health services range from the Alfred, Monash and Royal Melbourne teaching and tertiary hospitals, with an annual turnover in the A\$1 billion range (around £500 million), to small rural services with a turnover of A\$3 million, or occasionally even less.

This reach of the state government – which also includes responsibility for public and population health – does not embrace general practice, which is funded by the Commonwealth largely on a fee-for-service basis. Neither does it embrace GP prescribing or the significant private sector diagnostic and private hospital arrangements.

In total there are no fewer than 85 health service boards in Victoria, additional boards for community services, and beyond that a large range of other providers. Large numbers of those to whom we spoke suggested that there are far too many boards, an issue to which this report will return.

For now it is worth observing that, notwithstanding the difficulties of direct comparison with elsewhere, England would have more than 800 bodies if it had the same ratio of health service organisations to population as Victoria. It has, in fact, only around 450 – and that includes 200 commissioning bodies because England has a full purchaser/provider split which Victoria does not. Direct provision of health care involves only around 250 organisations in England. Scotland in many ways is more directly comparable to Victoria than England – it has a similar sized population, its own rural hinterland and no purchaser/provider divide. However, Scotland has only 14 health boards against Victoria's 85.

It is worth noting that the figure of 85 could be misleading in that 43 of these boards are very small rural boards. A better way of thinking about this arrangement may be that there are 20 or so large health services that are mostly in Melbourne. However, not all of them are. Barwon Health, for example, covers the area in and around Geelong and is the fourth largest board. Add to this 20 medium-sized ones, chiefly regional services but including some specialist services in Melbourne, and then add in the 43 rurals.

As part of a national health reform programme, all states are re-instituting boards and all now use case-mix funding. But, as one senior figure in the Victoria health department puts it, 'it is not just having boards that matters, it is how they work, and how we use them'. A senior figure on the national scene meanwhile noted that New South Wales, for example, has had boards on and off over many years, 'but they have tended to be advisory in nature rather than more directly operational and responsible'. The New South Wales health department, for example, still issues reams of detailed circulars to its health service on operations – circulars that are largely absent in Victoria.

Given the intense and probably inevitable rivalry between states in Australia, there is a range of ways to assess views on the benefits, or otherwise, of devolved governance in Victoria. There are, for example, the views of those working within the system, those of people who have worked elsewhere in Australia but now work in Victoria or vice versa, plus the views of people in health care consultancies and other outsiders who can take a comparative stance.

Kath Cook is one insider who moved out. She helped set up the current system of devolved governance, and went on to be chief executive at Western Health in Victoria in 2007 before leaving two years ago to work in KPMG's health care consultancy. She is now chief executive at MidCentral District Health Board in New Zealand. She says: 'I can't tell you how different it felt when I was a chief executive to the days when I first came into the state. By the time I became a chief executive at Western Health, the system was really embedded and nobody knew any different. The whole dynamic, the working together, the respect for each other, respect for the role of the department, respecting the role of the chief executives, the boards and their organisations – it was so different to what it was like in 2002, I cannot tell you. One result is that we have great longevity of chief executives in Victoria. I moved on after five years, and that would be considered to probably be kind of short.'

'The freedom to actually govern and manage your health service has meant that you've had a much more sophisticated set of chief executives than many other states may have enjoyed.'

Equally, Shane Solomon, who left Victoria in 2006, says: 'I'd say that Victoria has by far the best chief executives in Australia – because they run their own show and feel like they are running their own show. They will complain about any government intervention at the state level. But the reality is that if they were working in any other state they would be horrified. And I know the other states extremely well from my consulting days.'

How far is the positive view of these insiders who left the system echoed by those who have a wider overview of Australian health care?

Dr Diane Watson heads the National Health Performance Authority, having previously worked in New South Wales and in Canada. Victoria's approach to governance has produced, she says, 'an engaged local community. People are really proud of their local accomplishments. People in senior positions are very engaged. In my view, this engagement positively reflects the degree to which people in Victoria assume responsibility. If something is not going so well then they set up plans to do something different and just implement them. There are other states where people are less likely to assume responsibility. It is easier to blame the department, or say they are not given enough resources, or to identify some other reason not to change the status quo. As a national observer, I'd say Victoria has created an ownership of responsibility culture that supports an improvement culture. Obviously, there is variation. But where improvement needs to occur they're more likely to accept their responsibility and take action. And that's healthy.'

Deborah Picone is chief executive of the Australian Commission on Safety and Quality in Health Care. She has held an array of executive positions, including as a former director general in New South Wales. Victoria, she judges, 'is something of a star in the firmament. My observation as an outsider is that the quality of their board members, by and large, is very good, and the way the department interacts with the system is also very mature. I think one of the key reasons for that is stability. I'd say one of the principal differences between New South Wales and Victoria is that they have been stable. Between 1986 and 2010 there were seven or eight major restructures in New South Wales.'

As soon as they got settled there was a change of government, or a change of policy, and they would restructure. Victoria has resisted that. They haven't been constantly churned up and down, so they have this long mature experience, and that shows in almost everything they do.'

Dr Tony O'Connell, now a special adviser to KPMG Australia, has been deputy director general in New South Wales and was director general in Queensland between 2011 and 2013. Devolved governance has 'allowed Victoria to be agile. It means people own change when it happens. It means that they take responsibility for managing their finances properly, in a way that you see less clearly in a more directly managed system. As a general principle, I think that is true. In Queensland we changed from all 17 chief executives reporting to me as director general, to a system of boards who appointed their chief executives, plus activity-based funding, along with a performance management system, which I modelled on Victoria – a system of earned autonomy. All that, plus a very significant investment that we made in redesign, produced a quantum leap in performance.'

Dr David Ashbridge is an outsider who moved in to Victoria, having been a medical practitioner and public health physician in the Northern Territory and ultimately chief executive of its health department between 2006 and 2010. He is currently chief executive of Barwon Health, the fourth largest Victoria health service and the largest regional one. Victoria's devolved governance allows for innovation and agility, he says. 'The pace at which I can make a decision and implement it can be measured in days and weeks. When I was in the government sector, there would have been more decision-making groups around that, and that would take a long time. When I moved from being the chief executive of a jurisdiction to here, the biggest difference was moving from being a senior bureaucrat to a major businessman who, with our local clinicians, could take decisions and implement them.'

'It is also smart politically. When things come up, the minister has the opportunity to say "well, that's an operational issue. You need to take that up with the relevant health board". In Australia there is often too much of a sense that the ministers need to know about operational detail. Devolved governance allows there to be one step, albeit a slightly artificial one, that allows the minister to say "this is an issue you'll need to take up with the board".'

One of Victoria's regional office managers who has also worked in New South Wales says that Victoria offers a spread of different-sized organisations that allow managers to build their skills – whether in pure management, or in clinical and financial oversight – and to move across organisations as their career progresses. 'As they become more senior, that allows the sharing of new ideas and expertise,' she says. 'The relative independence of boards also allows them to advocate for their local community within the political environment.' She also argues from experience that the existence of local and relatively independent boards, engaged with their local communities, helps to raise significant sums of non-government cash for capital investment locally – although it is hard to find comparative financial data to demonstrate that point.

Quarterly monitoring about performance and a reasonably clear performance management regime also create trust. Alan Lilly, the

chief executive of Eastern Health, and Alex Cockram at Western Health both say there is a fair degree of 'openness, trust and a willingness to discuss [with the department] key challenges' while the performance management system produces – by and large – a culture of 'no surprises'. 'That part is also important,' according to Professor Cockram. 'It would be hard to build trust if we were all kept in the dark and a lot of second guessing was going on.'

It should be stressed that, while these interviewees all reflect positive views of devolved governance in Victoria, few if any of them regard the system as perfect. All have opinions – some contradictory – on what could be done to improve governance and health performance in the state.

