

Governance, engagement, and service innovation

Trevor Carr¹

¹Victorian Healthcare Association

Introduction

The architecture of health service governance within the Victorian context is unique within the landscape of health systems across Australia. The unique nature of the Victorian system derives from the ongoing existence of governing boards. All other States of Australia operate their health systems through decision making processes that are fundamentally centralised.

Within Victoria, the existence of Boards governing health services provides a mechanism through which the setting of strategy is devolved to the local service, with the strategy then implemented through a Chief Executive appointed for this purpose.

The Boards are generally representative of the local community, thus providing to the community a sense of 'ownership' of their health service. This creates a real sense of connection between those charged with local decision making power, and the community being served as a result of those decisions. This is particularly so throughout rural Victoria.

Governance

Discussion

The rural health care system is complex and diverse with services ranging from large regional hospitals providing high level acute intervention, through to small local health care services whose main focus may be on aged and community services. Through a diverse mix of health care professionals, services range from intensive care to first aide, from residential care to home care, and from acute psychiatric to generalist counselling.

There are seventy-one rural public health services, including comprehensive health services in the major regional centres. In smaller communities, the health services often integrate acute health, aged care and primary care, operating through discrete budgets, which in most cases, are less than \$15m. There are also 17 independently governed Community Health Services delivering a broad range of primary care services to rural Victorians.

A distinctive feature of the Victorian health care system is the significant role it plays in delivering residential aged care services which complement health care for older people, including community care and home care. To emphasise this point, some 6,500 residential care beds exist within the public sector in Victoria, and represent 40% of all residential care provision in rural Victoria.

Rural Victoria has approximately 1,300 General Practitioners and other independent clinical providers, who are critical to the provision of comprehensive health care. The importance of General Practice is amplified through the common appointment of GPs to the Visiting Medical staff of the local hospital within their community.

Boards of rural public hospitals and multi purpose services

The board of a rural public hospital (or multi purpose service) is accountable to the Minister for Health for the governance of the organisation. The board is responsible for setting the strategic directions of the organisation as well as general oversight of operations and financial control.

Each rural public hospital has a Chief Executive Officer who is responsible to the board for implementing the board's policy decisions, providing advice where sought by the board, proper day-to-day management of the resources of the agency, and reporting on the agency's performance.

Rural public hospitals are encouraged to use best business practice in their operations, foster innovation in clinical care and service delivery, and respond to the output funding environment by introducing responsible management systems, which devolve budget responsibility and foster initiatives to improve performance.

The process for appointment is one of application to the Minister for Health. Individual agencies are advised of the applicants to their service, and those members of the existing Board not subject to the current application round will generally make recommendation to the Governor in Council following an interview process. In considering the recommendation from the agency, the Governor in Council will seek to ratify a board reflecting a balanced skill mix, skills and expertise relating to the governance of health services, and ability to represent the views of the community.

The application process requires a full disclosure of any potential conflict of interest, and staff will not be appointed to the board of an organisation. As a general rule, individuals with other pecuniary interests in the organisation will not be appointed. For example, contractors providing goods or services, or where the individual's personal/professional interests are directly affected by strategic decisions of the board. This includes GPs providing a direct service to the health service as a Visiting Medical Officer.

Board members are formally designated as part-time 'non-executive directors'. Generally, board meetings occur monthly and there may be additional extraordinary meetings or board functions which members are expected to attend. Each board has several subcommittees that meet monthly and members would be expected to participate on some of these, including potentially chairing a sub-committee.

The system of health service governance in Victoria operates within a legislative framework and a broader policy context established at the central level. Generally, the decision of Boards within their legislative gamut and the broader policy context is implemented without the need for further central sign-off.

By way of example, the overarching policy context for Rural Boards within Victoria is the Rural Directions statement. Rural directions recognises that country Victorians have a range of different health care needs, many of which are specific to rural living.

Traditional methods of care are changing, and as technology advances and new ways of treatment become available, it is important to make sure country Victorians can make the most of new treatment options. To ensure that rural health services change for the better, the policy context of the State Government is concentrated on three main areas:

- improving people's health and wellbeing
- creating the best health system possible
- strengthening and sustaining the health system into the future.

This enables governing bodies to establish annual business plans and longer term strategic plans that reflect the resource expectations and capacity of their organisations.

