# Joint submission by the South Australian Council of Social Service and Health Consortium partners in response to the Review of the *Health Care Act 2008*.

**August 2021**

## 1. Introduction

The South Australian Council of Social Service and our health consortium partners welcome this opportunity to provide commentary and contribute to the independent review of the *Health Care Act 2008* (HCA). It is understood that the purpose of the Review is to consider the operation of the Health Care Act 2008 (HCA), with a focus on the reforms to the governance of the South Australian public health system which commenced on 1 July 2019, including a focus on the extent to which the new governance and accountability framework has achieved its expected benefits in line with the objects and principles of the HCA.

We note that the South Australia health care system has undergone significant changes since the Act came into being in 2008, with far reaching changes having been effected more recently by the 2019 and 2021 amending legislation. While noting that the focus of this current review is on the changes to the Act as at 1st July 2019, it is also recognised that the *Health Care (Governance) Amendment Act 2021* has since been passed by the South Australian Parliament and was assented to on 17th June 2021.

Notwithstanding that the terms of reference for this Review focus on 'the extent to which the new governance and accountability framework established under the HCA on 1 July 2019 has been fit for purpose', the more recent amending legislation of 2021 and the ways in which it reinforces the changes resulting from the *Health Care (Governance) Amendment Act 2018* also remain of concern to SACOSS and our partner organisations and will be referenced in this submission.

This submission provides a summary of our key areas of concern, many of which have previously been raised in our correspondence and communications with the Minister for Health and Wellbeing, and SA Health regarding proposed amendments to the Act. These concerns are outlined in response to selected terms of reference of this Review that are of relevance to our sectoral partners, with more detailed consideration given to terms of reference 1(b); 1(c); 2; 3 and 4.

This submission notes that, in addition to the listed terms of reference established for this Review, Section 102 of the Act requires that the Review also considers '… the extent to which (a)(i) the objects of this Act have been attained; and (ii) the principles of this Act have been applied'. In addition to responding to the specific terms of reference of this Review, reference to certain objects and principles of the Act will also be made in this submission.

## 2. Reform Objectives and Terms of Reference

For ease of reference for our broader readership, the Reform Objectives of the governance of the South Australian public health system and the Terms of Reference for this Review are set out below:

*Reform objectives*
Through local level accountability and decision making, the aims of the reforms are:

- strengthened LHN performance monitoring and oversight by the Department through monitoring performance against the service agreements;
- improved clinical and corporate governance and risk management oversight within LHNs;
- improved value in terms of quality and safety of services, costs and service accessibility within LHNs;

- increased clinician and community engagement in service delivery at the local level within LHNs;
- greater service responsiveness and innovation in the way LHN services are provided; and
- better LHN health service decisions, tailored to local needs.

*Terms of Reference*
In accordance with the HCA, the Review will be undertaken by an independent person appointed by the Minister, with expertise in health care administration or health service delivery, who will prepare a report within six months of their appointment.

The Review will examine and consider:

1. The extent to which the new governance and accountability framework established under the HCA on 1 July 2019, has been fit for purpose in achieving the State Government's commitment to:
   a) devolve decision making in the public health system to the metropolitan and regional governing boards;
   b) put real responsibility and accountability at the local level, with strengthened oversight; and
   c) improve patient safety and hold governing boards accountable for delivering real progress.
2. The extent to which the new governance and accountability framework has, to date, driven progress towards achievement of the reform objectives listed above.
3. The extent to which the new governance and accountability framework achieves an effective balance between local decision-making in relation to LHNs and health system-planning, integration and management.
4. Any recommendations, through consultation with relevant stakeholders, for improvements to the current governance and accountability framework for the South Australian Health system.

## 3. Commentary in response to selected terms of reference

***Term of Reference 1(b)***
***The extent to which the new governance and accountability framework has been fit for purpose in achieving the State Government's commitment to put real responsibility and accountability at the local level, with strengthened oversight.***

The reform objectives guiding the governance of the South Australian public health system, do not appear to have a strong overarching policy reform agenda for accountability and responsibility at the local level, and the implementation of these measures appear to be more focused on monitoring quantitative indicators and administrative performance against the service level agreements, with little focus on the importance and value of accountability to the community and healthcare consumers, and in accordance with associated national and state plans which impact on the ways in which health services are required to be accountable. While the monitoring and oversight of KPIs is important, it remains unclear how responsibility for the 'bigger picture' and higher order policy issues are being kept in focus.