For all the stress on how these arrangements let boards and chief executives run their own show, this is far from an entirely laissez-faire system. At the time of writing, 16 health services out of 85 were in some form of performance monitoring. In other words there were specific concerns about their performance, or they were failing to meet – by a sufficient and defined margin – the KPIs set out by the department. These KPIs fall into three groups – financial performance; access targets, which include waits for treatment; and the more recent introduction in 2014 of four very high-level, very limited, and very prominent quality indicators. They include a measure of hospital-acquired infections, hand hygiene, patient experience and influenza vaccination rates for staff.

Over the three years from 2011/12 to 2013/14, the department's analysis of data from 85 of the health services shows that 54 had not been subject to any increased monitoring while 31 had. Six had been subject to continuous increased monitoring throughout the three years, all because of financial issues. Two of those also faced concerns over their governance, and one over safety and quality. In any one quarter, 16 health services, or nearly one in five, were undergoing performance monitoring.

Over a longer time period of eight years, and looking at two-year aggregate figures, some 30 per cent of services were on increased monitoring at some point in the first two years during which the revamped health service agreements – the 'statements of priorities' – were in operation. That 30 per cent has shrunk to 10 per cent during the latest two years, a period when the rate of growth in health expenditure has slowed.

This points to an approach where deterioration in performance, on the measures used, is spotted. Increased monitoring takes place, and boards, chief executives and staff respond – even if, as in any country's health service, a small number (in Victoria's case) of health services have persistent problems, sometimes due to particular local circumstances.

The system is not perfect. As one chief executive remarked, 'some of the performance monitoring measures can be gamed. On some we have much more up-to-date internal information than the department uses for its formal measures, and we have much more frequent and

timely patient experience data.’ Nonetheless, this looks like a tolerably effective system.

Devolved governance, it is argued, allows for innovation. One chief executive with extensive experience elsewhere in Australia summed it up for us: ‘In a more directly managed system there can be a tendency for everyone to be required to do everything at the same time. There is a somewhat plodding nature to it, so you can end up going at the pace of the slowest mover. Victoria has benefited I think from – not all the health services but a number of them – doing things a bit differently and doing things at a pace where you don’t actually have to seek permission to do that. You can do things without putting up a policy paper to the department that requires a tick off from the secretary of the department before you can get on with it.’

Finding examples of innovation that would not have happened in a more line-managed system is, by definition, not easy. There is no counterfactual within the same system to provide a comparison. But examples of innovations that chief executives cited include Victoria’s approach to handling significant trauma – where the more serious cases are sent to accident and emergency (A&E) departments best equipped to deal with them, with the most serious being transported direct to Melbourne’s two major trauma centres. This model has been copied elsewhere, and it significantly informed England’s reform of trauma centres. One local health service, on the initiative of its local pathologists, completely revamped its pathology service – putting it out to tender – without feeling the need to ask departmental permission. Australia’s first dedicated elective surgery centre was launched on the initiative of a single health service. Monash Health is launching a specialist heart hospital, even though some might query whether a standalone cardiology hospital is the right approach for the 21st century. There are other examples.

Equally, when the department itself launches and supports an initiative, there are cases – Hospital in the Home, for example – where individual health services have experimented with it, and in this particular case are still experimenting with how far it can be expanded. As a result, Victoria has certainly the most extensive Hospital in the Home programme in Australia, and quite possibly in the world. The state now has the equivalent of a large hospital’s worth of patients – more than 550 at any one time – receiving care in their homes that would otherwise have taken place in hospital. Conditions covered include cellulitis, venous thrombosis, intravenous antibiotics, chemotherapy at home and in some cases transplant recovery. Some services have started to provide mobile x-ray so that falls and injuries among older people, either at home or in care homes, can be assessed for fractures without the need for them to be transported to A&E.

This programme is so extensive in part because of two Victorian quirks. First, the state has somewhat rigid minimum agreed nurse–staff ratios for A&E and for medical wards. Indeed, these are about to be made statutory by the current government. They do not apply outside hospital.² The positive, entirely unintended, consequence of

² These ratios were established by the Enterprise Bargaining Agreement.

this somewhat questionable arrangement of fixed hospital staff ratios is that it makes it easier to demonstrate that care at home can be not only better for patients but also less costly. The second quirk is that the department pays the same price for the treatment whether it occurs in or out of hospital. Combined, these two factors make it easier to show that Hospital in the Home is cost-effective. Nonetheless, there is no question that this programme has seen high levels of local innovation.

What all this points to is an approach that certainly does not appear broken, and which has considerable strengths. But, while it is perceived to work well, what does it produce in terms of performance?

4 Victoria's health service performance

As already noted, comparison of performance across health systems is not an easy art. Questions often arise over the comparability of definitions, coding and data. Activity is easier to measure than quality.

Australia has no shortage of data. But much of it is not as easily accessible in the public domain as it might and probably should be. A key reason is suspicion.

For example, most of Melbourne's major health services – indeed most of Australia's largest hospitals – contribute to the Australian and New Zealand Health Roundtable (www.healthroundtable.org/). This holds extensive data on individual hospital performance across the two countries. But it is a private members' club. The data is not published. Indeed, hospitals are referred to within it by code names, although the members know the code. The data is not routinely available to the health department in Victoria.

The reason for such apparent secrecy, as one of those involved explains, is that 'the Roundtable was conceived as a learning and improvement environment. It was there to support hospitals and clinicians and to help them improve, not as a tool to let others rap them over the knuckles. There was mistrust of the media – what they would do with the data. And mistrust of government – how it would use it to monitor performance.'

Several of the chief executives interviewed for this report said they would be more than happy to see the data in the public domain and indeed that they had argued internally for publication – but that idea still struck fear into some of the membership.

Equally, there are tensions and suspicions between the states and the Commonwealth over data publication, particularly as it gets closer to measuring quality rather than just activity. This is partly driven by the split in funding between the Commonwealth and the states, and mistrust over how each side would use the data. As one senior national figure put it, 'none of the states and territories really like their data published. They are happy, of course, if it shows them in a good light, but not if it shows them in a poor one. And they are suspicious about what the Commonwealth would do with it if a lot more was in the public domain. It is a major problem.'

Outside Australia, some jurisdictions are increasingly seeing publication of performance, particularly **clinical** performance, as a significant driver of change. When first produced, the validity of the data is frequently challenged. But publication leads to improvements in data quality. There is good evidence that the ability to see how a hospital, or more usefully a unit (and these days, in some countries, even an individual consultant) performs encourages those with poorer results to seek out the reasons for this and improve. In England, for example, open publication by cardiac surgeons of their individual results led to a significant collective improvement in performance (Bridgewater *et al* 2013).

The net result of the position in Australia is that there is a large amount of data in the public domain on state-level activity, and there are

some across-state measures of quality, published, for example, by the Australian Institute of Health and Welfare, and by the Productivity Commission in its annual *Report on Government Services* (Productivity Commission 2015). This is mostly annual data, published in arrears, rather than anything closer to real time. In addition, there is relatively little in the public domain that illustrates variation of performance **within** states.

Since 2012, that has begun to change with the creation of a National Health Performance Authority (NHPA) (see www.nhpa.gov.au). It has started publication of comparable performance of health care organisations, both across the state and at the local level, producing, for example, reports on various measures of waiting, immunisation rates, health care-acquired infections and length of stay.