However, examples do exist where government intervention has occurred because of suspect operational performance, or politically sensitive strategy. In fact, the Health Services Act within Victoria is very specific in relation to the powers of the Minister which includes the ultimate power to dismiss the Board and to appoint in their place an administrator. Such action has been initiated on a handful of occasions, and is an effective mechanism in focusing the attention of Boards to the task expected of them!

The responsibilities of governance are prescribed by the Victorian Health Services Act 1988 (the Act). In summary, they include:

- developing the strategic plan for the operation of the service and monitoring the implementation of this plan
- developing financial and business plans, strategies and budgets to ensure the accountable and efficient provision of health services
- establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served
- monitor the performance of the service to ensure that effective and accountable risk management and quality improvement systems are in place
- the appointment of a Chief Executive Officer, including determination of terms and conditions of appointment (this function is subject to agreement with the Secretary of the Department) and agreed processes for performance review
- fostering formal and informal relationships with other service providers to enable effective and efficient service delivery and continuity of care
- establish processes that give voice to patients and the community being served by the health service in relation to their needs and views regarding the service.

Boards are constructed from people with an interest in the local health service, they are mostly voluntary, they are held accountable to the local population being served and their governance responsibilities regarding business and clinical outcomes provide a mechanism that ensures awareness and scrutiny in the best public interest.

Public accountability is provided through mechanisms that include annual meetings open to the public, published financial accounts, and published quality of care reports.

Unfortunately, there is currently no public accountability requirement in relation to the service model being provided and this can result in competition between service providers that would, in other circumstances, be collaborating to act in partnership.

As the role of governance includes all aspects of the business, a key benefit of the governance model within Victoria is the proximity of clinical governance to clinical service—that is, it is not removed to a central location! This governance responsibility, and the concomitant development of process and reporting to facilitate the responsibility, significantly underpins clinical delineation and scope of practice within Victoria.

The issue of health service governance received some attention during the 2007 Federal Election process, with the Coalition Health Policy committing to the creation of local boards of management as part of the next AHCA. Although Labour policy at this time was less explicit, what was clear was a commitment to the establishment of a National Health and Hospitals Reform Commission.

As we now know, the National Health and Hospitals Reform Commission has declared as one of the principles of reform provision for public voice in shaping decisions about the organisation of health services. The interim report of the NHHRC left open the question of governance arrangements in the future, deferring discussion to 3 options for accountability in the future. Option 1 is to retain the status quo in relation to the organisation and funding of hospitals, and Option 2 is the creation of Regional Health Authorities as fund holders, usurping the role of State Governments.

Adding further weight to the likely return of a system of public representation in the governance of health services across Australia is the commentary in industry journals supporting such action.

By example, Stewart and Dwyer in the Medical Journal of Australia responded to the Final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals—otherwise known as the Garling report, by noting that *'the most disappointing aspect of the Garling report is its failure to recommend structural changes that would address the loss of local accountability within hospitals and areas since area health service boards were abolished in 2005'*. Stewart and Dwyer go on to state that *this loss has been a major cause of the current mistrust of hospital and area administrators and plummeting clinician morale'*.

The NSW Opposition has picked up on this to an extent, by committing to the setting up of 20 district health boards to ensure more local input into the provision of health care. While well short of the Victorian approach, the key point is that 'local input' is seen to be important to the outcomes produced by the system.

Although the shape of participation is unknown at this stage, it would appear that the absence of recognition through the interim report of the NHHRC will lead to the unique nature of Boards in Victoria becoming less unique in the future.

Engagement

Engagement with the community being served by public hospitals in rural Victoria is mandated for a small number of regional hospitals, and voluntarily exercised by a majority of hospitals.

The mandate comes via the Health Services Act which requires the Board of a public health service to appoint at least one community advisory committee. The Act is quite clear in requiring that persons so appointed are in a position to truly represent the views of the community, and specifically excludes individuals who are health service providers or who are or have recently been health service employees. The objective is of course to ensure that the committee is free of professional or agency bias.

Health services also engage the views of their community through independent representation on sub-committees. The most notable use of this mechanism of engagement is through representation on quality committees, and occasionally Finance & Audit committees (although this is usually through speciality representation).

Connection to the local community is also illustrated via various auxiliary mechanisms, and fundraising efforts. Local philanthropy plays a very important part in the connection of the health service to the

community. While the overall contribution as a proportion of total budget varies, the 'ownership' afforded through local philanthropy provides an important psychological link. Anecdotally, the strength of this psychology is inversely correlated to the size of the hospital—that is, the smaller the town, the stronger the link.