Accountability and its associated metrics are primarily located within each LHN's Service Level Agreement (SLA), which includes targets against which the LHNs are held accountable. The LHNs and their Boards need to ensure that the SLAs are developed in consultation with community representatives and peak bodies and with reference to the applicable standards on primary health, preventative health, health promotion, Aboriginal health, and consumer engagement to ensure inclusive non-discriminatory health care services, as well as policy and planning that is informed and influenced by evidence-based consumer and community engagement. In particular, the development of SLAs needs to be cognisant of promoting and adhering to the principles which underpin the Priority

Reforms in the SA Implementation Plan for Closing the Gap,[1] which relate to successful socio-economic development and improved health and life outcomes for Aboriginal communities. This requires that LHNs and their governing boards are not only accountable to the health service system but also to Aboriginal community-controlled organisations and the broader community.

In addition to increasing accountability to health consumers and the community, SLAs should include a requirement to specify how and when any barriers to access and inclusion arising from the fragmentation of services and/or lack of cultural or workforce competence should be measured and reduced over time. To this end, SLAs need to be made public and copies of signed agreements need to be placed on relevant SA Health websites, with any revisions or changes in strategies being explained and documented.

In the case of mental health services, the SLAs are primarily based on a limited number of national mental health key performance indicators (KPIs), with one major focus being the wait times in the emergency department. The requirement to move towards reducing involuntary inpatient treatment in mental health settings is welcomed but, in general, it seems that the SLAs – including those pertaining to mental health services – are not informed by a coherent policy reform agenda.

The policy agenda in, for example, the SA Mental Health Services Plan is complex and represents significant reform. It includes a stronger human rights focus (in line with recent World Health Organisation (WHO) guidance[2]), NGO re-design, an increased Lived Experience Workforce, and alternatives to crisis care such as provided through the Urgent Mental Health Care Centre (UMHCC), amongst others. There is a strong evidence base for the effectiveness of each of these initiatives. Evaluations and data from these initiatives, in the event that they are implemented, will in all likelihood, demonstrate their value from the perspective of delivering more efficient and effective mental health supports than those provided in traditional hospital settings.

The SA Mental Health Services Plan was developed with input from a range of stakeholders including strong input from consumers and carers. Anecdotal evidence suggests that responses to the Mental Health Services Plan are not uniform, with it being strongly criticised by senior LHN staff and concerns being raised that it will not affect emergency department (ED) wait times, including the wait times at the UHMCC. The UMHCC has only been operating for a few months but it is clear already that people using the service value it as a much better alternative to attending emergency departments, with reduced associated stress and trauma. A specific Philosophy of Care was developed through a co-design process to guide the culture of how people want to be treated in this new service.

In terms of mental health reform, the limited reform objectives of the Health Care Act do not provide balanced guidance for governance actors to deliver better services in line with modern understandings and more progressive approaches. The lack of reference in the reform objectives to human rights obligations (for example, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the Optional Protocol to the Convention Against Torture (OPCAT)) is a significant omission. Similarly, there is no emphasis on adopting updated approaches (or a consideration of

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[1] *South Australia's Implementation Plan for the National Agreement on Closing the Gap*, accessed at https://www.dpc.sa.gov.au/responsibilities/aboriginal-affairs-and-reconciliation/closing-the-gap/south-australias-implementation-plan/South-Australias-Implementation-Plan-for-Closing-the-Gap.pdf

[2] World Health Organisation, 2021, *Guidance On Community Mental Health Services*: *Promoting person-centred and rights-based approaches*, accessed at https://www.who.int/publications/i/item/9789240025707?search-result=true&query=Guidance+on+community+mental+health+services:+Promoting+person-centred+and+rights-based+approaches&scope=&rpp=10&sort_by=score&order=desc

guidance from WHO) about how to deliver better human rights outcomes in mental health. The lack of high-level guidance or principles essentially means that we risk prioritising the wrong health goals.

We would welcome the LHN Boards having an increased function and responsibility to ensure a focus on broader health promotion, disease prevention, primary health, and Aboriginal health care in their local areas – the functions as currently framed in the Act are very hospital-centric and curtailed by a narrow auditing accountability framework. To this end, and aligned with the Department's stated commitment to consumer and community engagement, and to accountability, the current governance arrangements and the development of SLAs would be improved by all Boards having at least one designated and supported position allocated to a community member with lived experience and a consumer perspective.