It can, however, only cover subjects to which the states and Commonwealth have agreed. Public hospitals are included, but private hospitals participate only on a voluntary basis – and private hospitals provide, for example, 60 per cent of all elective surgery. The results are available as national reports and on a MyHospitals website (www.myhospitals.gov.au/) that lets the public see the performance of their local hospital against its peers across Australia. But those results are only available across broad categories – for example, comparing peer groups of major metropolitan, or large regional, or medium-sized hospitals. Depending on the subject covered, the data is sometimes also categorised by whether these groupings of hospitals have more or fewer vulnerable patients – so the groupings make a broad allowance for likely case mix. Unsurprisingly, the NHPA's data shows considerable variation in performance within states.

However, the underpinning data – for example, the precise case mix – is not in the public domain. Furthermore, it is not even available to all states' health departments. In other words, New South Wales, for example, knows the underlying data it has provided to the performance authority. But it cannot, off its own bat, see that provided by other states. The NHPA can help overcome that in particular instances. For example, when Victoria's specialist cancer hospital turned out to have a high rate of hospital-acquired infections and explained that away by the mix of patients it treated, the NHPA brokered it being put in touch with a specialist cancer hospital with a similar patient mix but lower infection rates elsewhere in Australia to allow learning to take place.

Thus the NHPA is a significant step forward in transparency. But its results are still not as transparent as they could be, and its future appears uncertain, given proposals by the current Commonwealth government to merge it with a number of other national bodies.

One further qualification is necessary before discussing Victoria's performance against that of other jurisdictions within Australia. The states and territories are of hugely different population sizes and geographies. Victoria has 150 public hospitals, the Australian Capital Territory just 3, and the Northern Territory only 5. While Tasmania has 23, most of them are tiny, with 10 beds or fewer. Against Victoria's population of just under 6 million, New South Wales has 7.5 million and Queensland 4.7 million. But the next two largest states by population, Western and South Australia, number only 2.6 million and 1.7 million

respectively, while the Northern Territory has a population of fewer than 250,000. A simple ranking of states and territories by health service performance can therefore be misleading.

So what indicators are available to illustrate any gains from Victoria's mix of devolved governance, case-mix funding and performance management?

This section looks at very high-level population outcomes, access and some limited measures of quality, before examining costs.

High-level outcomes

Many of these are determined by social factors rather than health care, but Victoria in general performs well against other jurisdictions on life expectancy, low birth weight babies and many of the most common causes of death such as cancer and circulatory and respiratory disease. It has a smaller indigenous population than other jurisdictions, and there is no significant variation against the national average for the non-indigenous population (Productivity Commission 2015).

Primary health

This is essentially a Commonwealth responsibility, but there are few large-scale differences from the national average in access to GPs, dentists and out-of-hospital pharmaceuticals (Productivity Commission 2015).

Emergency department performance

The vast bulk of A&E attendances are handled in public hospitals, although there has been a recent trend for private hospitals in the largest cities to open emergency departments. Australia has waiting time targets for such attendances at public hospitals, the targets being set at state level, although no state in fact achieves them consistently. There is a new national target that, by the end of 2015, 90 per cent of patients should have left the emergency department within four hours.

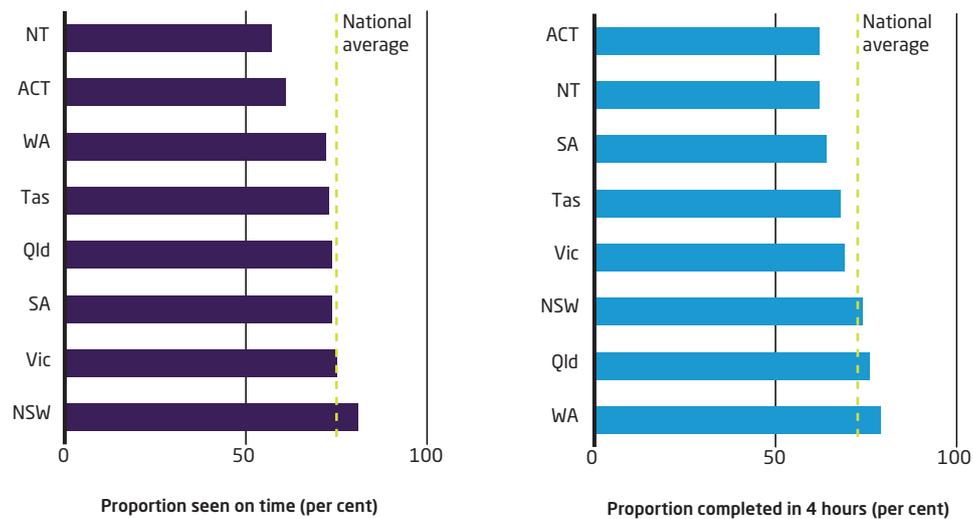
In 2013/14, Victoria's performance was at, or very marginally better than, the Australian average.

More granular hospital-level data from the NHPA shows Victoria's hospitals spread across the range for the emergency department four-hour wait. Thus the Alfred, for example, was among the top 10 per cent of performers nationally for major metropolitan hospitals in 2012/13. Frankston and Western was among the bottom 10 per cent. A similar pattern applies to other types of hospital in the state (NHPA 2014).

Access to elective care

There are also targets for admission to public hospitals for elective care, but these come with some important qualifications. Australia has high levels of private medical insurance – almost 50 per cent of the population has such cover. Of all hospital admissions, 40 per cent are to private hospitals – a far higher proportion than in the United

Figure 7 Performance against waiting time targets for emergency department attendances



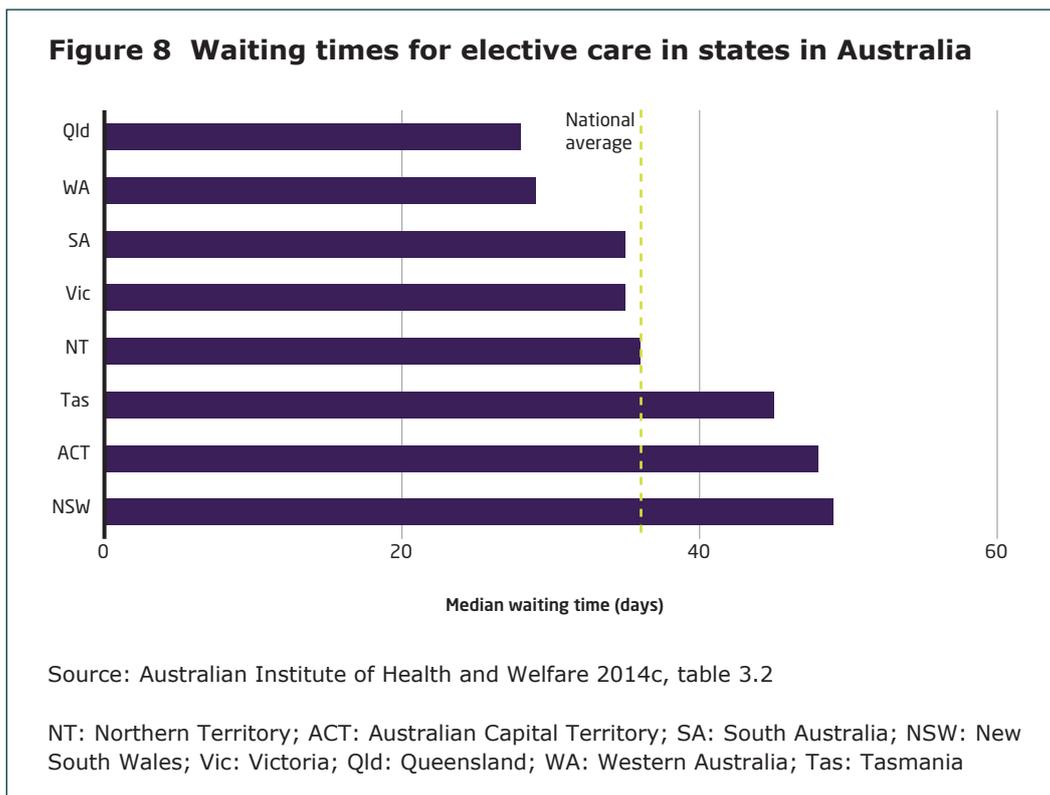
Source: Australian Institute of Health and Welfare 2014a, table 3.1

NT: Northern Territory; ACT: Australian Capital Territory; SA: South Australia; NSW: New South Wales; Vic: Victoria; Qld: Queensland; WA: Western Australia; Tas: Tasmania

Kingdom, for example. Private hospitals routinely deal with life-threatening conditions as well as more routine surgery such as hernias or joint replacements. For example, some 60 per cent of planned surgery for bowel, breast and lung cancer is performed in private, not public, hospitals, and the vast bulk of this is covered by private medical insurance or out-of-pocket payments, rather than the public sector 'buying in' such procedures from the private sector. The level of private medical insurance in Victoria is little different from the Australian average – just marginally below. But individual patient decisions on whether to use their private cover, which can come with a co-payment, will clearly impact on waits for access to public hospitals.