Representation on governing Boards is heavily weighted to people living within the local community. Only the 5 largest regional health facilities within Victoria attract a Director stipend, all other hospital Boards are served through volunteerism. In the instance of the paid positions, there is an increasing prevalence of representation from outside the community (although certainly not to the extent of exclusion or majority). In all other instances, representation will generally be purely from the local community.

Formal engagement with the local community is also afforded through the conduct of public meetings. At a minimum, the annual meeting of the organisation will be publicly conducted. In addition to this statutory meeting, many organisations also conduct open information sessions, particularly if the hospital is proposing a service change, major fundraising effort, or capital reconstruction.

Service innovation

Many examples exist within the Victorian context of local service innovation sponsored through the health service strategy endorsed by the governing body of that health service. Service planning is tailored to reflect both the need of a local community and the capacity of the health service to resource a care pathway to meet needs. The following comments reflect examples of innovations initiated at a local level to address service modalities and/or workforce issues.

The funding model for small rural health services throughout Victoria enables these health services to move funding from bed based care models to ambulatory service models to 'fit' the need of the community being served.

At the Numurkah District Health Service, this strategy was effectively applied to the development of ambulatory care services including physiotherapy, social welfare, diabetes and coronary care clinics, podiatry, etc.. Prior to the role change and redirection of the operating funds through the Small Rural Health funding model, \$500,000 was used from agency reserves to construct a purpose built ambulatory care centre. None of these initiatives required Ministerial sign-off and the re-direction of funds was initiated through guidelines developed by the DHS and approved at a local Regional office level.

A rural dental health workforce initiative and a program to reduce heart disease among rural men are amongst other examples of service innovation evident throughout Victoria.

The filling the cavities in the rural dental workforce program was an initiative of Goulburn Valley Health in Shepparton. Rather than rely on traditional methods of recruiting staff, GV Health offers dental graduates 12 month training placements at its 12 chair public dental clinic that includes a dental laboratory.

The training program also offers graduates exposure to private dental practice via a link with the nearby Cobram Hospital that owns a private dental clinic.

GV Health's strong links with Melbourne University mean that final year dental and oral health students are offered a four week rural placement that has resulted in increased competition for the 12 month

dental positions. The outcome of this initiative is an unprecedented situation where there are now 20 applicants vying for two dental graduate positions this year.

Portland District Health created the 'Towards a Healthy Heart' initiative that aims to reduce the rates of heart disease among rural men aged between 30-60 years. The team at Portland identified from a quantitative analysis that heart disease was a major cause of premature death among men and cardiac-related admissions to the local health service were increasing.

The death of a Portland resident from premature heart attack led employees from one major employer to approach the health service seeking answers to preventing heart disease.

Portland District Health Service responded by funding its Towards a Healthy Heart program that from the outset involved the entire local community including: employers, sporting groups and local government.

The program offered Portland men four risk factor assessments, 12 weeks of group education, 12 weeks of physical activity and individualised health coaching, where necessary.

The resulting behaviour change was the key to success with participants losing an average of three kilograms and reducing their risk factors for heart disease in multiple areas.

The implementation of a strategy such as those illustrated does not require the input of any individual or authority from outside the individual parties to the initiative.

Recommendation

It has been disappointing from a Victorian perspective, to not witness a higher level of interest in the governance arrangements that exist within Victoria during the recent focus on health care reform through the National Health and Hospital Reform Commission.

While not perfect (as is the case with all health systems), the engagement of communities through boards of governance drawn from the local community, does provide an enhanced capacity for engagement and service innovation. Important in the Australian context, is that 'local' be recognised from a geographic community of interest perspective. By definition, it would be impossible in the Australian rural context to expect to find a 'local' culture within a geographic spread aimed at a 'cookie cutter' population of say 500,000 people.

I recommend that all Australian jurisdictions develop legislation, based on the Victorian model, to facilitate the return of health service governance to boards that are truly connected to the community being served.

Presenter

Trevor Carr is the Chief Executive of the Victorian Healthcare Association (VHA), an industry body representing the Victorian public hospital and community health sector. With over 80 rural members, it is imperative that the VHA keep abreast of the implications to rural health service delivery arising from macro policy change. Trevor has hands-on experience within rural health care through a previous role as Chief Executive of a rural agency delivering a broad mix of acute, primary and residential care services. Trevor has enjoyed working within the Victorian health care industry and with Boards of Governance for over 30 years.