***Term of Reference 1(c)***
***The extent to which the new governance and accountability framework has been fit for purpose in achieving the State Government's commitment to improve patient safety and hold governing boards accountable for delivering real progress.***

While it needs to be acknowledged at the outset that SA Health and its associated institutions and services are to be commended for the state's response to managing the Coronavirus pandemic and that this has placed additional pressure on health services, there are a number of concerns about whether and the extent to which patient safety has been improved and governing boards are being held accountable for delivering progress.

In considering whether the new framework is fit for purpose in terms of patient safety and accountability, it is necessary to also focus on the arrangements that existed prior to the HCA reforms and to consider the functions and relationships that previously existed and which played an important role in patient safety but that have been lost as a result of the reforms.

Given that the reforms of the South Australian health system (informed by earlier initiatives such as the McCann Review[3] and subsequent restructuring exercises) and the introduction of the LHNs and their governing boards have resulted in much of the primary focus being on tertiary health and hospital-based services, there has been a shift away from community-based health services, chiefly provided by community health centres. This is having a significant impact on patient safety, which has been compromised as a result of services being truncated, relocated and becoming less user-friendly and accessible. These community health centres played a crucial community development role in performing both their disease prevention and health promotion functions as well as addressing a range of the social determinants of health[4] that impact on people's health and wellbeing, such as adequate housing, employment and social connection. Despite the value and successes of these centres and their contribution to patient wellbeing and safety, they no longer exist under the new governance arrangements and their functions have not been appropriately adopted by the LHNs, with a few centres

[3] Government of South Australia, 2012, Review of Non-Hospital Based Services - A Report by Warren McCann, Internal Consultant, Office of Public Employment and Review, accessed at http://www.cpsu.asn.au/upload/Campaign/nonhospital-report-PHCS-20121203.pdf

[4] See:
Marmot, M. 2017. 'The health gap: Doctors and the social determinants of health', in Scandinavian Journal of Public Health Volume: 45 issue: 7, pp. 686-693, accessed at https://doi.org/10.1177/1403494817717448;
Brown, L., Thurecht, L. and Nepal, B (2012) The Cost of Inaction on the Social Determinants of Health, National Centre for Social and Economic Modelling NATSEM, Canberra; and
World Health Organisation (WHO), 2010, A Conceptual Framework for Action on the Social Determinants of Health, Geneva, accessed at https://www.who.int/publications/i/item/9789241500852

now operating as hospital out-patient departments, providing direct client care and dealing with people who are ill. Their work in disease prevention and health promotion has been significantly downplayed.[5]

Many of these community health centres played an important role in reaching people who had otherwise experienced health services as culturally unfriendly, as formal and intimidating institutions, and where they did not feel safe to discuss their health needs. In particular, these centres reached the more disenfranchised groups in society, including people who were homeless, those with low incomes, women escaping domestic violence, recent migrants, and Aboriginal and Torres Strait Islander people. The loss of the centres has resulted in a decrease in patient safety and wellbeing, with many people avoiding the current health services and clinical institutions. The availability of community health services is integral to patient safety because they offer outreach and a way to reach people who otherwise would not seek health care.[6]

More holistic, accessible and community-based services, such as those previously provided through the community health centres, would save the health system a significant amount of money because they prevent the use of hospital emergency departments down the line when people's health issues are not addressed and turn into emergencies. There is ample evidence which indicates that when people do not have an accessible and user-friendly community health centre to drop into or to find support, their needs are compounded and acute health issues can quickly develop into more serious and costly chronic health problems.[7]

The cutting of community health services and the restructuring of the health system through the establishment of LHNs may have resulted in short-term savings to the health budget but, in the longer term, is likely to increase levels of health care service demand and the pressure on already stretched health budgets – cuts to accessible community health programs serve to increase the pressure on the hospital system. This situation is jeopardising patient safety in a number of ways.

In addition to patient safety being compromised as a result of the reduction on community-based and accessible services, recurrent cost-shifting exercises, and increasing pressure being placed on hospitals and emergency departments, the current crisis in ambulance ramping and 'bed blocking' in hospitals is a case in point. There are repeated media reports[8] and commentaries provided by the South Australia Ambulance Service (SAAS) and the Ambulance Employees Association, which highlight concerns about ambulance ramping and the extent to which patient safety and health is jeopardised, partly due to increased pressures placed on emergency departments.