Furthermore, unlike in England for example, waits are counted only from the first outpatient appointment to the time to treat. Waits from the GP to the first outpatient appointment are not routinely recorded. Anecdotally, they are very varied and can be considerable. Thus waiting time data for elective care can paint only part of the picture. Within those qualifications, however, overall waits for surgery in Victoria are again at the national average, although waits are shorter in two of the larger states – Queensland and Western Australia.

At a more detailed level, Victoria has hospitals with some of the shortest waits for breast cancer surgery, for example, and none in the bottom 10 per cent of performers (NHPA 2013c).



Length of stay

Victoria's length of stay in public hospitals – taking a short length of stay to be an indicator of efficiency and quality in the absence of a high re-admission rate – shows considerable variation across the state. But at a state level Victoria has the second lowest average length of stay adjusted for case mix.

Unplanned re-admissions and adverse events

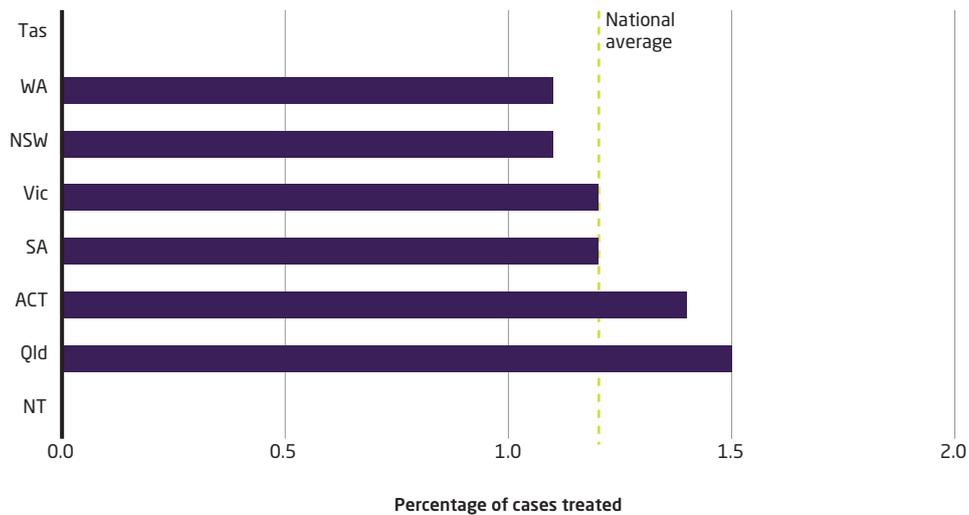
Victoria had lower rates of unplanned re-admissions than the national average for seven surgical procedures monitored by the Australian Institute for Health and Welfare, and the lowest for three of them – knee replacement, tonsillectomy and prostatectomy – although the figures for re-admission are not case-mix adjusted and capture only re-admissions to the same hospital. Its 28-day re-admission rate for all episodes of care is on the national average, better than Queensland but slightly worse than New South Wales and Western Australia.

Victoria also appears to have marginally higher rates of admissions with an adverse event: 6.8 per 100 cases against a national average of 6.5 on the latest figures. That might be a consequence of the longstanding use of case mix because for some conditions adverse events are paid for, encouraging the reporting of complications and adverse events.

Health care-acquired infections

Health care-acquired infections became a mounting concern across the globe in the 2000s and Victoria's health department led the way in Australia by insisting that its health services seek to tackle them.

Figure 9 28-day re-admission rates following elective surgery in Australian states



Source: Australian Institute of Health and Welfare 2014c

NT: Northern Territory; ACT: Australian Capital Territory; SA: South Australia; NSW: New South Wales; Vic: Victoria; Qld: Queensland; WA: Western Australia; Tas: Tasmania

That produced a rapid fall in methicillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infections and in methicillin-resistant *Staphylococcus aureus* (MRSA), with infection rates halving in three years. The rest of Australia is catching up, with South Australia now performing better.

Hospital accreditation

One very broad indicator of quality is hospital accreditation. Victoria insisted on hospitals being accredited ahead of a national move towards such a requirement. The national approach underwent a significant revamp in January 2013. The new accreditation regime is respected, not least by some chief executives in Victoria who have relatively recent experience of England's approach to similar issues.³

The 10 standards to be met include an overall assessment of safety and quality governance, the prevention and control of health care-associated infections, medication safety, falls prevention, clinical handover, the prevention and management of pressure injuries, and how well the hospital responds to clinical deterioration in acute health care (Australian Commission on Safety and Quality in Health Care 2012). There are core standards which must be met for an organisation to be accredited, and there are developmental standards where evidence is needed of activity to improve quality and safety.

When the standards were introduced from the beginning of 2013, only 60 per cent of health organisations nationally passed all the core

³ Unattributable interviews.

Figure 10 Rates of *Staphylococcus aureus* bacteraemia in Australian public hospitals 2013–14



In 2013-14:

- the national rate of *Staphylococcus aureus* bacteraemia (SAB) in public hospitals was 0.87 cases per 10,000 days of patient care
- rates differed among the states and territories, but all jurisdictions had rates below the national benchmark
- 1,621 cases of SAB were reported
- 3 in 4 cases were treatable with commonly used antibiotics - MSSA cases
- 1 in 4 cases was antibiotic resistant - MRSA cases.

Source: Australian Institute of Health and Welfare 2014d

NT: Northern Territory; ACT: Australian Capital Territory; SA: South Australia; NSW: New South Wales; Vic: Victoria; Qld: Queensland; WA: Western Australia; Tas: Tasmania

standards on first assessment. The figure for Victoria was more than 90 per cent, a proportion described as 'pretty remarkable' by Deborah Picone, chief executive of the accreditation body, the Australian Commission on Safety and Quality in Health Care. All Victoria's health services are now fully accredited.

