Government of South Australia
Office of the Guardian
for Children and Young People

Response to SA Health

Non-Hospital Based Services Review

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To: Health System Development Division, SA Health

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1. Introduction

1.1 Among other statutory functions, the Guardian for Children and Young People acts as an advocate for the interests of children and young people under the guardianship, or in the custody, of the Minister for Education and Child Development. The Guardian also advocates for young people in youth training centres and promotes good information sharing among agencies to protect the safety of children and young people. It is in this capacity that the following submission is made.

1.2 This submission is prepared on the basis of the Office's experience in advocating for children and young people, monitoring the provision of services, talking with young people about their experiences and with other experts in the provision of care and services. Thank you for the opportunity to comment on the proposed changes to non-hospital based health services in SA.

2. General

2.1 In the context of grave budgetary constraints the requirement to allocate scarce public resources to the most effective public services is pressing. In health expenditure the decisions are not only among 'like' services but also among unlike services. The reality is that decisions are made between tertiary and primary health services, or to simplify it, between a highly specialised medical employee in a hospital delivering services to patients in acute need and a small team of community based health professionals and para-professionals delivering services to people in non-acute need as a preventative measure.

The **risk in eroding primary health care services is that the demand on tertiary services in hospitals escalates, and the expense per person likewise rises.** The review report acknowledges this with, "…it would be self defeating at best to disinvest in those programs which are contributing to [reductions in inpatient activity]." (p.14)

2.2 The second major contextual consideration is the future of the Commonwealth government in the delivery of primary health care services. It is evident that the Commonwealth government sees that it has a major role in planning, integration and funding of primary health care services but has not as yet made a strong commitment to delivering services.[1] Again, the review report accepts that the more likely scenario in the foreseeable future is that "… the State will continue to be responsible for both the funding and provision of a significant part of the primary health care spectrum…" (p.6)

[1] The Commonwealth government is also not yet meeting its commitment of financing 50 per cent of public hospital funding. In SA, the Commonwealth contribution is now 38 per cent. The arrangement between Commonwealth and States is dynamic, as is the revenue source and total.

In this period of uncertainty about which level of government will emerge as the major *provider* of primary health care services **it is important that a vacuum is not created by premature withdrawal or curtailment of primary services**.

Negotiation with the Commonwealth government, and specifically with Medicare Locals, should precede decisions to close programs.

2.3 The recommendations about programs were partly based on evaluation of each program's delivery on the goals of hospital avoidance and management of chronic disease. These criteria are not sufficient to judge a program's effectiveness in improving population health.

3. Youth Primary Health Services

3.1 The proposed changes to organisational structures, in creating a single metropolitan service with greater emphasis on outreach, are expected to create some benefits in reducing overhead costs. **An outreach service for young people is also often beneficial.** In creating a stronger 'hub-and-spoke' service delivery model, it is important though that the 'hub' is well enough resourced to ensure effective support and clinical service to the 'spokes' and to provide accessible direct service to people who want more privacy about their use of particular health services.

3.2 If the changes are implemented it will also need to be acknowledged that there will be a consequent reduction in accessibility for young people from Western and Eastern metropolitan regions and no improvement in accessibility to youth primary health service for those in country regions.

3.3 The policy objective of providing public health services to *vulnerable* young people is a good use of public money, where alternative health providers exist. In recent years the state-funded youth primary health services have targeted services to the most vulnerable. This has been evident to the Office of the Guardian in the improved accessibility of services to young people who are, or have been, under the guardianship of the Minister.

The risk in narrowing definitions of 'vulnerability' (and associated eligibility) to their cultural or legal status (in lawful detention or under the Minister's guardianship) is that young people who are *more* vulnerable are excluded. While there are many benefits in targeting the *promotion* of services to defined groups, the assessment of vulnerability and need is best done with more refined tools.

The 'performance' question is less one of 'how many young people who are under guardianship did you provide a service to?' and more one of 'how many vulnerable young people using your service were under guardianship?' **In and of itself, being under guardianship is *not* a risk factor.** Indeed, young people who are in care[2] and the adults who support them are intent on making it as secure and safe

[2] The use of the term 'in care' is often used in preference to the more formal and sometimes stigmatised term of 'under guardianship of the Minister'.