As at May 2021, data released by the SA Ambulance Service indicates that the hours lost while ambulances were ramped outside South Australian hospitals had reached the worst level in 18 months, with patients and crews spending a total of 2,281 hours ramped during February; thereby posing significant risks to patient safety.[9]

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[5] Baum, F., Freeman, T., Lawless, A. and Jolley, G. 2012. 'Community development: Improving patient safety by enhancing the use of health services', Australian Family Physician. Royal Australian College of General Practitioners, 41(6), pp. 424–428, accessed at https://search.informit.org/doi/10.3316/informit.409076493207533

6 Baum et al. 2012 https://search.informit.org/doi/10.3316/informit.409076493207533

[7] Baum, F. 2013. 'A backward step for community health in South Australia' in The Conversation, October 15, 2013, accessed at https://theconversation.com/a-backward-step-for-community-health-in-south-australia-18889

8 InDaily, Wednesday, 24 February 2021. 'Blame game heats up over SA ambulance ramping' accessed at https://indaily.com.au/news/2021/02/24/blame-game-heats-up-over-sa-ambulance-ramping/

[9] ABC News Report, Posted Fri 7 May 2021, *Statistics reveal thousands of hours lost to ramping outside SA hospitals accessed at https://www.abc.net.au/news/2021-05-07/sa-ramping-statistics/100125640*

By way of example, on 22 February 2021, all metropolitan hospitals went 'code white'[10], with 88 patients waiting for a bed and 15 ambulances ramped at the Royal Adelaide Hospital. A similar scenario was reported[11] on 17 May 2021 when 17 ambulances were ramped at the Royal Adelaide Hospital, no ambulances were available in Whyalla and that, for the second time in May, the number of people waiting for a ward bed while waiting in emergency departments hit a record figure of 139 patients, with 65 of these patients waiting for between eight hours to more than 24 hours.

A large part of the ramping problem is caused by 'bed-block' inside hospitals and emergency departments. According to the Australian Nursing and Midwifery Federation[12], both doctors and nurses have been vocal in calling for more resources to help alleviate the pressure and to address the widespread fatigue among LHN staff who are called upon to do extra shifts and overtime in both country and metropolitan areas in order to respond to demand.

While these increasingly frequent occurrences of ramping, over-stretched staff, and 'bed-block' inside hospitals and emergency departments can, in a narrow sense, point to a weakness in the local governing board's responsibility for improving patient safety and delivering 'real progress', there are a number of factors beyond the governing boards' control – such as the availability and provision of ambulance services, as well as the state-wide budget allocations for staffing and resourcing, both of which are outside their immediate jurisdiction and responsibility. This highlights the importance of recognising that each LHN and its functions and operations are inter-dependent and inter-connected with a range of other health services and environmental conditions and that LHNs and their governing board should not be treated as atomised and self-contained units whose performance can be measured in absolute terms, and in the absence of understanding performance and accountability in a broader service-wide context. The new governance structure of the LHNs places responsibilities and accountabilities on the individual governing boards for a range of factors that are beyond their control – this remains an inherent flaw in the decentralised governance arrangements and, potentially, points to a deflection of accountability and responsibility on the part of the overarching state healthcare service.

Having provided commentary on Terms of Reference 1(c) above, this submission also notes the principles of the Act and its Section 5(i) which states that 'recognition should be given to the fact that there is a significant public benefit in having a single emergency ambulance service that provides an efficient use of assets, a highly-responsive service, and high levels of integration with other health services provided within the public health system'. In order for this public benefit to be realised and maintained, it is essential that the ambulance service is not hampered by blockages occurring at hospital sites. Given the commentary and examples cited about the ongoing challenges experienced by the ambulance service in South Australia, it would appear that principle 5(i) of the Act has been lost sight of and requires further attention if patient safety is to be improved and governing boards are to be held accountable for delivering real progress.

***Terms of Reference (2)***
***The extent to which the new governance and accountability framework has, to date, driven progress towards achievement of the reform objectives listed above.***

In response to the reform objectives of 'increased … community engagement in service delivery at the local level within LHNs' and 'greater service responsiveness and innovation in the way LHN services are

[10] Code white is SA Health's highest rating for the level of pressure on a hospital, indicating services and patient safety could be compromised by the situation.
[11] InDaily, 18 May 2021, *Ambulance shortages amid more ramping and ED crowding,* accessed at https://indaily.com.au/news/2021/05/18/ambulance-shortages-amid-more-ramping-and-ed-crowding/
[12] InDaily, 18 May 2021, *Ambulance shortages amid more ramping and ED crowding,* accessed at https://indaily.com.au/news/2021/05/18/ambulance-shortages-amid-more-ramping-and-ed-crowding/

provided and … tailored to local needs', the following points are provided for the Review panel's consideration.