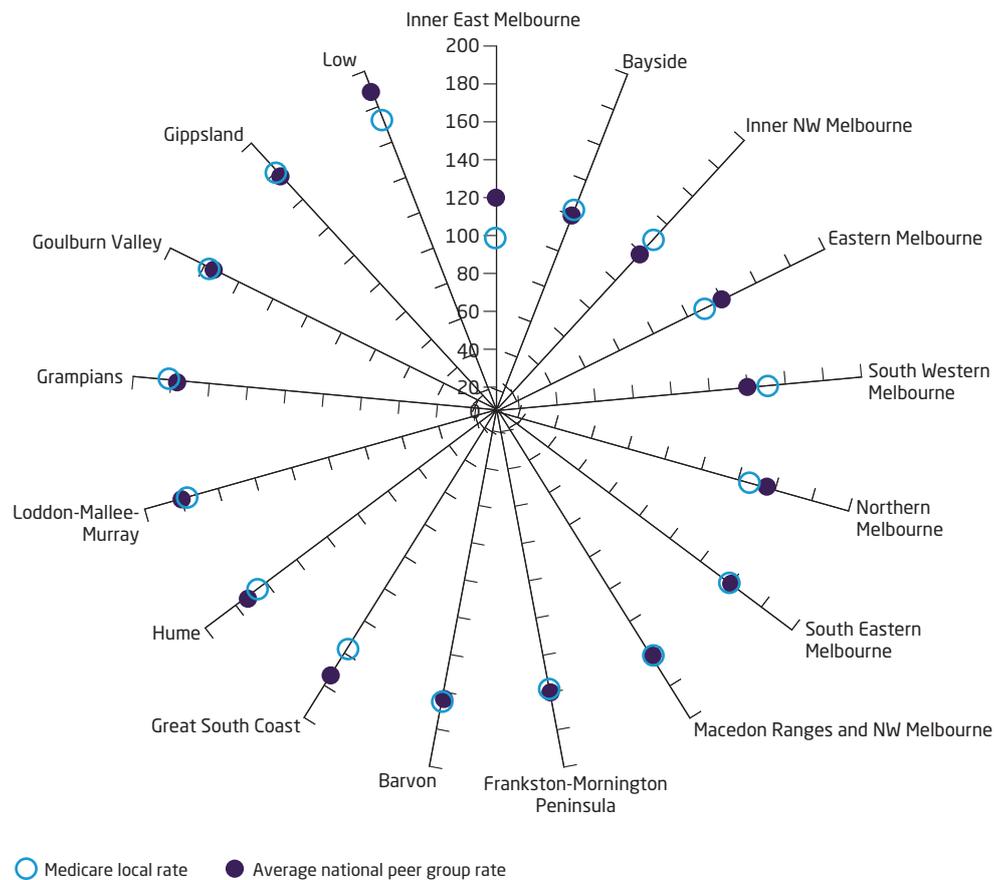
Avoidable and treatable deaths

Another much broader measure of the effectiveness of health care which is sometimes used for international comparisons is potentially avoidable and treatable deaths. The former are defined as deaths before the age of 75 that might have been avoided through better prevention or health care. That picks up the combined effect of lifestyle, public health, primary care and secondary care, without being able to distinguish the relative impact of each. Potentially treatable deaths are those which might have been avoided by better medical services, whether primary or secondary. The two categories are not mutually exclusive.

The NHPA has analysed both potentially avoidable and potentially treatable death rates for local communities across Australia, broadly grouped by areas of similar geographic, demographic and socio-economic circumstances (NHPA 2013b). The results for Victoria are shown in Figures 11 and 12.

The overall picture shows that Victoria is not out of line with the national average, with more results that are at least as good or better, rather than worse, than the national peer group results.

Figure 11 Rates of avoidable deaths: Victoria Medicare local rates compared with national peer group rates



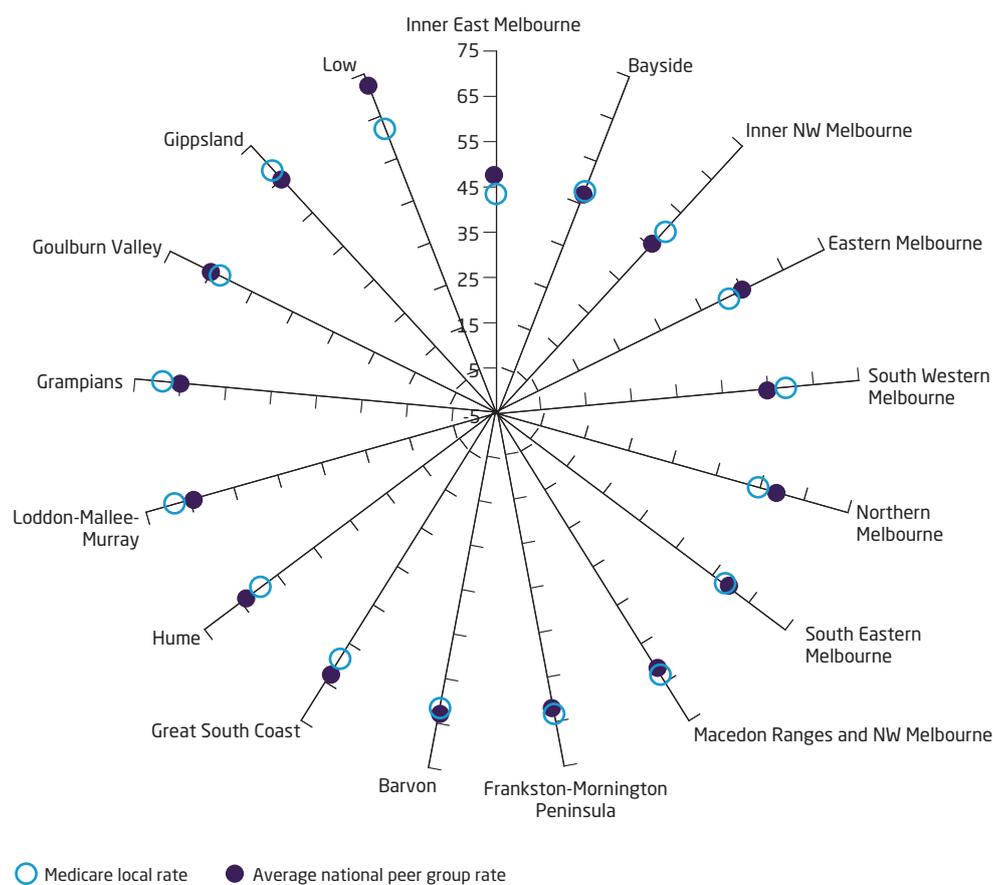
Source: Victoria Health Department redrawing of NHPA data

It must be stressed that this brief overview of the performance of Victoria’s health system is a highly selective one. It draws on easily available public domain data. Other indicators could have been chosen – some to show examples of very high performance within Victoria and others to show poorer results, and all showing variation within it.

What emerges, however, is that on these indicators Victoria performs at the very least adequately compared with other Australian jurisdictions, and on some measures well. On the limited measures of hospital-level data available through the NHPA, Victoria’s hospitals tend to ‘sort themselves through the pack’, as one senior official put it. There is good-to-average, and in some cases excellent, performance, along with some that is poor or poorer. In none of the measures are Victoria’s health services clustered near the bottom. On state-wide measures, the picture is broadly the same – average-to-good performance with some exceptions.

Whatever else Victoria’s model of devolved governance, performance management and case-mix funding has brought, it has not prompted the state to fall behind others on these measures. Neither has it led to it standing out head and shoulders above them.

Figure 12 Rates of deaths from potentially treatable conditions: Victoria Medicare local rates compared with national peer group rates



Source: Victoria Health Department redrawing of NHPA data

There is, however, one area of measurement where Victoria does indeed stand out – on cost. Victoria was the first state to introduce case-mix funding, in 1993/4. Others followed suit, adopting various versions of case mix, not all identical to Victoria’s. It is now the approach used by the Commonwealth to distribute funds to the state.

Despite others adopting case-mix funding, Victoria has consistently had lower costs per case than other jurisdictions.

Over the five years from 2008/9 to 2012/13, not only has Victoria been cheaper than the national average by 9.5 per cent, 11.5 per cent, 12 per cent, 13.7 per cent and 12 per cent, it has consistently been cheaper than each of the other larger states.