(and normal) as possible. A disproportionate number may have multiple high-risk behaviours in their adolescence but it is harmful to label all out of home care experience as a high risk factor.

Within the 'in-care' population group, there are sub-groups whose health needs are more likely to be complex and chronic, notably those in unstable care (recent and frequent changes of placement), those living in residential or emergency care for long periods of time and those who have multiple admissions to the youth training centres. Equally, those young people who have unstable housing and family support, and frequent stays in homelessness services or training centres, but who are not under guardianship, are very likely to have chronic health needs.

3.4 The proposed savings targets are based on narrowing the target population from 12-25 years to 12-19 years. This is likely to have a significant adverse impact on young people who are leaving care. All other public policy for this group is moving the other way, that is, to extending responsibilities beyond 17 to at least 21 years and, more often, to 25 years of age.[3] This recognises that **age alone is a poor indicator of readiness to live independently or engage with adult services**, and that 18 – 20 is too sudden for a cut-off age.

3.5 The proposed budget cuts of 36.7 per cent and the three per cent efficiency dividend are based on assumptions of fewer episodes of service (fewer clients) and the same intensity of service. However, heightened targeting also means heightened intensity of service and **any savings targets must be realistic about the real cost of providing *effective* service, not just a service**.

3.6 A more effective and cost efficient way forward is to have a single metropolitan youth health service which demonstrates:

- Delivering services to the most vulnerable young people within the age range of 12-25 years.
- Positive health outcomes for its young clients which avoid hospitalisation and chronic disease, *and* demonstrate improvements in mental and physical health.
- Service delivery models based on evidence of effectiveness.
- Collaborates with related services such as CAMHS, Families SA, Yarrow Place Youth Service and non-government youth services.
- Contributes to the priorities of government.

3.7 Decisions made about youth health services will **have a significant impact on other programs and government priorities**, such as improvements in child protection and reducing risk among vulnerable young people. For this reason,

[3] See for example, National Framework for Protecting Australia's Children (2011) *Transitioning from out-of-home care to Independence: A Nationally Consistent Approach to Planning* www.fachsia.gov.au/our-responsibilities/families-and-children/publications

among others, a more effective review would be conducted by a group who rely on the youth health services, who would assess delivery options, evaluate effectiveness and consider interaction with other areas of public policy and programs.

4. Children's Primary Health Services

4.1 The recommendation to *not* reduce funding to children's primary health services at this time is good and recognises the considerable benefit in providing services early in the life of a child, by assisting families who otherwise would not get such help.

4.2 However, it raises the question of **why the arguments used here for retaining the services in full do not apply to youth health services**. Both target people who are not eligible for, cannot afford or experience other barriers to other services, both provide early intervention to prevent chronic disease and disadvantage in future years, and both experience high demand. The only differences appear to be the structural changes underway in the child health area and government priority to early childhood development.

5. Child Protection Services

5.1 The review also defers any recommendations of budget savings from the two child protection services (CPS) based at Women's and Children's Hospital and Flinders Medical Centre. This recognises the need for more detailed work on configuration of these services. **A review of Child Protection Services is overdue** because there are too many unanswered questions about why the models of service delivery are different and whether resource allocation is fair. To outsiders, the decisions appear to be based only on different histories and governance, rather than on demonstration of effectiveness.

5.2 The review of Child Protection Services will need to consider its interaction with other parts of the child protection system because the purpose of CPS is to provide an essential service (assessments and therapy) for children who have suffered abuse or neglect. In other words it is an integral part of a broader approach to child safety, and does not stand alone in its delivery of a child health program.

6. Final remarks

6.1 While it is necessary to consider all feasible options for restraining spending when expenditure growth in health is well beyond what the state can afford, it is also necessary to think through the consequences of where the restraints are imposed. The evidence for investing in certain primary health services as a cost-saving measure over time is clear.

6.2 Concurrent with the review of non-hospital based health services is the review and planning for improved services to families, where children are at risk. **Decisions about where budget savings are made in the health portfolio will have**

significant implications for the effectiveness and feasibility of reform in the child protection and wellbeing area.

6.3 If the Office can be of further assistance in either clarifying or expanding on the comments above please contact Pam Simmons, Guardian. It is the Office's practice to make its submissions available to the public. Please let the Guardian know if you have any concerns about this.