A number of our health sector partners have highlighted that the existing attempts at 'community engagement' are insufficiently far-reaching. While the National and Quality Healthcare Standard Two references the importance of partnering with consumers and that increasingly in mental health services there are calls for and a recognition of lived experience as a key enabler for change, these factors are not provided for or detailed in the Health Care Act or the functions and practice of LHNs, albeit that very useful guides currently exist to support the establishment of these practices.[13] Models of Lived Experience based on research and co-designed with the lived experience community in SA offers solutions for LHNs, government and other agencies to progress and meaningfully partner with consumers and carers and be responsive to their needs.[14]

In particular, this submission responds to the reform objectives of 'community engagement' and 'service responsiveness' in relation to the principle outlined in 5(b) of the Act that 'Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures', and in 5(f) that 'health services should be provided as part of an integrated system (iv) that supports improved health outcomes for communities with particular health needs', and (iv a) (as per the 2021 amendment) 'that is inclusive of … Aboriginal and Torres Strait Islander health services …'.

This submission highlights concerns relating to the realisation of the reform objectives associated with levels of community engagement and service responsiveness, as well as the principle that recognition and respect be given to Aboriginal heritage and culture. In addition, attention needs to be given to revisiting SLAs and partnerships with Aboriginal health services and community-controlled organisation in accordance with the principles of the SA Implementation Plan for Closing the Gap.

Both the inequity of and the disparities in population health and of health outcomes between Aboriginal and non-Aboriginal South Australians has been the subject of extensive research, and which highlights that the consequences of institutional racism and discrimination have serious effects on Aboriginal health outcomes. This research characterises the nature of the health services and indicates the link between institutional racism in the delivery of these services and the low levels of access to health services by Aboriginal and Torres Strait Islander peoples in South Australia.[15]

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[13] Loughhead, M, Hodges, E, McIntyre, H, and Procter, NG 2021, *A Roadmap for strengthening lived experience leadership for transformative systems change in South Australia*, SA Lived Experience Leadership and Advocacy Network and University of South Australia, Adelaide, at https://www.lelan.org.au/wp-content/uploads/2021/08/ALEL_digital_linked.pdf

[14] Hodges, E, Loughhead, M, McIntyre, H, and Procter, NG 2021, The Model of Lived Experience Leadership. SA Lived Experience Leadership and Advocacy Network and University of South Australiahttps://www.lelan.org.au/wp-content/uploads/2021/08/Model-of-Lived-Experience-Leadership_ALEL-Project.pdf

[15] These various research studies highlight, for instance, that the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 reported evidence that 'racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people' (Awofeso, N. 2011. 'Racism: a major impediment to optimal Indigenous health and health care in Australia'. *Australian Indigenous Health Bulletin*, volume 11, number 3. As cited in: Australian Government. 2013. National Aboriginal and Torres Strait Islander Health Plan 2013–2023), and recognised that work needed to be done to 'address systemic racism within the health system' (Australian Government. 2013. National Aboriginal and Torres Strait Islander Health Plan 2013–2023).

The initial 2008–2010 health system review conducted by the Health Performance Council (HPC) found that Aboriginal health outcomes were 'unacceptable' with 'limited access to services perceived by Aboriginal people to

The need for work to investigate institutional racism in South Australia's health system has become a recurring theme, both prior to the timeframe of this review and since July 2019 when the amended Act came into effect. The Health Performance Council's (HPC) four-yearly statutory report for 2015–2018 [16] to the Minister for Health made a number of recommendations for Ministerial action to recognise, reflect and address the needs and expectations of the communities who are served, working towards ensuring the health workforce also reflects the communities served, and on practising zero tolerance for discrimination and racism. The SA Health Department and Government's response[17] to this four-yearly report, made no comment on several of the HPC's recommendations, which had included the need to undertake workplace audits on institutional racism and discrimination; increase the recording of Aboriginal identification in the health system; monitor and report on the mix of skills in Local Health Network Governing Boards; and require Aboriginal representation on Governing Boards.

The Health Performance Council's 2019 post-implementation review of what was then Country Health SA's[18] Aboriginal Community Consumer Engagement Strategy, revealed considerable evidence of racism and prompted the Council to provide advice to the Minister to 'Identify and, as necessary, tackle any systemic racism and the actual or perceived tendency of staff to the disregard of Aboriginal issues'[19]. The Government's response to this review points to the current Review's key term of reference and the extent to which the new governance and accountability framework established under the HCA on 1 July 2019, has been fit for purpose in achieving the State Government's commitment to: 'devolve decision making in the public health system to the … regional governing boards, and put real responsibility and accountability at the local level, with strengthened oversight'. It would appear that a number of the regional Local Health Networks (LHNs) that previously fell under Country Health SA, have not necessarily been responsible and accountable at the local and regional level in responding to concerns raised regarding Aboriginal interests and institutional racism across regional health services.