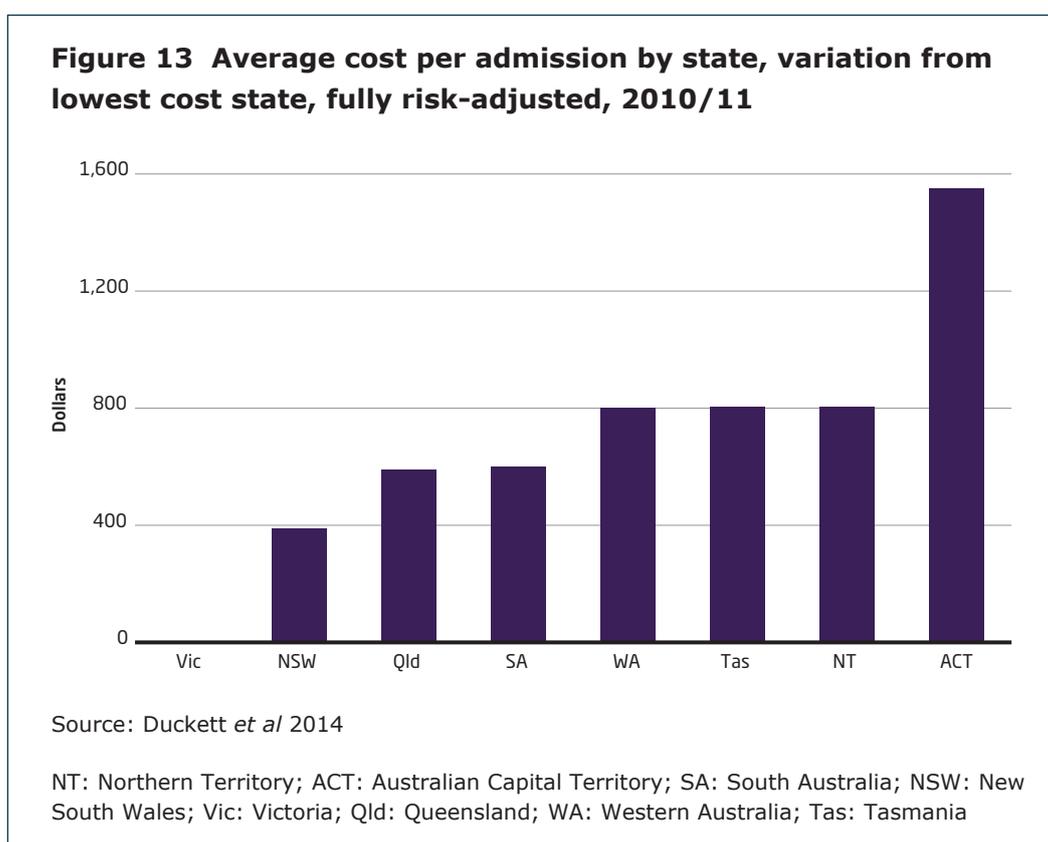
Furthermore, a recent study showed that the gap between the highest and lowest cost hospitals within Victoria, while not insignificant, was smaller than in most other states. This gap was significantly smaller compared with some of the larger, and therefore most comparable, states (Duckett *et al* 2014).

This study by Stephen Duckett and colleagues at the Grattan Institute (Duckett *et al* 2014) also sought to identify avoidable hospital costs. Again Victoria performed well, showing both a smaller range of

Table 2 Estimated average cost (A\$) per weighted separation excluding depreciation by jurisdiction, 2008/9 to 2012/13

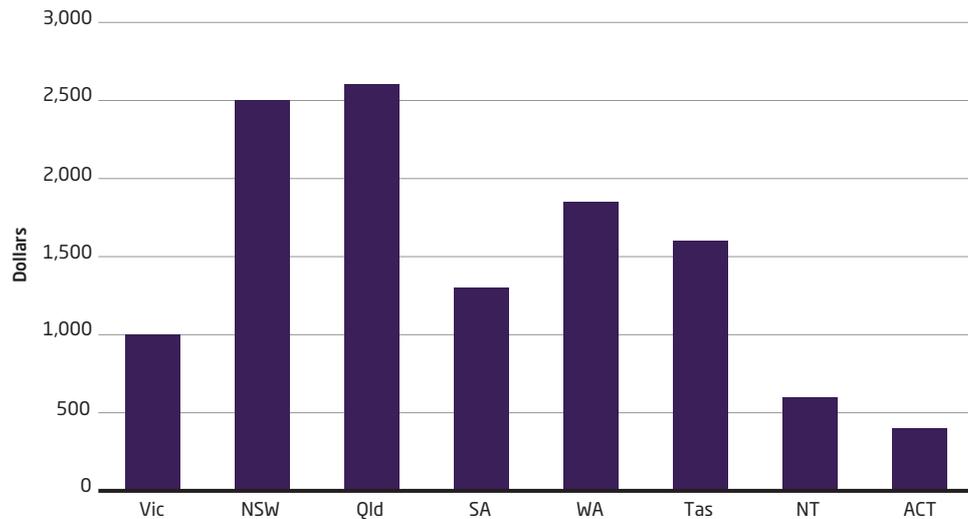
Jurisdiction	2008/09 \$	2009/10 \$	2010/11 \$	2011/12 \$	2012/13 \$
New South Wales	3,890	4,280	4,407	4,715	4,813
Victoria	3,686	3,893	3,944	4,057	4,213
Queensland	4,095	4,596	4,694	4,825	4,800
South Australia	4,112	4,506	4,738	5,049	5,113
Western Australia	5,099	5,165	5,045	5,241	5,411
Tasmania	4,698	5,502	5,300	5,142	5,106
Northern Territory	4,613	5,311	5,692	5,872	5,802
Australian Capital Territory	4,448	5,530	6,069	6,324	6,256
National	4,052	4,401	4,499	4,703	4,784

Source: Independent Health Pricing Authority



avoidable costs as measured in the study and a lower average, and in particular lower figures for both compared with the other larger jurisdictions.

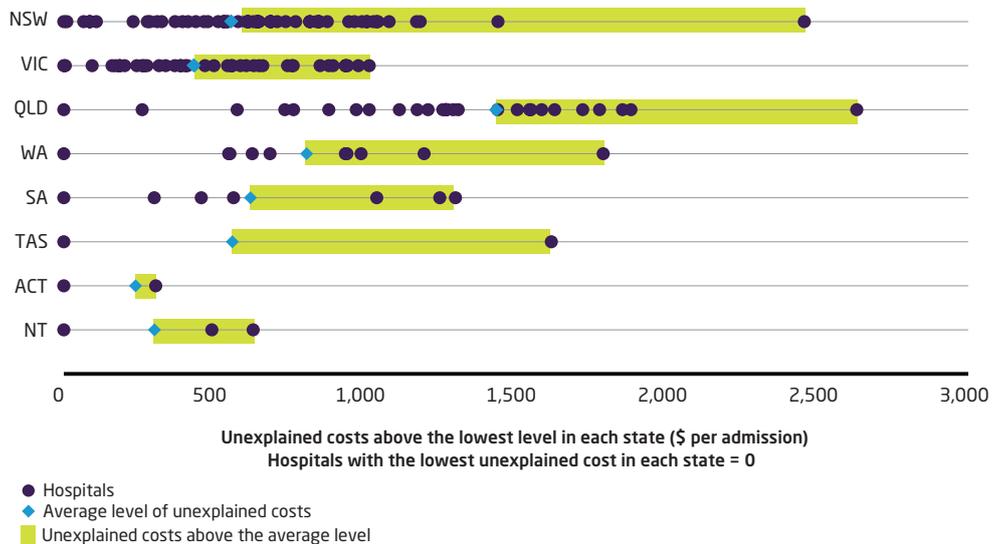
Figure 14 Gap between highest and lowest cost hospital in each state, average cost per admission, fully risk-adjusted, 2010/11



Source: Duckett *et al* 2014

NT: Northern Territory; ACT: Australian Capital Territory; SA: South Australia; NSW: New South Wales; Vic: Victoria; Qld: Queensland; WA: Western Australia; Tas: Tasmania

Figure 15 Avoidable costs by state, A\$ per admission 2010/11



Source: Duckett *et al* 2014

NT: Northern Territory; ACT: Australian Capital Territory; SA: South Australia; NSW: New South Wales; Vic: Victoria; Qld: Queensland; WA: Western Australia; Tas: Tasmania

Conclusion on performance

This report has made no attempt to compare, for example, the quality of Victoria's leading tertiary, teaching and academic institutions against those elsewhere in Australia, or globally. Nor has it assessed its standing in translational research which, these days, is seen as a key contributor to both a country's economic strength and the quality of its health care system. We do, however, note the current development of plans for two genuine academic health science centres, specialising in translational research, in Melbourne. Rather this review of performance has looked at a number of very broad brush, very selective parameters of cost, access and clinical quality. Within those limitations, what overall picture emerges?