While it is acknowledged that SA Health has a range of Aboriginal-specific services across the State as well as community health services and Aboriginal Community Controlled Health Services across regional South Australia and in Adelaide – such as Watto Purrunna Aboriginal Primary Health Care Service (northern and central regions), the Pangula Mannamurna Aboriginal Corporation in Mount Gambier,

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be culturally appropriate and relevant to their needs' (Health Performance Council [South Australia]. 2010. *Reflecting on Results — Review of the Public Health System's Performance for 2008-2010*.
Two substantial reviews undertaken by the HPC of Aboriginal health and the health system's response to it recommended the need to 'reduce and remove perceived and real institutional racism towards Aboriginal people within the health system' (Health Performance Council, SA. 2014. *Aboriginal Health in South Australia 2011-2014: A Case Study*, and 2017. *Aboriginal health in South Australia 2017 case study)*.
See also: C J Bourke; H Marrie; A Marrie. 2018. 'Transforming institutional racism at an Australian hospital'. *Australian Health Review*, volume 43, issue 6. DOI: 10.1071/AH18062

*[Please note that many of the HPC Reports are no longer available as the Health Performance Council's website has been de-commissioned and/or key reports are no longer publicly available.]*

[16] Health Performance Council [South Australia]. 2018. *Review of the performance of South Australian health systems, the health of South Australians and changes in health outcomes over the reporting period 2015-2018.* Previously available at https://www.hpcsa.com.au/reviews/2015-2018-report
[17] Department for Health and Wellbeing, Government of South Australia. 2019. *SA Health's formal response to the Health Performance Council's four-yearly review.* Previously available from https://www.hpcsa.com.au/reviews/2015- 2018-report.
[18] It is noted that as at 1 July 2019, Country Health SA transitioned to six new regional local health networks (LHNs) and the Rural Support Service.
[19] Health Performance Council [South Australia]. 2019. *Post-implementation review of Country Health SA's Aboriginal Community & Consumer Engagement Strategy.* No longer available from HPC website – formerly available at https://www.hpcsa.com.au/reports/postimplementation-review-of-country-health-sas-aboriginal-community-and-consumer-engagement-strategy

and Aboriginal Health Services at Noarlunga and Clovelly Park, amongst others – the mainstream services in many regional areas and regional LHNs appear to be uneven and, at times, unresponsive to the ways in which institutional racism and the lack of cultural competence impact on Aboriginal health consumers.

In mid-2019, the HPC undertook an audit to measure and report on institutional racism in South Australia's health system, with particular reference to any disparities for Aboriginal people. A central purpose of the audit and its measurement framework is that it creates an entry point for engagement and as a prompt for improvement. In particular, the application of the auditing matrix framework enables hospitals and health care services to identify and work towards reducing institutional racism and produce better health outcomes. The initial audit of institutional racism, conducted by the Health Performance Council (2020), found that nine of the ten geographic Local Health Networks in South Australia was assessed as having 'very high evidence of institutional racism', with the Women and Children's Health Network assessed as having 'moderate evidence of institutional racism'.[20]

The apparent lack of engagement and response on the part of the Department and the Minister for Health and Wellbeing to address institutional racism and the health interests and outcomes of Aboriginal South Australians illustrates a failure to adhere to or implement key objects and principles of the Act, including, amongst others, Object (4)(a): *to enable the provision of an integrated health system that provides optimal health outcomes for South Australians;* as well as the following principles of the Act: (5)(b)*Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures;*
(5)(f) *health services should be provided as part of an integrated system (iv) that supports improved health outcomes for communities with particular health needs*; and
(5)(h) *service providers should seek to engage with the community in the planning and provision of health services*.

In light of the above critique of the repeated calls for the needs of Aboriginal health consumers to be appropriately responded to and for institutional racism to be addressed, it would appear that a contrary finding is to be made regarding the Review's terms of reference regarding 'the extent to which the new governance and accountability framework … has been fit for purpose in achieving the State Government's commitment to responding to: *Any recommendations, through consultation with relevant stakeholders, for improvements to the current governance and accountability framework for the South Australian Health system.'* It appears that the Department has not been responsive to key recommendations made by stakeholders for improvements to the governance and accountability framework, including those which address institutional racism, despite their repeated and documented efforts.