As in any health system, there will on occasion be a serious failure, as the recent events at the Djerriwarrh Health Service illustrates.

Taken as a whole, however, and allowing for in-state variation, Victoria performs at least adequately and, on some of the chosen measures, appreciably more than adequately, without clearly standing out from the Australian pack. Cost is the one exception to that. Victoria's performance on cost, however, has not come at the expense of quality. To put it crudely, performance is not cheap and nasty; it is cheap and, by and large, pretty good.

In making that judgement it is worth remembering that 40 per cent of all hospital admissions and 60 per cent of elective surgery admissions in Australia are to private hospitals. These are not the state's direct responsibility. Private hospitals are subject to national accreditation, and large parts of their consultant workforce are shared with the public hospitals. Private hospitals do provide some data for national review and comparison. But much of the data on their performance is in fact held either by the private insurers who, in the main, pay their bills, or is held in clinical review systems – and very little of that is in the public domain. Equally, general practice, where the bulk of patient contacts take place, is not within the state's control, being a Commonwealth function.

Nonetheless, for those parts of the Victorian health system that are within the state's purview and potentially within its control, Victoria's health department and its public health services can legitimately make a claim to offer the best value health care in Australia – placing it therefore among the better performing global systems, given Australia's position on OECD measures.⁴

From that, follows the question 'what has been the individual contribution to this performance of the combination of case-mix funding, devolved governance and performance management – the three-legged stool on which Victoria bases its claim to Australian exceptionalism?'

⁴ There are qualifications to this judgement including the relatively high proportion of patients who experience cost-related access problems in Australia (see p 12). The source of many of those problems, for example, the cost of GP visits, diagnostics, prescriptions or private insurance costs, are not within the state's control.

Answering it is not easy. A partial unsatisfactory answer is that other states have case-mix funding, though it applies in various guises, so it is unlikely to be case mix alone. Devolved governance and performance management must, therefore, play a part. But disaggregating the relative contribution of those two, or of those two plus Victoria's longer history of using case-mix funding, is an impossible task.

What can legitimately be said is that the model is delivering good results very efficiently. So amendments to it should be undertaken with care.

Equally, however, we heard criticisms of all three elements. These could point to a strengthening of the model, parts of which undoubtedly need amendment to deal with the growing global problem of patients with multiple co-morbidities.

5 How might Victoria's values be updated?

What follows is a mixture of outside observation by the authors based on what we saw and heard, and on what The King's Fund thinks it has learnt from its own analysis of different health care systems. We include views we heard from senior figures from outside Victoria, plus a compilation of views from within the Victorian health care system.

It is important to acknowledge from the outset that all publicly funded health care systems face choices over how to lead and manage performance and how to support improvement and innovation. These include whether to centralise control or to devolve decision-making; whether to regulate and inspect performance or invest in leadership and improvement capabilities; how far to use competition or collaboration to stimulate innovations in care; and how far to publish data, as opposed to holding it internally, as a stimulus for both professionals and organisations to improve their own performance through peer review. These choices are not binary, in The King's Fund's view. A judgement is needed on the balance between them, and that judgement will partly be shaped by the particular politics in which a country's health care system operates. The King's Fund is clear, however, that in meeting the competing objectives in health care systems – those of individual patients, taxpayers and staff – and in selecting the balance between the competing tools outlined above, it is always best to avoid micromanagement of performance from the centre. This is something that, over the past decade and more, Victoria has eschewed.

Micromanagement carries well-known risks. It all too easily disempowers local leaders, creating a culture of compliance and risk aversion that can lead to gaming and misreporting of performance data, with the net result that it stifles innovation. This challenge can be particularly great in smaller jurisdictions where the more intense local accountability of politicians for health system performance can be felt more strongly than in larger ones. So, against that background, and given that we heard criticisms of all three elements of the Victorian model – devolved governance, case-mix funding and performance management – and indeed of other aspects of the way the Victorian health care system operates, where might improvements be made?

It is important to state that the criticisms we heard, both externally and internally, varied somewhat. The solutions varied even more widely.

For example, some saw the issue of 'hordes of boards' – Victoria has 85 of them – as a significant matter that the state should simply tackle by rationalising them as some other states have done. Some argued that they should be merged into the regional entities or, failing that, that the same performance and governance regime should be applied to them as to the larger health services. Others told us that merging rural boards into regional ones was political dynamite, given the huge attachment locally to the smaller rural entities. There was also the view that the issue was largely irrelevant given the decidedly small share that boards take of overall public spending on health care. In other words there was little efficiency gain to be made – though there might be a safety and quality gain – and a considerable political price to pay.

That issue aside, we heard, nonetheless, of a number of ways in which the model of devolved governance could be strengthened. There are other changes which are undoubtedly needed to deal with the growing global problem of patients with multiple co-morbidities.

In a nutshell, as one longstanding senior official in the department put it to us, 'devolved governance is both Victoria's greatest strength but also its greatest weakness'.

We heard, for example, of a number of areas where the role of ministers in the system might best be both restricted and enhanced in order to make the model work better.

These are grouped into four broad, but in practice sometimes overlapping, categories.

Ministerial responsibilities for devolved governance

For example, there is a case for creating an independent appointments commission to remove a perception that, regardless of changing party political control, ministerial appointments to boards have become too 'political'. The sense is that they focus less than they should on the skill mix that boards require. A less radical alternative would be to create an independent commission to advise ministers on appointments.

There are issues around the way capital is handled. It is anything but devolved. None of it is built into the funding formula that providers receive for their activity. Any item costing more than A\$300,000 – such as CT scanners, new boilers, kitchens or lifts – has to be bid for from the department. The health minister in turn has to bid in Cabinet against other priorities for such depreciation and capital costs, rather than depreciation and maintenance costs forming part of the current budget. Furthermore, capital appears to be highly constrained. The combined effect of these factors is a perverse incentive that makes it easier to bid for a new hospital than to get money to refurbish an existing one. In other words there is poor use of capital stock.

There is also a perception, rightly or wrongly, that where new hospitals or hospital wings do get built, their location is too influenced by party political considerations. This is a criticism we heard not of one particular state government, but of state governments over the years.

So there is a case for reviewing the balance between revenue and capital spending. And it could help to build an element of capital into the activity-based funding payments, certainly for the larger boards, while providing more transparency and objectivity over how new build decisions are taken.

The council of board chairs, we heard, is a less effective organisation than it has been and could be. It could be an important forum allowing ministers to 'steer' Victoria's health care system in the direction it needs to go – towards better integrated care and towards a conversation with the public that is less hospital-centric than it is at present.

That last – creating a less hospital-centric conversation with the public and patients in Victoria – is an important contextual shift that many said was needed.

An approach worth thinking about politically is that taken in Canterbury, New Zealand, where the board developed a piece of rhetoric around 'one system, one budget' – even though Canterbury does not, by any measure, have a single source of funding for its health and social care. The argument was that each health and social care dollar can only be spent once, so it needs to be spent in the way that achieves the best integration of care for those who need it. By not just adopting the rhetoric but slowly acting on it so that those involved could see it was becoming a reality, improvements in the integration of care followed (Timmins and Ham 2013).

The challenge is much greater in Australia than in New Zealand, given the immense complexity of the funding arrangements. However, there is an opportunity here for politicians to reshape the dialogue around health and social care. The recent reversion of the health department into a department of health and human services also presents an opportunity, however difficult, to think about how that approach might be adapted to the Victorian context. It does so despite the very different cultures of the previously separate human services and health departments, where the former is much more involved in the direct provision of services than the health department, with its 'devolved' approach to governance.

Transparency

Victoria – and indeed Australia – is behind a number of other jurisdictions which include Sweden, England and parts of the United States in using timely, public, easily accessible and easily interpretable data on performance, including crucially clinical and quality data, as a means to harness the natural competitiveness of both clinicians and managers to improve services. Publishing such data provides the public with a clearer picture of the quality of the local services they receive. At least as importantly, it can also be a way of spotting trouble early.

When the work for this study was being undertaken, Victoria had not had – at least to anyone's knowledge – what might be dubbed a major hospital scandal: the equivalent of the paediatric cardiac deaths in Bristol or a Mid Staffordshire in England's NHS, or the equivalent of the Bundaberg, or Campbell and Camden events in Queensland and New South Wales. But, as one senior official in the department put it, 'How would we know?' One answer when that was played back to others in the department was that Victoria is relatively small – a population of six million. People know each other. So alarm signals would come by word of mouth and local knowledge. That argument, however, did not prevent Bundaberg and Campbell and Camden being caught as early as they might have been, and it did not prevent the events at Bacchus and Melton.

A significant increase in the quantity, quality and accessibility of publicly available performance data – in other words greater transparency – would be an advantage.

That is probably the most important area where greater transparency could create pressure for improved services, and it is the one we heard most strongly supported during our visit. In addition, however, although the theory of devolved governance is that it supposedly

enhances accountability to local communities, these have relatively little information with which to hold boards accountable. Board meetings are not held in public. Board minutes are not published. And we heard senior clinical directors say they were discouraged from sharing performance data with more junior staff. Boards do hold an annual open public meeting, and they do produce an annual report – but in the main these are slim, often quite glossy documents that (with a few exceptions) are public relations puffs for how well a local service is doing rather than anything that resembles a true ‘account’ of the local health service.

Adjust the balance between competition and collaboration

One of the gains of devolved governance has been to produce competition between boards to be perceived as providing the best service – within the measures available. The other side of the coin is that there is less collaboration between services than there might be. Options to improve that include encouraging successful public providers to take on the running of challenged ones, which could lead to the development of provider chains and networks that already exist in some jurisdictions. Such an approach could also address concerns that some of the smaller boards are still providing surgical and other services that are beyond their safe capabilities. Another approach would involve ‘buddying’, under which high-performing providers offer support under a management contract as a way of using scarce leadership expertise for the greater benefit of health services across a system. This has recently been tried in England, with mixed results (Foundation Trust Network 2014).

A further strengthening of collaboration could well come from the department taking a greater role in clinical service planning. The commitment not to undermine devolved governance has left something of a vacuum. So while a few important services have been rationalised (trauma, with huge success, and bariatric surgery, for example), there remain unresolved issues over where and on what scale other specialist services such as cancer, cardiac and stroke should best be located to produce the best possible outcomes. The recent Travis report also addresses that issue (Travis 2015). We detected a perhaps unsurprising degree of mutual frustration. The department felt that it was up to the boards to seek and agree such changes so that when they happen there is true local ownership of them. Some senior leaders – both board chairs and chief executives – accepted the value of that approach but still felt the department could do more to lubricate and facilitate the conversations needed for such changes to happen, and that at times it could and should use its funding power to shape such changes.

The department could also do more to support services in building their own capacity for ‘improvement from within’ – reinforcing devolved governance as a means of improvement at the same time as it takes a stronger lead on clinical service planning.

Enhance the drive towards more integrated care

Finally, and in some ways most importantly, we discovered an appetite for developing better approaches to integrated care. As already noted,

Victoria has what may well be the world's furthest advanced Hospital at Home service. But we were told it needs to move beyond that to adapt its activity-based funding model to reward health services for preventing hospital admissions in the first place, in addition to substituting care at home for care in hospital. In other words, seeking out funding models that reward health services for keeping patients out of hospital in the first place, rather than just funding them for in-hospital treatment or Hospital at Home services.

Victoria already has a range of such programmes, some of which have been recently rationalised. But we heard that the time has come to go further and experiment, at scale, with bundled payments – something more on the lines of the 'year of care' approach to patients with multiple chronic conditions that is being developed around the world.

The department shares an interest in doing this with private sector insurers. Australia's subsidies to take out private health insurance and to maintain it mean the private insurers are facing a similar growth in the numbers of older patients with multiple chronic conditions who would benefit from integrated care, not just the 'one-off cure' approach. Some initial experiments and programmes working with private insurers are already under way. There is room, we were told, to develop them, and, potentially, to work more closely with the new primary health networks whose stated aim is more integrated care, even if their financial firepower to achieve that is at present limited. Were some of the ideas in the current national government's proposals to reshape the balance of funding between the Commonwealth and the states to become a reality, new avenues for achieving integrated care would open up, and those should be borne in mind.

Final observations

This report shows that Victorians do indeed have a quality health care system which manages to operate well despite the immense complications caused by the Commonwealth/state split, by the way general practice is funded in Australia, and by the complications, as well as advantages, that a significant private sector brings. Victoria can legitimately claim to have Australia's most cost-effective public health system. But it could do better, and it faces all the same challenges as health care systems in other parts of the developed world.

It could also probably do with being depoliticised in a number of key areas – ministerial appointments and decisions on capital, for example. That is inevitably a challenge to politicians. Alan Milburn, one of England's more reforming health secretaries, has repeatedly said: 'There is not a surfeit of politicians who think that their historical purpose, having got power is somehow to give it away. But in health, sometimes, that's what you've got to do [if you want things to work better]' (Timmins and Davies 2015).

Against that, politicians of all parties should play a larger role in making the case to the electorate for more integrated care, reducing the hospital-centric nature of the public discourse around health in Victoria.

There is a strong case for greater transparency – the timely publication of more data on clinical performance and outcomes in an easily

accessible format. Producing such data as close to real time as possible, rather than just annually a long time in arrears is a way of harnessing the natural competitive instincts of boards, executives and clinicians to improve, as a means of informing the public and patients and helping them choose better health care. It is also a way of identifying poor standards of care and acting as a safeguard against a more heavy-handed approach to inspection.

Without destroying the benefits of the Victorian values of 'earned autonomy' and devolved governance, there is a case for the department to become more involved in clinical service planning, rather than just being a funder which provides advice and feedback. This is a matter of degree, not a wholesale switch to a different approach. There is also certainly an argument for it to move beyond small-scale experiments with integrated care payments for those with multiple chronic conditions to a more vigorous development of such approaches.

Finally, there is a case that Victoria should pursue a twin-track approach to more integrated care – building it out of the hospitals and health services that it has, while also mindful that with some rebalancing of the Commonwealth/state funding streams, the fledgling primary health networks could offer another route, certainly in parts of the state.

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