***Term of Reference (3)***
***The extent to which the new governance and accountability framework achieves an effective balance between local decision-making in relation to LHNs and health system-planning, integration and management.***

As indicated in the examples cited in the commentary provided under term of reference (1c) above, there appears to be a lack of effective balance between local decision making and the broader health system-planning, integration and management. While the locus of considerable decision-making and accountability has been devolved to the LHNs and their governing boards, insufficient recognition is given to the broader socio-economic and structural factors – many of which are state-wide, if not national in their nature – that impact at the local level and for which LHNs have little responsibility or

[20] Government of South Australia, Health Performance Council, September 2020, *Institutional racism: Audit of South Australia's Local Health Networks* https://apo.org.au/sites/default/files/resource-files/2020-09/apo-nid308045.pdf

ability to control. A more holistic and integrated approach is required if health services are to be optimised.

Some of the content of local decision-making may be considered 'micro-level' and localised and can be undertaken at a local level, but much of it requires a more dynamic interplay between the LHNs and the state systems of planning and management. The current governance and accountability framework appears to reinforce somewhat static, siloed and compartmentalised approaches, with little integration or a whole-of-health systems approach.

With the devolution of decision-making to LHNs, and the ongoing need for co-ordinated health system-planning, integration and management, the ability of the health system to develop a whole-of-health-system approach is made all the more difficult. While the establishment of LHNs may enable a more responsive approach to local health needs and dynamics, the decentralisation to LHNs may serve to atomise the ability to undertake health system planning, integration and management at a higher and whole-of-system level.

***Term of Reference (4)***
***The extent to which the new governance and accountability framework achieves consultation with relevant stakeholders, for improvements to the current governance and accountability framework***

This Review's terms of reference indicate a consideration of whether the new devolved governance arrangements enable a consideration of 'any recommendations, through consultation with relevant stakeholders, for improvements to the current governance and accountability framework for the South Australian Health system'.

It is noted that, under the *Health Care (Governance) Amendment Act 2021*, section 5(f) requires that the Chief Executive is 'to engage with consumer representatives and other interested parties in the development of health care policy, planning and service delivery'. However, it remains unclear as to what the mechanisms are for this to occur.

The previous mechanisms through which such engagement with consumer representatives and other interested parties could occur have been considerably curtailed. SACOSS and our endorsing partners note the attempts over time to reduce structures and mechanisms for consultation, engagement, independent oversight and the role of independent safeguarding bodies. This is evidenced by the Department ceasing funding to the Health Consumers' Alliance and the consequent decision being taken to dissolve the Alliance in September 2020 and, more recently, by the expressed intention to dissolve the Health Performance Council in the *Health Care (Governance) Amendment Bill 2020* which proposed the dissolution of the Health Performance Council (Clause 8 – Repeal of Part 3 – Health Performance Council).

*Independent state-wide research and data analysis*
While it is appreciated that the Health Performance Council (HPC) continues to exist, we remain concerned about the extent of its scaled back resourcing and the extent to which this will limit its capacity to provide independent and publicly responsive and available research and data analysis.

We trust that the HPC will be well-resourced to provide independent monitoring, data analysis and reporting, and provide support to community and consumer engagement initiatives and mechanisms. The data that has previously been routinely collected and stored by the HPC has proved to be a valuable resource and could be used even more effectively and transparently to inform both clinicians and consumers and enable the scrutiny and accountability of system performance, and the examination of the efficacy of care across the state and for different user-groups.

We believe that an accessible and reliable evidence-base in the form of high-quality information and data analytics will contribute to the design and implementation of sound health policy and implementation strategies, informed by consumer engagement and input.

*Representation of health consumers*

South Australia is the only jurisdiction in Australia which does not have government support for State-wide health consumer advocacy. With the dissolution of the Health Consumers Alliance in 2020, South Australia no longer enjoys the benefits of health policy and service delivery being informed by independent, systematised health consumer advocacy.

Under the current governance arrangements, the LHNs are expected to be responsible for consulting with consumers and the community. While this may occur in a piecemeal and ad hoc manner, the changed governance structures and responsibilities have meant that independent health consumer contributions, advocacy, lived experience and input is not ensured or facilitated; there are no clear mechanisms that ensure that independent state-wide consumer and community input can inform state-wide health policy, more so in the absence of active and broad-based consumer and community consultation and engagement; and there is an absence of foundational training and information sharing that enable health consumers to contribute and engage with health services.

The current status of community and health consumer engagement appears to be siloed and, at best, based on separate LHN consumer registers and complaints processes rather than consumer engagement being viewed as an integral part of healthcare provision. There appears to be little or no opportunity for consumers to communicate, share information or collaborate across the localised LHNs.

There are a number of inherent dangers in health care systems that do no incorporate or value input from those whom the system is supposed to serve, namely, health care consumers. It appears that there is reduced consumer representation on state-wide decision-making committees, with limited and ad hoc community and consumer input being included in health policy development. This arrangement undermines the potential for the Minister or Chief Executive Officer to access advice on emerging health issues and the identification of any risks that could pre-empt possible threats to services and patient safety.

In the absence of a recognised health consumer body, the ability of the health service system under the new governance and accountability framework to engage and consult with relevant stakeholders and the broader community of health consumers is being significantly undermined. As a result, South Australia's health services are becoming less than optimal. In the absence of community engagement and input, 'services are less coordinated, less grounded in the realities of people's lives and thus less effective and less desirable (Fay Fuller Foundation p. 100)'.[21]

The persistent inequities that are evident across the health care system and the lack of inclusivity of community consumer voices regarding their health experiences and outcomes, primarily as a result of the absence of community engagement mechanisms, as well as the absence of the active collection of data from consumers and their families/carers, remains a worrying vacuum in the new governance structure. We believe there would be significant benefit in the formation of a community representative and advisory body to be established in order for state-wide consumer interests to be heard and to inform state health policy and service delivery.

[21] Fay Fuller Foundation 2018, *Health Needs and Priorities in South Australia – Gathering a Stakeholder Informed Evidence Base,* accessed at https://www.fayfullerfoundation.com.au/knowledge-centre/health-needs-and-priorities-in-south-australia/

## Concluding remarks

It is evident that there is a continuity in the many challenges faced by health care consumers and the health service system that existed prior to the decentralisation of the system to LHNs and that persist under the new governance arrangements. These are persistent and systemic issues that cannot be fixed through structural adjustments and re-allocating governance responsibilities – they run far deeper and point to issues of social inequality, the social determinants of health and the locus of the burden of disease. To address these issues will require fundamental change that goes beyond the purview of SA Health, the Minister for Health and Wellbeing, and the provisions of the Health Care Act. However, these issues do need to be situated within the frame of improving the health and wellbeing of all South Australians, and necessitate an approach to health care that is preventative and focuses on primary health care, rather than an over-emphasis on hospital-centric services, as evidenced by the recent State Budget, with the bulk of health funding allocated to the tertiary end of health care provision with limited resources directed toward health promotion, preventative and primary measures.

There is a great deal that the health services system could and should do within its current resources to better address some of the important issues in health that we have raised in this submission – such as racism and discrimination, human rights outcomes, the social determinants of health, and the inclusion of community and consumer voices. The Health Care Act (and other key drivers for good governance) need to be strengthened to ensure a more balanced context to guide governance and accountability. One way to improve this would be to embed a principle requiring impactful consumer input so as to encourage co-design, co-production and other innovations to ensure that community and consumer voices are heard at all levels. Other examples are the inclusion of high-level principles that would then require consideration when governance actors are attempting to address difficult challenges. Examples include the adoption of principles about equity, adherence to the core principles in the Closing the Gap Agreement and Implementation Plan, as well as the inclusion of a suite of principles that underpin human rights outcomes and the implementation of our international obligations. If key guiding documents for governance such as the Health Care Act contained principles such as these, it would create a more balanced environment which would proactively require governance actors to innovate, problem solve and generate efficiencies in ways that deliver on the broader outcomes required of a modern health system.

In conclusion, we remain concerned that the restructuring of the health care system through decentralised LHNs has reduced the ability of the health system to direct broad-based systemic change or the application of programs and services across the system in a more dynamic and responsive manner, and that the system is in danger of becoming increasingly compartmentalised and siloed at a local level while the bigger-picture policy imperatives are in danger of being lost.

SACOSS and our partner organisations would like to see a more collaborative approach to developing and designing health care service systems and policies, as well as addressing challenges facing the health budget and the associated governance and accountability mechanisms, and which take into proper account the social determinants of health and the real drivers of health costs. Failure to do this will jeopardise patient safety and wellbeing and will inevitably mean the continued spiralling of health costs and worse health outcomes for the South Australian community.

**Endorsing partners:**
Aboriginal Health Council of SA
Lived Experience Leadership & Advocacy Network
SA Network of Drug and Alcohol Services
Australian Health Promotion Association SA
Mental Health Coalition
Occupational Therapy Australia
Public Health Association of Australia SA
South Australian Council of Social Service.